An act relating to the Agency for Health Care Administration; amending s. 409.904, F.S.; providing for the agency to pay for health insurance premiums for certain Medicaid-eligible persons; providing for the agency to pay for specified cancer treatment; providing Medicaid eligibility for certain disabled persons under a Medicaid buy-in program, subject to specific federal authorization; directing the Agency for Health Care Administration to seek a federal grant, demonstration project, or waiver for establishment of such buy-in program, subject to a specific appropriation; amending s. 409.905, F.S.; prescribing conditions upon which an adjustment in a hospital's inpatient per diem rate may be based; prescribing additional limitations that may be placed on hospital inpatient services under Medicaid; amending s. 409.906, F.S.; providing for reimbursement and use-management reforms with respect to community mental health services; revising standards for payable intermediate care services; authorizing the agency to pay for assistive-care services; amending s. 409.908, F.S.; prohibiting nursing home reimbursement rate increases associated with changes in ownership; modifying requirements for nursing home cost reporting; requiring a report; revising standards, guidelines, and

limitations relating to reimbursement of Medicaid providers; amending s. 409.911, F.S.; updating data requirements and share rates for disproportionate share distributions; amending s. 409.9116, F.S.; modifying the formula for disproportionate share/financial assistance distribution to rural hospitals; amending s. 409.91195, F.S.; requiring the Medicaid Pharmaceutical and Therapeutics Committee to recommend a preferred drug formulary; revising the membership of the Medicaid Pharmaceutical and Therapeutics Committee; providing for committee responsibilities; requiring the agency to publish the preferred drug formulary; providing for a hearing process; amending s. 409.912, F.S.; authorizing the agency to establish requirements for prior authorization for certain populations, drug classes, or particular drugs; specifying conditions under which the agency may enter certain contracts with exclusive provider organizations; revising components of the agency's spending-control program; prescribing additional services that the agency may provide through competitive bidding; authorizing the agency to establish, and make exceptions to, a restricted-drug formulary; directing the agency to establish a demonstration project in Miami-Dade County to provide minority health care; amending s. 409.9122, F.S.; providing for disproportionate assignment of certain Medicaid-eligible

children to children's clinic networks; providing for assignment of certain Medicaid recipients to managed-care plans; amending s. 409.915, F.S.; exempting counties from contributing toward the increased cost of hospital inpatient services due to elimination of Medicaid ceilings on certain types of hospitals and for special Medicaid reimbursement to hospitals; revising the level of county participation; providing for distribution of funds under the disproportionate share program for specified hospitals for the 2001 federal fiscal year; providing for the distribution of County Health Department Trust Funds; requiring the certificate-of-need workgroup to review and make recommendations regarding specified regulations; providing for a temporary rate reduction; providing for an exemption from review for transfer of certain beds and services to a satellite facility; providing for future repeal; providing an appropriation; amending s. 408.036, F.S.; exempting specified projects from required review by the Agency for Health Care Administration; providing that the act fulfills an important state interest; amending ss. 240.4075, 240.4076, F.S.; including nursing homes, family practice teaching hospitals and specialty children's hospitals as facilities eligible under the program; exempting such hospitals from the

fund-matching requirements of the program; transferring the program from the Board of Regents to the Department of Health; providing effective dates.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsections (9), (10), and (11) are added to section 409.904, Florida Statutes, to read:

409.904 Optional payments for eligible persons.--The agency may make payments for medical assistance and related services on behalf of the following persons who are determined to be eligible subject to the income, assets, and categorical eligibility tests set forth in federal and state law. Payment on behalf of these Medicaid eligible persons is subject to the availability of moneys and any limitations established by the General Appropriations Act or chapter 216.

(9) A Medicaid-eligible individual for the individual's health insurance premiums, if the agency determines that such payments are cost-effective.

(10) Eligible women with incomes below 200 percent of the federal poverty level and under age 65, for cancer treatment pursuant to the federal Breast and Cervical Cancer Prevention and Treatment Act of 2000, screened through the National Breast and Cervical Cancer Early Detection program.

(11) Subject to specific federal authorization, a person who, but for earnings in excess of the limit established under s. 1905(q)(2)(B) of the Social Security Act, would be considered for receiving supplemental security income, who is at least 16 but less than 65 years of age, and whose assets, resources, and earned or unearned income, or

both, do not exceed 250 percent of the most current federal poverty level. Such persons may be eligible for Medicaid services as part of a Medicaid buy-in established under s. 409.914(2) specifically designed to accommodate those persons made eligible for such a buy-in by Title II of Pub. L. No. 106-170. Such buy-in shall include income-related premiums and cost sharing.

Section 2. Subject to a specific appropriation, the Agency for Health Care Administration is directed to seek a federal grant, demonstration project, or waiver, as may be authorized by the United States Department of Health and Human Services, for purposes of establishing a Medicaid buy-in program or other programs to assist individuals with disabilities in gaining employment. The services to be provided are those required to enable such individuals to gain or keep employment. The grant, demonstration project, or waiver shall be submitted to the Secretary of Health and Human Services at such time, in such manner, and containing such information as the secretary shall require, as authorized under Title II of Pub. L. No. 106-170, the "Ticket to Work and Work Incentives Act of 1999."

Section 3. Subsection (5) of section 409.905, Florida Statutes, is amended to read:

409.905 Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law. Nothing in this section shall be

construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, number of services, or any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216.

(5) HOSPITAL INPATIENT SERVICES.--The agency shall pay for all covered services provided for the medical care and treatment of a recipient who is admitted as an inpatient by a licensed physician or dentist to a hospital licensed under part I of chapter 395. However, the agency shall limit the payment for inpatient hospital services for a Medicaid recipient 21 years of age or older to 45 days or the number of days necessary to comply with the General Appropriations Act.

(a) The agency is authorized to implement reimbursement and utilization management reforms in order to comply with any limitations or directions in the General Appropriations Act, which may include, but are not limited to: prior authorization for inpatient psychiatric days; prior authorization for nonemergency hospital inpatient admissions for individuals 21 years of age and older; authorization of emergency and urgent-care admissions within 24 hours after admission;enhanced utilization and concurrent review programs for highly utilized services; reduction or elimination of covered days of service; adjusting reimbursement ceilings for variable costs; adjusting reimbursement ceilings for fixed and property costs; and implementing target rates of increase. The agency may limit prior authorization for hospital inpatient services to selected diagnosis-related groups, based on an analysis of the cost and potential for unnecessary hospitalizations represented by certain diagnoses. Admissions for normal delivery and newborns are exempt from requirements

for prior authorization. In implementing the provisions of this section related to prior authorization, the agency shall ensure that the process for authorization is accessible 24 hours per day, 7 days per week and authorization is automatically granted when not denied within 4 hours after the request. Authorization procedures must include steps for review of denials. Upon implementing the prior authorization program for hospital inpatient services, the agency shall discontinue its hospital retrospective review program.

(b) A licensed hospital maintained primarily for the care and treatment of patients having mental disorders or mental diseases is not eligible to participate in the hospital inpatient portion of the Medicaid program except as provided in federal law. However, the department shall apply for a waiver, within 9 months after June 5, 1991, designed to provide hospitalization services for mental health reasons to children and adults in the most cost-effective and lowest cost setting possible. Such waiver shall include a request for the opportunity to pay for care in hospitals known under federal law as "institutions for mental disease" or "IMD's." The waiver proposal shall propose no additional aggregate cost to the state or Federal Government, and shall be conducted in Hillsborough County, Highlands County, Hardee County, Manatee County, and Polk County. The waiver proposal may incorporate competitive bidding for hospital services, comprehensive brokering, prepaid capitated arrangements, or other mechanisms deemed by the department to show promise in reducing the cost of acute care and increasing the effectiveness of preventive care. When developing the waiver proposal, the department shall take into account price, quality, accessibility, linkages of the hospital to community services and family

support programs, plans of the hospital to ensure the earliest discharge possible, and the comprehensiveness of the mental health and other health care services offered by participating providers.

(c) Agency for Health Care Administration shall adjust a hospital's current inpatient per diem rate to reflect the cost of serving the Medicaid population at that institution if:

1. The hospital experiences an increase in Medicaid caseload by more than 25 percent in any year, primarily resulting from the closure of a hospital in the same service area occurring after July 1, 1995; or

2. The hospital's Medicaid per diem rate is at least 25 percent below the Medicaid per patient cost for that year.

No later than November 1, 2001 ~~2000~~, the agency must provide estimated costs for any adjustment in a hospital inpatient per diem pursuant to this paragraph to the Executive Office of the Governor, the House of Representatives General Appropriations Committee, and the Senate Appropriations ~~Budget~~ Committee. Before the agency implements a change in a hospital's inpatient per diem rate pursuant to this paragraph, the Legislature must have specifically appropriated sufficient funds in the ~~2001-2002~~ General Appropriations Act to support the increase in cost as estimated by the agency. ~~This paragraph is repealed on July 1, 2001.~~

Section 4. Subsection (8) of section 409.906, Florida Statutes, is amended, and subsection (25) is added to that section, to read:

409.906 Optional Medicaid services.--Subject to specific appropriations, the agency may make payments for

services which are optional to the state under Title XIX of the Social Security Act and are furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any optional service that is provided shall be provided only when medically necessary and in accordance with state and federal law. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. If necessary to safeguard the state's systems of providing services to elderly and disabled persons and subject to the notice and review provisions of s. 216.177, the Governor may direct the Agency for Health Care Administration to amend the Medicaid state plan to delete the optional Medicaid service known as "Intermediate Care Facilities for the Developmentally Disabled." Optional services may include:

(8) COMMUNITY MENTAL HEALTH SERVICES.--

(a) The agency may pay for rehabilitative services provided to a recipient by a mental health or substance abuse provider ~~licensed by the agency~~ and under contract with the agency or the Department of Children and Family Services to provide such services. Those services which are psychiatric in nature shall be rendered or recommended by a psychiatrist, and those services which are medical in nature shall be rendered or recommended by a physician or psychiatrist. The agency must develop a provider enrollment process for community mental health providers which bases provider enrollment on an assessment of service need. The provider

enrollment process shall be designed to control costs, prevent fraud and abuse, consider provider expertise and capacity, and assess provider success in managing utilization of care and measuring treatment outcomes. Providers will be selected through a competitive procurement or selective contracting process. In addition to other community mental health providers, the agency shall consider for enrollment mental health programs licensed under chapter 395 and group practices licensed under chapter 458, chapter 459, chapter 490, or chapter 491. The agency is also authorized to continue operation of its behavioral health utilization management program and may develop new services if these actions are necessary to ensure savings from the implementation of the utilization management system. The agency shall coordinate the implementation of this enrollment process with the Department of Children and Family Services and the Department of Juvenile Justice. The agency is authorized to utilize diagnostic criteria in setting reimbursement rates, to preauthorize certain high-cost or highly utilized services, to limit or eliminate coverage for certain services, or to make any other adjustments necessary to comply with any limitations or directions provided for in the General Appropriations Act.

(b) The agency is authorized to implement reimbursement and use management reforms in order to comply with any limitations or directions in the General Appropriations Act, which may include, but are not limited to: prior authorization of treatment and service plans; prior authorization of services; enhanced use review programs for highly used services; and limits on services for those determined to be abusing their benefit coverages.

(25) ASSISTIVE-CARE SERVICES.--The agency may pay for assistive-care services provided to recipients with functional or cognitive impairments residing in assisted living facilities, adult family-care homes, or residential treatment facilities. These services may include health support, assistance with the activities of daily living and the instrumental acts of daily living, assistance with medication administration, and arrangements for health care.

Section 5. Paragraph (a) of subsection (1), paragraph (b) of subsection (2), and subsections (4), (9), (11), (13), (14), and (18) of section 409.908, Florida Statutes, are amended, and subsection (22) is added to that section, to read:

409.908 Reimbursement of Medicaid providers.--Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the

availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(1) Reimbursement to hospitals licensed under part I of chapter 395 must be made prospectively or on the basis of negotiation.

(a) Reimbursement for inpatient care is limited as provided for in s. 409.905(5), except for:

1. The raising of rate reimbursement caps, excluding rural hospitals.

2. Recognition of the costs of graduate medical education.

3. Other methodologies recognized in the General Appropriations Act.

4. Hospital inpatient rates shall be reduced by 6 percent effective July 1, 2001 and restored effective April 1, 2002.

During the years funds are transferred from the Department of Health ~~Board of Regents~~, any reimbursement supported by such funds shall be subject to certification by the Department of Health ~~Board of Regents~~ that the hospital has complied with s. 381.0403. The agency is authorized to receive funds from state entities, including, but not limited to, the Department of Health ~~Board of Regents~~, local governments, and other local political subdivisions, for the purpose of making special exception payments, including federal matching funds, through the Medicaid inpatient reimbursement methodologies. Funds received from state entities or local governments for this purpose shall be separately accounted for and shall not be commingled with other state or local funds in any manner. The

agency may certify all local governmental funds used as state match under Title XIX of the Social Security Act, to the extent that the identified local health care provider that is otherwise entitled to and is contracted to receive such local funds is the benefactor under the state's Medicaid program as determined under the General Appropriations Act and pursuant to an agreement between the Agency for Health Care Administration and the local governmental entity. The local governmental entity shall use a certification form prescribed by the agency. At a minimum, the certification form shall identify the amount being certified and describe the relationship between the certifying local governmental entity and the local health care provider. The agency shall prepare an annual statement of impact which documents the specific activities undertaken during the previous fiscal year pursuant to this paragraph, to be submitted to the Legislature no later than January 1, annually.~~Notwithstanding this section and s. 409.915, counties are exempt from contributing toward the cost of the special exception reimbursement for hospitals serving a disproportionate share of low-income persons and providing graduate medical education.~~

(2)

(b) Subject to any limitations or directions provided for in the General Appropriations Act, the agency shall establish and implement a Florida Title XIX Long-Term Care Reimbursement Plan (Medicaid) for nursing home care in order to provide care and services in conformance with the applicable state and federal laws, rules, regulations, and quality and safety standards and to ensure that individuals eligible for medical assistance have reasonable geographic access to such care.

1. Changes of ownership or of licensed operator do not qualify for increases in reimbursement rates associated with the change of ownership or of licensed operator. The agency shall amend the Title XIX Long Term Care Reimbursement Plan to provide that the initial nursing home reimbursement rates, for the operating, patient care, and MAR components, associated with related and unrelated party changes of ownership or licensed operator filed on or after September 1, 2001, are equivalent to the previous owner's reimbursement rate.

2. The agency shall amend the long-term care reimbursement plan and cost reporting system to create direct care and indirect care subcomponents of the patient care component of the per diem rate. These two subcomponents together shall equal the patient care component of the per diem rate. Separate cost-based ceilings shall be calculated for each patient care subcomponent. The direct care subcomponent of the per diem rate shall be limited by the cost-based class ceiling and the indirect care subcomponent shall be limited by the lower of the cost-based class ceiling, by the target rate class ceiling or by the individual provider target. The agency shall adjust the patient care component effective January 1, 2002. The cost to adjust the direct care subcomponent shall be net of the total funds previously allocated for the case mix add-on. The agency shall make the required changes to the nursing home cost reporting forms to implement this requirement effective January 1, 2002.

3. The direct care subcomponent shall include salaries and benefits of direct care staff providing nursing services including registered nurses, licensed practical nurses, and certified nursing assistants who deliver care directly to residents in the nursing home facility. This excludes nursing

administration, MDS, and care plan coordinators, staff development, and staffing coordinator.

4. All other patient care costs shall be included in the indirect care cost subcomponent of the patient care per diem rate. There shall be no costs directly or indirectly allocated to the direct care subcomponent from a home office or management company.

5. On July 1 of each year, the agency shall report to the Legislature direct and indirect care costs, including average direct and indirect care costs per resident per facility and direct care and indirect care salaries and benefits per category of staff member per facility.

6. Under the plan, interim rate adjustments shall not be granted to reflect increases in the cost of general or professional liability insurance for nursing homes unless the following criteria are met: have at least a 65 percent Medicaid utilization in the most recent cost report submitted to the agency, and the increase in general or professional liability costs to the facility for the most recent policy period affects the total Medicaid per diem by at least 5 percent. This rate adjustment shall not result in the per diem exceeding the class ceiling. This provision shall ~~apply only to fiscal year 2000-2001 and shall~~ be implemented to the extent existing appropriations are available. ~~The agency shall report to the Governor, the Speaker of the House of Representatives, and the President of the Senate by December 31, 2000, on the cost of liability insurance for Florida nursing homes for fiscal years 1999 and 2000 and the extent to which these costs are not being compensated by the Medicaid program. Medicaid-participating nursing homes shall be required to report to the agency information necessary to~~

~~compile this report. Effective no earlier than the rate-setting period beginning April 1, 1999, the agency shall establish a case-mix reimbursement methodology for the rate of payment for long-term care services for nursing home residents. The agency shall compute a per diem rate for Medicaid residents, adjusted for case mix, which is based on a resident classification system that accounts for the relative resource utilization by different types of residents and which is based on level-of-care data and other appropriate data. The case-mix methodology developed by the agency shall take into account the medical, behavioral, and cognitive deficits of residents. In developing the reimbursement methodology, the agency shall evaluate and modify other aspects of the reimbursement plan as necessary to improve the overall effectiveness of the plan with respect to the costs of patient care, operating costs, and property costs. In the event adequate data are not available, the agency is authorized to adjust the patient's care component or the per diem rate to more adequately cover the cost of services provided in the patient's care component. The agency shall work with the Department of Elderly Affairs, the Florida Health Care Association, and the Florida Association of Homes for the Aging in developing the methodology.~~

It is the intent of the Legislature that the reimbursement plan achieve the goal of providing access to health care for nursing home residents who require large amounts of care while encouraging diversion services as an alternative to nursing home care for residents who can be served within the community. The agency shall base the establishment of any maximum rate of payment, whether overall or component, on the

available moneys as provided for in the General Appropriations Act. The agency may base the maximum rate of payment on the results of scientifically valid analysis and conclusions derived from objective statistical data pertinent to the particular maximum rate of payment.

(4) Subject to any limitations or directions provided for in the General Appropriations Act, alternative health plans, health maintenance organizations, and prepaid health plans shall be reimbursed a fixed, prepaid amount negotiated, or competitively bid pursuant to s. 287.057, by the agency and prospectively paid to the provider monthly for each Medicaid recipient enrolled. The amount may not exceed the average amount the agency determines it would have paid, based on claims experience, for recipients in the same or similar category of eligibility. The agency shall calculate capitation rates on a regional basis and, beginning September 1, 1995, shall include age-band differentials in such calculations. Effective July 1, 2001, the cost of exempting statutory teaching hospitals, specialty hospitals, and community hospital education program hospitals from reimbursement ceilings and the cost of special Medicaid payments shall not be included in premiums paid to health maintenance organizations or prepaid health care plans. Each rate semester, the agency shall calculate and publish a Medicaid hospital rate schedule that does not reflect either special Medicaid payments or the elimination of rate reimbursement ceilings, to be used by hospitals and Medicaid health maintenance organizations, in order to determine the Medicaid rate referred to in ss. 409.912(16), 409.9128(5), and 641.513(6).

(9) A provider of home health care services or of medical supplies and appliances shall be reimbursed on the basis of competitive bidding or for the lesser of the amount billed by the provider or the agency's established maximum allowable amount, except that, in the case of the rental of durable medical equipment, the total rental payments may not exceed the purchase price of the equipment over its expected useful life or the agency's established maximum allowable amount, whichever amount is less.

(11) A provider of independent laboratory services shall be reimbursed on the basis of competitive bidding or for the least of the amount billed by the provider, the provider's usual and customary charge, or the Medicaid maximum allowable fee established by the agency.

(13) Medicare premiums for persons eligible for both Medicare and Medicaid coverage shall be paid at the rates established by Title XVIII of the Social Security Act. For Medicare services rendered to Medicaid-eligible persons, Medicaid shall pay Medicare deductibles and coinsurance as follows:

(a) Medicaid shall make no payment toward deductibles and coinsurance for any service that is not covered by Medicaid.

(b) Medicaid's financial obligation for deductibles and coinsurance payments shall be based on Medicare allowable fees, not on a provider's billed charges.

(c) Medicaid will pay no portion of Medicare deductibles and coinsurance when payment that Medicare has made for the service equals or exceeds what Medicaid would have paid if it had been the sole payor. The combined payment of Medicare and Medicaid shall not exceed the amount Medicaid

would have paid had it been the sole payor. The Legislature finds that there has been confusion regarding the reimbursement for services rendered to dually eligible Medicare beneficiaries. Accordingly, the Legislature clarifies that it has always been the intent of the Legislature before and after 1991 that, in reimbursing in accordance with fees established by Title XVIII for premiums, deductibles, and coinsurance for Medicare services rendered by physicians to Medicaid eligible persons, physicians be reimbursed at the lesser of the amount billed by the physician or the Medicaid maximum allowable fee established by the Agency for Health Care Administration, as is permitted by federal law. It has never been the intent of the Legislature with regard to such services rendered by physicians that Medicaid be required to provide any payment for deductibles, coinsurance, or copayments for Medicare cost sharing, or any expenses incurred relating thereto, in excess of the payment amount provided for under the State Medicaid plan for such service. This payment methodology is applicable even in those situations in which the payment for Medicare cost sharing for a qualified Medicare beneficiary with respect to an item or service is reduced or eliminated. This expression of the Legislature is in clarification of existing law and shall apply to payment for, and with respect to provider agreements with respect to, items or services furnished on or after the effective date of this act. This paragraph applies to payment by Medicaid for items and services furnished before the effective date of this act if such payment is the subject of a lawsuit that is based on the provisions of this section, and that is pending as of, or is initiated after, the effective date of this act.

(d) Notwithstanding ~~The following provisions are exceptions to~~ paragraphs (a)-(c):

1. Medicaid payments for Nursing Home Medicare part A coinsurance shall be the lesser of the Medicare coinsurance amount or the Medicaid nursing home per diem rate.

~~2. Medicaid shall pay all deductibles and coinsurance for Nursing Home Medicare part B services.~~

2.~~3.~~ Medicaid shall pay all deductibles and coinsurance for Medicare-eligible recipients receiving freestanding end stage renal dialysis center services.

~~4. Medicaid shall pay all deductibles and coinsurance for hospital outpatient Medicare part B services.~~

3.~~5.~~ Medicaid payments for general hospital inpatient services shall be limited to the Medicare deductible per spell of illness. Medicaid shall make no payment toward coinsurance for Medicare general hospital inpatient services.

4.~~6.~~ Medicaid shall pay all deductibles and coinsurance for Medicare emergency transportation services provided by ambulances licensed pursuant to chapter 401.

(14) A provider of prescribed drugs shall be reimbursed the least of the amount billed by the provider, the provider's usual and customary charge, or the Medicaid maximum allowable fee established by the agency, plus a dispensing fee. The agency is directed to implement a variable dispensing fee for payments for prescribed medicines while ensuring continued access for Medicaid recipients. The variable dispensing fee may be based upon, but not limited to, either or both the volume of prescriptions dispensed by a specific pharmacy provider and the volume of prescriptions dispensed to an individual recipient. The agency is authorized to limit reimbursement for prescribed medicine in order to comply with

any limitations or directions provided for in the General Appropriations Act, which may include implementing a prospective or concurrent utilization review program.

(18) Unless otherwise provided for in the General Appropriations Act, a provider of transportation services shall be reimbursed the lesser of the amount billed by the provider or the Medicaid maximum allowable fee established by the agency, except when the agency has entered into a direct contract with the provider, or with a community transportation coordinator, for the provision of an all-inclusive service, or when services are provided pursuant to an agreement negotiated between the agency and the provider. The agency, as provided for in s. 427.0135, shall purchase transportation services through the community coordinated transportation system, if available, unless the agency determines a more cost-effective method for Medicaid clients. Nothing in this subsection shall be construed to limit or preclude the agency from contracting for services using a prepaid capitation rate or from establishing maximum fee schedules, individualized reimbursement policies by provider type, negotiated fees, prior authorization, competitive bidding, increased use of mass transit, or any other mechanism that the agency considers efficient and effective for the purchase of services on behalf of Medicaid clients, including implementing a transportation eligibility process. The agency shall not be required to contract with any community transportation coordinator or transportation operator that has been determined by the agency, the Department of Legal Affairs Medicaid Fraud Control Unit, or any other state or federal agency to have engaged in any abusive or fraudulent billing activities. The agency is authorized to competitively procure transportation services or

make other changes necessary to secure approval of federal waivers needed to permit federal financing of Medicaid transportation services at the service matching rate rather than the administrative matching rate.

(22) The agency may request and implement Medicaid waivers from the federal Health Care Financing Administration to advance and treat a portion of the Medicaid nursing home per diem as capital for creating and operating a risk-retention group for self-insurance purposes, consistent with federal and state laws and rules.

Section 6. Paragraph (c) of subsection (1), paragraph (b) of subsection (3), and subsection (7) of section 409.911, Florida Statutes, are amended to read:

409.911 Disproportionate share program.--Subject to specific allocations established within the General Appropriations Act and any limitations established pursuant to chapter 216, the agency shall distribute, pursuant to this section, moneys to hospitals providing a disproportionate share of Medicaid or charity care services by making quarterly Medicaid payments as required. Notwithstanding the provisions of s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients.

(1) Definitions.--As used in this section and s. 409.9112:

(c) "Base Medicaid per diem" means the hospital's Medicaid per diem rate initially established by the Agency for Health Care Administration on January 1, 1999 ~~prior to the beginning of each state fiscal year~~. The base Medicaid per diem rate shall not include any additional per diem increases

received as a result of the disproportionate share distribution.

(3) In computing the disproportionate share rate:

(b) The agency shall use 1994 ~~the most recent calendar year~~ audited financial data ~~available at the beginning of each state fiscal year~~ for the calculation of disproportionate share payments under this section.

(7) ~~For fiscal year 1991-1992 and all years other than 1992-1993,~~The following criteria shall be used in determining the disproportionate share percentage:

(a) If the disproportionate share rate is less than 10 percent, the disproportionate share percentage is zero and there is no additional payment.

(b) If the disproportionate share rate is greater than or equal to 10 percent, but less than 20 percent, then the disproportionate share percentage is 1.8478498 ~~2.1544347~~.

(c) If the disproportionate share rate is greater than or equal to 20 percent, but less than 30 percent, then the disproportionate share percentage is 3.4145488 ~~4.6415888766~~.

(d) If the disproportionate share rate is greater than or equal to 30 percent, but less than 40 percent, then the disproportionate share percentage is 6.3095734 ~~10.0000001388~~.

(e) If the disproportionate share rate is greater than or equal to 40 percent, but less than 50 percent, then the disproportionate share percentage is 11.6591440 ~~21.544347299~~.

(f) If the disproportionate share rate is greater than or equal to 50 percent, but less than 60 percent, then the disproportionate share percentage is 73.5642254 ~~46.41588941~~.

(g) If the disproportionate share rate is greater than or equal to 60 percent but less than 72.5 percent, then the disproportionate share percentage is 135.9356391 ~~100~~.

(h) If the disproportionate share rate is greater than or equal to 72.5 percent, then the disproportionate share percentage is 170.

Section 7. Subsection (2) of section 409.9116, Florida Statutes, is amended to read:

409.9116 Disproportionate share/financial assistance program for rural hospitals.--In addition to the payments made under s. 409.911, the Agency for Health Care Administration shall administer a federally matched disproportionate share program and a state-funded financial assistance program for statutory rural hospitals. The agency shall make disproportionate share payments to statutory rural hospitals that qualify for such payments and financial assistance payments to statutory rural hospitals that do not qualify for disproportionate share payments. The disproportionate share program payments shall be limited by and conform with federal requirements. Funds shall be distributed quarterly in each fiscal year for which an appropriation is made. Notwithstanding the provisions of s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients.

(2) The agency shall use the following formula for distribution of funds for the disproportionate share/financial assistance program for rural hospitals.

(a) The agency shall first determine a preliminary payment amount for each rural hospital by allocating all available state funds using the following formula:

PDAER = (TAERH x TARH)/STAERH

Where:

PDAER = preliminary distribution amount for each rural hospital.

TAERH = total amount earned by each rural hospital.

TARH = total amount appropriated or distributed under this section.

STAERH = sum of total amount earned by each rural hospital.

(b) Federal matching funds for the disproportionate share program shall then be calculated for those hospitals that qualify for disproportionate share in paragraph (a).

(c) The state-funds-only payment amount shall then be calculated for each hospital using the formula:

SFOER = Maximum value of (1) SFOL - PDAER or (2) 0

Where:

SFOER = state-funds-only payment amount for each rural hospital.

SFOL = state-funds-only payment level, which is set at 4 percent of TARH.

In calculating the SFOER, PDAER includes federal matching funds from paragraph (b).

(d) The adjusted total amount allocated to the rural disproportionate share program shall then be calculated using the following formula:

ATARH = (TARH - SSFOER)

Where:

ATARH = adjusted total amount appropriated or distributed under this section.

SSFOER = sum of the state-funds-only payment amount calculated under paragraph (c) for all rural hospitals.

(e) The distribution of the adjusted total amount of rural disproportionate share hospital funds shall then be calculated using the following formula:

DAERH = [(TAERH x ATARH)/STAERH]

Where:

DAERH = distribution amount for each rural hospital.

(f) Federal matching funds for the disproportionate share program shall then be calculated for those hospitals that qualify for disproportionate share in paragraph (e).

(g) State-funds-only payment amounts calculated under paragraph (c) and corresponding federal matching funds are then added to the results of paragraph (f) to determine the total distribution amount for each rural hospital.

~~In determining the payment amount for each rural hospital under this section, the agency shall first allocate all available state funds by the following formula:~~

~~DAER = (TAERH x TARH)/STAERH~~

~~Where:~~

~~DAER = distribution amount for each rural hospital.~~

~~STAERH = sum of total amount earned by each rural hospital.~~

~~TAERH = total amount earned by each rural hospital.~~

~~TARH = total amount appropriated or distributed under this section.~~

~~Federal matching funds for the disproportionate share program shall then be calculated for those hospitals that qualify for disproportionate share payments under this section.~~

Section 8. Section 409.91195, Florida Statutes, is amended to read:

409.91195 Medicaid Pharmaceutical and Therapeutics Committee.--There is created a Medicaid Pharmaceutical and Therapeutics Committee within the Agency for Health Care Administration for the purpose of developing a preferred drug formulary pursuant to 42 U.S.C. s. 1396r-8. ~~The committee shall develop and implement a voluntary Medicaid preferred prescribed drug designation program. The program shall provide information to Medicaid providers on medically appropriate and cost-efficient prescription drug therapies through the development and publication of a voluntary Medicaid preferred prescribed-drug list.~~

(1) The Medicaid Pharmaceutical and Therapeutics Committee shall be comprised as specified in 42 U.S.C. s. 1396r-8 and consist of eleven members appointed by the Governor. Four members shall be physicians, licensed under chapter 458; one member licensed under chapter 459; five members shall be pharmacists licensed under chapter 465; and one member shall be a consumer representative. ~~of nine members appointed as follows: one practicing physician licensed under chapter 458, appointed by the Speaker of the House of Representatives from a list of recommendations from the Florida Medical Association; one practicing physician licensed under chapter 459, appointed by the Speaker of the House of~~

~~Representatives from a list of recommendations from the Florida Osteopathic Medical Association; one practicing physician licensed under chapter 458, appointed by the President of the Senate from a list of recommendations from the Florida Academy of Family Physicians; one practicing podiatric physician licensed under chapter 461, appointed by the President of the Senate from a list of recommendations from the Florida Podiatric Medical Association; one trauma surgeon licensed under chapter 458, appointed by the Speaker of the House of Representatives from a list of recommendations from the American College of Surgeons; one practicing dentist licensed under chapter 466, appointed by the President of the Senate from a list of recommendations from the Florida Dental Association; one practicing pharmacist licensed under chapter 465, appointed by the Governor from a list of recommendations from the Florida Pharmacy Association; one practicing pharmacist licensed under chapter 465, appointed by the Governor from a list of recommendations from the Florida Society of Health System Pharmacists; and one health care professional with expertise in clinical pharmacology appointed by the Governor from a list of recommendations from the Pharmaceutical Research and Manufacturers Association.~~The members shall be appointed to serve for terms of 2 years from the date of their appointment. Members may be appointed to more than one term. The Agency for Health Care Administration shall serve as staff for the committee and assist them with all ministerial duties. <u>The Governor shall ensure that at least some of the members of the Medicaid Pharmaceutical and Therapeutics Committee represent Medicaid participating physicians and pharmacies serving all segments and diversity of the Medicaid population, and have experience in either</u>

developing or practicing under a preferred drug formulary. At least one of the members shall represent the interests of pharmaceutical manufacturers.

(2) Committee members shall select a chairperson and a vice chairperson each year from the committee membership.

(3) The committee shall meet at least quarterly and may meet at other times at the discretion of the chairperson and members. The committee shall comply with rules adopted by the agency, including notice of any meeting of the committee pursuant to the requirements of the Administrative Procedure Act.

(4) Upon recommendation of the Medicaid Pharmaceutical and Therapeutics Committee the agency shall adopt a preferred drug list. To the extent feasible, the committee shall review all drug classes included in the formulary at least every 12 months, and may recommend additions to and deletions from the formulary, such that the formulary provides

~~(2) Upon recommendation by the committee, the Agency for Health Care Administration shall establish the voluntary Medicaid preferred prescribed-drug list. Upon further recommendation by the committee, the agency shall add to, delete from, or modify the list. The committee shall also review requests for additions to, deletions from, or modifications of the list. The list shall be adopted by the committee in consultation with medical specialists, when appropriate, using the following criteria: use of the list shall be voluntary by providers and the list must provide~~ for medically appropriate drug therapies for Medicaid patients which achieve cost savings contained in the General Appropriations Act.

(5) Except for mental health-related drugs, anti-retroviral drugs, and drugs for nursing home residents and other institutional residents, reimbursement of drugs not included in the formulary is subject to prior authorization ~~in the Medicaid program~~.

(6)~~(3)~~ The Agency for Health Care Administration shall publish and disseminate the preferred drug formulary ~~voluntary Medicaid preferred prescribed drug list~~ to all Medicaid providers in the state.

(7) The committee shall ensure that pharmaceutical manufacturers agreeing to provide a supplemental rebate as outlined in this chapter have an opportunity to present evidence supporting inclusion of a product on the preferred drug list. Upon timely notice, the agency shall ensure that any drug that has been approved or had any of its particular uses approved by the United States Food and Drug Administration under a priority review classification will be reviewed by the Medicaid Pharmaceutical and Therapeutics Committee at the next regularly scheduled meeting. To the extent possible, upon notice by a manufacturer the agency shall also schedule a product review for any new product at the next regularly scheduled Medicaid Pharmaceutical and Therapeutics Committee.

(8) Until the Medicaid Pharmaceutical and Therapeutics Committee is appointed and a preferred drug list adopted by the agency, the agency shall use the existing voluntary preferred drug list adopted pursuant to Chapter 2000-367, Section 72, Laws of Florida. Drugs not listed on the voluntary preferred drug list will require prior authorization by the agency or its contractor.

(9) The Medicaid Pharmaceutical and Therapeutics Committee shall develop its preferred drug list recommendations by considering the clinical efficacy, safety, and cost effectiveness of a product. When the preferred drug formulary is adopted by the agency, if a product on the formulary is one of the first four brand-name drugs used by a recipient in a month the drug shall not require prior authorization.

(10) The Medicaid Pharmaceutical and Therapeutics Committee may also make recommendations to the agency regarding the prior authorization of any prescribed drug covered by Medicaid.

(11) Medicaid recipients may appeal agency preferred drug formulary decisions using the Medicaid fair hearing process administered by the Department of Children and Family Services.

Section 9. Section 409.912, Florida Statutes, is amended to read:

409.912 Cost-effective purchasing of health care.--The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. The agency shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services. The

agency may establish prior authorization requirements for certain populations of Medicaid beneficiaries, certain drug classes, or particular drugs to prevent fraud, abuse, overuse, and possible dangerous drug interactions. The Pharmaceutical and Therapeutics Committee shall make recommendations to the agency on drugs for which prior authorization is required. The agency shall inform the Pharmaceutical and Therapeutics Committee of its decisions regarding drugs subject to prior authorization.

(1) The agency may enter into agreements with appropriate agents of other state agencies or of any agency of the Federal Government and accept such duties in respect to social welfare or public aid as may be necessary to implement the provisions of Title XIX of the Social Security Act and ss. 409.901-409.920.

(2) The agency may contract with health maintenance organizations certified pursuant to part I of chapter 641 for the provision of services to recipients.

(3) The agency may contract with:

(a) An entity that provides no prepaid health care services other than Medicaid services under contract with the agency and which is owned and operated by a county, county health department, or county-owned and operated hospital to provide health care services on a prepaid or fixed-sum basis to recipients, which entity may provide such prepaid services either directly or through arrangements with other providers. Such prepaid health care services entities must be licensed under parts I and III by January 1, 1998, and until then are exempt from the provisions of part I of chapter 641. An entity recognized under this paragraph which demonstrates to the satisfaction of the Department of Insurance that it is backed

by the full faith and credit of the county in which it is located may be exempted from s. 641.225.

(b) An entity that is providing comprehensive behavioral health care services to certain Medicaid recipients through a capitated, prepaid arrangement pursuant to the federal waiver provided for by s. 409.905(5). Such an entity must be licensed under chapter 624, chapter 636, or chapter 641 and must possess the clinical systems and operational competence to manage risk and provide comprehensive behavioral health care to Medicaid recipients. As used in this paragraph, the term "comprehensive behavioral health care services" means covered mental health and substance abuse treatment services that are available to Medicaid recipients. The secretary of the Department of Children and Family Services shall approve provisions of procurements related to children in the department's care or custody prior to enrolling such children in a prepaid behavioral health plan. Any contract awarded under this paragraph must be competitively procured. In developing the behavioral health care prepaid plan procurement document, the agency shall ensure that the procurement document requires the contractor to develop and implement a plan to ensure compliance with s. 394.4574 related to services provided to residents of licensed assisted living facilities that hold a limited mental health license. The agency must ensure that Medicaid recipients have available the choice of at least two managed care plans for their behavioral health care services. The agency may reimburse for substance-abuse-treatment services on a fee-for-service basis until the agency finds that adequate funds are available for capitated, prepaid arrangements.

1. By January 1, 2001, the agency shall modify the contracts with the entities providing comprehensive inpatient and outpatient mental health care services to Medicaid recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk Counties, to include substance-abuse-treatment services.

2. By December 31, 2001, the agency shall contract with entities providing comprehensive behavioral health care services to Medicaid recipients through capitated, prepaid arrangements in Charlotte, Collier, DeSoto, Escambia, Glades, Hendry, Lee, Okaloosa, Pasco, Pinellas, Santa Rosa, Sarasota, and Walton Counties. The agency may contract with entities providing comprehensive behavioral health care services to Medicaid recipients through capitated, prepaid arrangements in Alachua County. The agency may determine if Sarasota County shall be included as a separate catchment area or included in any other agency geographic area.

3. Children residing in a Department of Juvenile Justice residential program approved as a Medicaid behavioral health overlay services provider shall not be included in a behavioral health care prepaid health plan pursuant to this paragraph.

4. In converting to a prepaid system of delivery, the agency shall in its procurement document require an entity providing comprehensive behavioral health care services to prevent the displacement of indigent care patients by enrollees in the Medicaid prepaid health plan providing behavioral health care services from facilities receiving state funding to provide indigent behavioral health care, to facilities licensed under chapter 395 which do not receive state funding for indigent behavioral health care, or

reimburse the unsubsidized facility for the cost of behavioral health care provided to the displaced indigent care patient.

5. Traditional community mental health providers under contract with the Department of Children and Family Services pursuant to part IV of chapter 394 and inpatient mental health providers licensed pursuant to chapter 395 must be offered an opportunity to accept or decline a contract to participate in any provider network for prepaid behavioral health services.

(c) A federally qualified health center or an entity owned by one or more federally qualified health centers or an entity owned by other migrant and community health centers receiving non-Medicaid financial support from the Federal Government to provide health care services on a prepaid or fixed-sum basis to recipients. Such prepaid health care services entity must be licensed under parts I and III of chapter 641, but shall be prohibited from serving Medicaid recipients on a prepaid basis, until such licensure has been obtained. However, such an entity is exempt from s. 641.225 if the entity meets the requirements specified in subsections (14) and (15).

(d) No more than four provider service networks for demonstration projects to test Medicaid direct contracting. The demonstration projects may be reimbursed on a fee-for-service or prepaid basis. A provider service network which is reimbursed by the agency on a prepaid basis shall be exempt from parts I and III of chapter 641, but must meet appropriate financial reserve, quality assurance, and patient rights requirements as established by the agency. The agency shall award contracts on a competitive bid basis and shall select bidders based upon price and quality of care. Medicaid recipients assigned to a demonstration project shall be chosen

equally from those who would otherwise have been assigned to prepaid plans and MediPass. The agency is authorized to seek federal Medicaid waivers as necessary to implement the provisions of this section. A demonstration project awarded pursuant to this paragraph shall be for 4 ~~2~~ years from the date of implementation.

(e) An entity that provides comprehensive behavioral health care services to certain Medicaid recipients through an administrative services organization agreement. Such an entity must possess the clinical systems and operational competence to provide comprehensive health care to Medicaid recipients. As used in this paragraph, the term "comprehensive behavioral health care services" means covered mental health and substance abuse treatment services that are available to Medicaid recipients. Any contract awarded under this paragraph must be competitively procured. The agency must ensure that Medicaid recipients have available the choice of at least two managed care plans for their behavioral health care services.

(f) An entity in Pasco County or Pinellas County that provides in-home physician services to Medicaid recipients with degenerative neurological diseases in order to test the cost-effectiveness of enhanced home-based medical care. The entity providing the services shall be reimbursed on a fee-for-service basis at a rate not less than comparable Medicare reimbursement rates. The agency may apply for waivers of federal regulations necessary to implement such program. This paragraph shall be repealed on July 1, 2002.

(g) Children's provider networks that provide care coordination and care management for Medicaid-eligible pediatric patients, primary care, authorization of specialty care, and other urgent and emergency care through organized

providers designed to service Medicaid eligibles under age 18. The networks shall provide after-hour operations, including evening and weekend hours, to promote, when appropriate, the use of the children's networks rather than hospital emergency departments.

(4) The agency may contract with any public or private entity otherwise authorized by this section on a prepaid or fixed-sum basis for the provision of health care services to recipients. An entity may provide prepaid services to recipients, either directly or through arrangements with other entities, if each entity involved in providing services:

(a) Is organized primarily for the purpose of providing health care or other services of the type regularly offered to Medicaid recipients;

(b) Ensures that services meet the standards set by the agency for quality, appropriateness, and timeliness;

(c) Makes provisions satisfactory to the agency for insolvency protection and ensures that neither enrolled Medicaid recipients nor the agency will be liable for the debts of the entity;

(d) Submits to the agency, if a private entity, a financial plan that the agency finds to be fiscally sound and that provides for working capital in the form of cash or equivalent liquid assets excluding revenues from Medicaid premium payments equal to at least the first 3 months of operating expenses or $200,000, whichever is greater;

(e) Furnishes evidence satisfactory to the agency of adequate liability insurance coverage or an adequate plan of self-insurance to respond to claims for injuries arising out of the furnishing of health care;

(f) Provides, through contract or otherwise, for periodic review of its medical facilities and services, as required by the agency; and

(g) Provides organizational, operational, financial, and other information required by the agency.

(5) The agency may contract on a prepaid or fixed-sum basis with any health insurer that:

(a) Pays for health care services provided to enrolled Medicaid recipients in exchange for a premium payment paid by the agency;

(b) Assumes the underwriting risk; and

(c) Is organized and licensed under applicable provisions of the Florida Insurance Code and is currently in good standing with the Department of Insurance.

(6) The agency may contract on a prepaid or fixed-sum basis with an exclusive provider organization to provide health care services to Medicaid recipients provided that ~~the contract does not cost more than a managed care plan contract in the same agency region and that~~ the exclusive provider organization meets applicable managed care plan requirements in this section, ss. 409.9122, 409.9123, 409.9128, and 627.6472, and other applicable provisions of law.

(7) The Agency for Health Care Administration may provide cost-effective purchasing of chiropractic services on a fee-for-service basis to Medicaid recipients through arrangements with a statewide chiropractic preferred provider organization incorporated in this state as a not-for-profit corporation. The agency shall ensure that the benefit limits and prior authorization requirements in the current Medicaid program shall apply to the services provided by the chiropractic preferred provider organization.

(8) The agency shall not contract on a prepaid or fixed-sum basis for Medicaid services with an entity which knows or reasonably should know that any officer, director, agent, managing employee, or owner of stock or beneficial interest in excess of 5 percent common or preferred stock, or the entity itself, has been found guilty of, regardless of adjudication, or entered a plea of nolo contendere, or guilty, to:

(a) Fraud;

(b) Violation of federal or state antitrust statutes, including those proscribing price fixing between competitors and the allocation of customers among competitors;

(c) Commission of a felony involving embezzlement, theft, forgery, income tax evasion, bribery, falsification or destruction of records, making false statements, receiving stolen property, making false claims, or obstruction of justice; or

(d) Any crime in any jurisdiction which directly relates to the provision of health services on a prepaid or fixed-sum basis.

(9) The agency, after notifying the Legislature, may apply for waivers of applicable federal laws and regulations as necessary to implement more appropriate systems of health care for Medicaid recipients and reduce the cost of the Medicaid program to the state and federal governments and shall implement such programs, after legislative approval, within a reasonable period of time after federal approval. These programs must be designed primarily to reduce the need for inpatient care, custodial care and other long-term or institutional care, and other high-cost services.

(a) Prior to seeking legislative approval of such a waiver as authorized by this subsection, the agency shall provide notice and an opportunity for public comment. Notice shall be provided to all persons who have made requests of the agency for advance notice and shall be published in the Florida Administrative Weekly not less than 28 days prior to the intended action.

(b) Notwithstanding s. 216.292, funds that are appropriated to the Department of Elderly Affairs for the Assisted Living for the Elderly Medicaid waiver and are not expended shall be transferred to the agency to fund Medicaid-reimbursed nursing home care.

(10) The agency shall establish a postpayment utilization control program designed to identify recipients who may inappropriately overuse or underuse Medicaid services and shall provide methods to correct such misuse.

(11) The agency shall develop and provide coordinated systems of care for Medicaid recipients and may contract with public or private entities to develop and administer such systems of care among public and private health care providers in a given geographic area.

(12) The agency shall operate or contract for the operation of utilization management and incentive systems designed to encourage cost-effective use services.

(13)(a) The agency shall identify health care utilization and price patterns within the Medicaid program which are not cost-effective or medically appropriate and assess the effectiveness of new or alternate methods of providing and monitoring service, and may implement such methods as it considers appropriate. Such methods may include disease management initiatives, an integrated and systematic

approach for managing the health care needs of recipients who are at risk of or diagnosed with a specific disease by using best practices, prevention strategies, clinical-practice improvement, clinical interventions and protocols, outcomes research, information technology, and other tools and resources to reduce overall costs and improve measurable outcomes.

(b) The responsibility of the agency under this subsection shall include the development of capabilities to identify actual and optimal practice patterns; patient and provider educational initiatives; methods for determining patient compliance with prescribed treatments; fraud, waste, and abuse prevention and detection programs; and beneficiary case management programs.

1. The practice pattern identification program shall evaluate practitioner prescribing patterns based on national and regional practice guidelines, comparing practitioners to their peer groups. The agency and its Drug Utilization Review Board shall consult with a panel of practicing health care professionals consisting of the following: the Speaker of the House of Representatives and the President of the Senate shall each appoint three physicians licensed under chapter 458 or chapter 459; and the Governor shall appoint two pharmacists licensed under chapter 465 and one dentist licensed under chapter 466 who is an oral surgeon. Terms of the panel members shall expire at the discretion of the appointing official. The panel shall begin its work by August 1, 1999, regardless of the number of appointments made by that date. The advisory panel shall be responsible for evaluating treatment guidelines and recommending ways to incorporate their use in the practice pattern identification program. Practitioners who are

prescribing inappropriately or inefficiently, as determined by the agency, may have their prescribing of certain drugs subject to prior authorization.

2. The agency shall also develop educational interventions designed to promote the proper use of medications by providers and beneficiaries.

3. The agency shall implement a pharmacy fraud, waste, and abuse initiative that may include a surety bond or letter of credit requirement for participating pharmacies, enhanced provider auditing practices, the use of additional fraud and abuse software, recipient management programs for beneficiaries inappropriately using their benefits, and other steps that will eliminate provider and recipient fraud, waste, and abuse. The initiative shall address enforcement efforts to reduce the number and use of counterfeit prescriptions.

4. The agency may apply for any federal waivers needed to implement this paragraph.

(14) An entity contracting on a prepaid or fixed-sum basis shall, in addition to meeting any applicable statutory surplus requirements, also maintain at all times in the form of cash, investments that mature in less than 180 days allowable as admitted assets by the Department of Insurance, and restricted funds or deposits controlled by the agency or the Department of Insurance, a surplus amount equal to one-and-one-half times the entity's monthly Medicaid prepaid revenues. As used in this subsection, the term "surplus" means the entity's total assets minus total liabilities. If an entity's surplus falls below an amount equal to one-and-one-half times the entity's monthly Medicaid prepaid revenues, the agency shall prohibit the entity from engaging in marketing and preenrollment activities, shall cease to

process new enrollments, and shall not renew the entity's contract until the required balance is achieved. The requirements of this subsection do not apply:

(a) Where a public entity agrees to fund any deficit incurred by the contracting entity; or

(b) Where the entity's performance and obligations are guaranteed in writing by a guaranteeing organization which:

1. Has been in operation for at least 5 years and has assets in excess of $50 million; or

2. Submits a written guarantee acceptable to the agency which is irrevocable during the term of the contracting entity's contract with the agency and, upon termination of the contract, until the agency receives proof of satisfaction of all outstanding obligations incurred under the contract.

(15)(a) The agency may require an entity contracting on a prepaid or fixed-sum basis to establish a restricted insolvency protection account with a federally guaranteed financial institution licensed to do business in this state. The entity shall deposit into that account 5 percent of the capitation payments made by the agency each month until a maximum total of 2 percent of the total current contract amount is reached. The restricted insolvency protection account may be drawn upon with the authorized signatures of two persons designated by the entity and two representatives of the agency. If the agency finds that the entity is insolvent, the agency may draw upon the account solely with the two authorized signatures of representatives of the agency, and the funds may be disbursed to meet financial obligations incurred by the entity under the prepaid contract. If the contract is terminated, expired, or not continued, the account balance must be released by the agency to the entity

upon receipt of proof of satisfaction of all outstanding obligations incurred under this contract.

(b) The agency may waive the insolvency protection account requirement in writing when evidence is on file with the agency of adequate insolvency insurance and reinsurance that will protect enrollees if the entity becomes unable to meet its obligations.

(16) An entity that contracts with the agency on a prepaid or fixed-sum basis for the provision of Medicaid services shall reimburse any hospital or physician that is outside the entity's authorized geographic service area as specified in its contract with the agency, and that provides services authorized by the entity to its members, at a rate negotiated with the hospital or physician for the provision of services or according to the lesser of the following:

(a) The usual and customary charges made to the general public by the hospital or physician; or

(b) The Florida Medicaid reimbursement rate established for the hospital or physician.

(17) When a merger or acquisition of a Medicaid prepaid contractor has been approved by the Department of Insurance pursuant to s. 628.4615, the agency shall approve the assignment or transfer of the appropriate Medicaid prepaid contract upon request of the surviving entity of the merger or acquisition if the contractor and the other entity have been in good standing with the agency for the most recent 12-month period, unless the agency determines that the assignment or transfer would be detrimental to the Medicaid recipients or the Medicaid program. To be in good standing, an entity must not have failed accreditation or committed any material violation of the requirements of s. 641.52 and must meet the

Medicaid contract requirements. For purposes of this section, a merger or acquisition means a change in controlling interest of an entity, including an asset or stock purchase.

(18) Any entity contracting with the agency pursuant to this section to provide health care services to Medicaid recipients is prohibited from engaging in any of the following practices or activities:

(a) Practices that are discriminatory, including, but not limited to, attempts to discourage participation on the basis of actual or perceived health status.

(b) Activities that could mislead or confuse recipients, or misrepresent the organization, its marketing representatives, or the agency. Violations of this paragraph include, but are not limited to:

1. False or misleading claims that marketing representatives are employees or representatives of the state or county, or of anyone other than the entity or the organization by whom they are reimbursed.

2. False or misleading claims that the entity is recommended or endorsed by any state or county agency, or by any other organization which has not certified its endorsement in writing to the entity.

3. False or misleading claims that the state or county recommends that a Medicaid recipient enroll with an entity.

4. Claims that a Medicaid recipient will lose benefits under the Medicaid program, or any other health or welfare benefits to which the recipient is legally entitled, if the recipient does not enroll with the entity.

(c) Granting or offering of any monetary or other valuable consideration for enrollment, except as authorized by subsection (21).

(d) Door-to-door solicitation of recipients who have not contacted the entity or who have not invited the entity to make a presentation.

(e) Solicitation of Medicaid recipients by marketing representatives stationed in state offices unless approved and supervised by the agency or its agent and approved by the affected state agency when solicitation occurs in an office of the state agency. The agency shall ensure that marketing representatives stationed in state offices shall market their managed care plans to Medicaid recipients only in designated areas and in such a way as to not interfere with the recipients' activities in the state office.

(f) Enrollment of Medicaid recipients.

(19) The agency may impose a fine for a violation of this section or the contract with the agency by a person or entity that is under contract with the agency. With respect to any nonwillful violation, such fine shall not exceed $2,500 per violation. In no event shall such fine exceed an aggregate amount of $10,000 for all nonwillful violations arising out of the same action. With respect to any knowing and willful violation of this section or the contract with the agency, the agency may impose a fine upon the entity in an amount not to exceed $20,000 for each such violation. In no event shall such fine exceed an aggregate amount of $100,000 for all knowing and willful violations arising out of the same action.

(20) A health maintenance organization or a person or entity exempt from chapter 641 that is under contract with the agency for the provision of health care services to Medicaid recipients may not use or distribute marketing materials used to solicit Medicaid recipients, unless such materials have

been approved by the agency. The provisions of this subsection do not apply to general advertising and marketing materials used by a health maintenance organization to solicit both non-Medicaid subscribers and Medicaid recipients.

(21) Upon approval by the agency, health maintenance organizations and persons or entities exempt from chapter 641 that are under contract with the agency for the provision of health care services to Medicaid recipients may be permitted within the capitation rate to provide additional health benefits that the agency has found are of high quality, are practicably available, provide reasonable value to the recipient, and are provided at no additional cost to the state.

(22) The agency shall utilize the statewide health maintenance organization complaint hotline for the purpose of investigating and resolving Medicaid and prepaid health plan complaints, maintaining a record of complaints and confirmed problems, and receiving disenrollment requests made by recipients.

(23) The agency shall require the publication of the health maintenance organization's and the prepaid health plan's consumer services telephone numbers and the "800" telephone number of the statewide health maintenance organization complaint hotline on each Medicaid identification card issued by a health maintenance organization or prepaid health plan contracting with the agency to serve Medicaid recipients and on each subscriber handbook issued to a Medicaid recipient.

(24) The agency shall establish a health care quality improvement system for those entities contracting with the agency pursuant to this section, incorporating all the

standards and guidelines developed by the Medicaid Bureau of the Health Care Financing Administration as a part of the quality assurance reform initiative. The system shall include, but need not be limited to, the following:

(a) Guidelines for internal quality assurance programs, including standards for:

1. Written quality assurance program descriptions.

2. Responsibilities of the governing body for monitoring, evaluating, and making improvements to care.

3. An active quality assurance committee.

4. Quality assurance program supervision.

5. Requiring the program to have adequate resources to effectively carry out its specified activities.

6. Provider participation in the quality assurance program.

7. Delegation of quality assurance program activities.

8. Credentialing and recredentialing.

9. Enrollee rights and responsibilities.

10. Availability and accessibility to services and care.

11. Ambulatory care facilities.

12. Accessibility and availability of medical records, as well as proper recordkeeping and process for record review.

13. Utilization review.

14. A continuity of care system.

15. Quality assurance program documentation.

16. Coordination of quality assurance activity with other management activity.

17. Delivering care to pregnant women and infants; to elderly and disabled recipients, especially those who are at risk of institutional placement; to persons with developmental

disabilities; and to adults who have chronic, high-cost medical conditions.

(b) Guidelines which require the entities to conduct quality-of-care studies which:

1. Target specific conditions and specific health service delivery issues for focused monitoring and evaluation.

2. Use clinical care standards or practice guidelines to objectively evaluate the care the entity delivers or fails to deliver for the targeted clinical conditions and health services delivery issues.

3. Use quality indicators derived from the clinical care standards or practice guidelines to screen and monitor care and services delivered.

(c) Guidelines for external quality review of each contractor which require: focused studies of patterns of care; individual care review in specific situations; and followup activities on previous pattern-of-care study findings and individual-care-review findings. In designing the external quality review function and determining how it is to operate as part of the state's overall quality improvement system, the agency shall construct its external quality review organization and entity contracts to address each of the following:

1. Delineating the role of the external quality review organization.

2. Length of the external quality review organization contract with the state.

3. Participation of the contracting entities in designing external quality review organization review activities.

4. Potential variation in the type of clinical conditions and health services delivery issues to be studied at each plan.

5. Determining the number of focused pattern-of-care studies to be conducted for each plan.

6. Methods for implementing focused studies.

7. Individual care review.

8. Followup activities.

(25) In order to ensure that children receive health care services for which an entity has already been compensated, an entity contracting with the agency pursuant to this section shall achieve an annual Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Service screening rate of at least 60 percent for those recipients continuously enrolled for at least 8 months. The agency shall develop a method by which the EPSDT screening rate shall be calculated. For any entity which does not achieve the annual 60 percent rate, the entity must submit a corrective action plan for the agency's approval. If the entity does not meet the standard established in the corrective action plan during the specified timeframe, the agency is authorized to impose appropriate contract sanctions. At least annually, the agency shall publicly release the EPSDT Services screening rates of each entity it has contracted with on a prepaid basis to serve Medicaid recipients.

(26) The agency shall perform choice counseling, enrollments, and disenrollments for Medicaid recipients who are eligible for MediPass or managed care plans. Notwithstanding the prohibition contained in paragraph (18)(f), managed care plans may perform preenrollments of Medicaid recipients under the supervision of the agency or its

agents. For the purposes of this section, "preenrollment" means the provision of marketing and educational materials to a Medicaid recipient and assistance in completing the application forms, but shall not include actual enrollment into a managed care plan. An application for enrollment shall not be deemed complete until the agency or its agent verifies that the recipient made an informed, voluntary choice. The agency, in cooperation with the Department of Children and Family Services, may test new marketing initiatives to inform Medicaid recipients about their managed care options at selected sites. The agency shall report to the Legislature on the effectiveness of such initiatives. The agency may contract with a third party to perform managed care plan and MediPass choice-counseling, enrollment, and disenrollment services for Medicaid recipients and is authorized to adopt rules to implement such services. The agency may adjust the capitation rate only to cover the costs of a third-party choice-counseling, enrollment, and disenrollment contract, and for agency supervision and management of the managed care plan choice-counseling, enrollment, and disenrollment contract.

(27) Any lists of providers made available to Medicaid recipients, MediPass enrollees, or managed care plan enrollees shall be arranged alphabetically showing the provider's name and specialty and, separately, by specialty in alphabetical order.

(28) The agency shall establish an enhanced managed care quality assurance oversight function, to include at least the following components:

(a) At least quarterly analysis and followup, including sanctions as appropriate, of managed care participant utilization of services.

(b) At least quarterly analysis and followup, including sanctions as appropriate, of quality findings of the Medicaid peer review organization and other external quality assurance programs.

(c) At least quarterly analysis and followup, including sanctions as appropriate, of the fiscal viability of managed care plans.

(d) At least quarterly analysis and followup, including sanctions as appropriate, of managed care participant satisfaction and disenrollment surveys.

(e) The agency shall conduct regular and ongoing Medicaid recipient satisfaction surveys.

The analyses and followup activities conducted by the agency under its enhanced managed care quality assurance oversight function shall not duplicate the activities of accreditation reviewers for entities regulated under part III of chapter 641, but may include a review of the finding of such reviewers.

(29) Each managed care plan that is under contract with the agency to provide health care services to Medicaid recipients shall annually conduct a background check with the Florida Department of Law Enforcement of all persons with ownership interest of 5 percent or more or executive management responsibility for the managed care plan and shall submit to the agency information concerning any such person who has been found guilty of, regardless of adjudication, or has entered a plea of nolo contendere or guilty to, any of the offenses listed in s. 435.03.

(30) The agency shall, by rule, develop a process whereby a Medicaid managed care plan enrollee who wishes to

enter hospice care may be disenrolled from the managed care plan within 24 hours after contacting the agency regarding such request. The agency rule shall include a methodology for the agency to recoup managed care plan payments on a pro rata basis if payment has been made for the enrollment month when disenrollment occurs.

(31) The agency and entities which contract with the agency to provide health care services to Medicaid recipients under this section or s. 409.9122 must comply with the provisions of s. 641.513 in providing emergency services and care to Medicaid recipients and MediPass recipients.

(32) All entities providing health care services to Medicaid recipients shall make available, and encourage all pregnant women and mothers with infants to receive, and provide documentation in the medical records to reflect, the following:

(a) Healthy Start prenatal or infant screening.

(b) Healthy Start care coordination, when screening or other factors indicate need.

(c) Healthy Start enhanced services in accordance with the prenatal or infant screening results.

(d) Immunizations in accordance with recommendations of the Advisory Committee on Immunization Practices of the United States Public Health Service and the American Academy of Pediatrics, as appropriate.

(e) Counseling and services for family planning to all women and their partners.

(f) A scheduled postpartum visit for the purpose of voluntary family planning, to include discussion of all methods of contraception, as appropriate.

(g) Referral to the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

(33) Any entity that provides Medicaid prepaid health plan services shall ensure the appropriate coordination of health care services with an assisted living facility in cases where a Medicaid recipient is both a member of the entity's prepaid health plan and a resident of the assisted living facility. If the entity is at risk for Medicaid targeted case management and behavioral health services, the entity shall inform the assisted living facility of the procedures to follow should an emergent condition arise.

(34) The agency may seek and implement federal waivers necessary to provide for cost-effective purchasing of home health services, private duty nursing services, transportation, independent laboratory services, and durable medical equipment and supplies through competitive bidding ~~negotiation~~ pursuant to s. 287.057. The agency may request appropriate waivers from the federal Health Care Financing Administration in order to competitively bid such ~~home health~~ services. The agency may exclude providers not selected through the bidding process from the Medicaid provider network.

(35) The Agency for Health Care Administration is directed to issue a request for proposal or intent to negotiate to implement on a demonstration basis an outpatient specialty services pilot project in a rural and urban county in the state. As used in this subsection, the term "outpatient specialty services" means clinical laboratory, diagnostic imaging, and specified home medical services to include durable medical equipment, prosthetics and orthotics, and infusion therapy.

(a) The entity that is awarded the contract to provide Medicaid managed care outpatient specialty services must, at a minimum, meet the following criteria:

1. The entity must be licensed by the Department of Insurance under part II of chapter 641.

2. The entity must be experienced in providing outpatient specialty services.

3. The entity must demonstrate to the satisfaction of the agency that it provides high-quality services to its patients.

4. The entity must demonstrate that it has in place a complaints and grievance process to assist Medicaid recipients enrolled in the pilot managed care program to resolve complaints and grievances.

(b) The pilot managed care program shall operate for a period of 3 years. The objective of the pilot program shall be to determine the cost-effectiveness and effects on utilization, access, and quality of providing outpatient specialty services to Medicaid recipients on a prepaid, capitated basis.

(c) The agency shall conduct a quality assurance review of the prepaid health clinic each year that the demonstration program is in effect. The prepaid health clinic is responsible for all expenses incurred by the agency in conducting a quality assurance review.

(d) The entity that is awarded the contract to provide outpatient specialty services to Medicaid recipients shall report data required by the agency in a format specified by the agency, for the purpose of conducting the evaluation required in paragraph (e).

(e) The agency shall conduct an evaluation of the pilot managed care program and report its findings to the Governor and the Legislature by no later than January 1, 2001.

(36) The agency shall enter into agreements with not-for-profit organizations based in this state for the purpose of providing vision screening.

(37)(a) The agency shall implement a Medicaid prescribed-drug spending-control program that includes the following components:

1. Medicaid prescribed-drug coverage for brand-name drugs for adult Medicaid recipients ~~not residing in nursing homes or other institutions~~ is limited to the dispensing of four brand-name drugs per month per recipient. Children ~~and institutionalized adults~~ are exempt from this restriction. Antiretroviral agents are excluded from this limitation. No requirements for prior authorization or other restrictions on medications used to treat mental illnesses such as schizophrenia, severe depression, or bipolar disorder may be imposed on Medicaid recipients. Medications that will be available without restriction for persons with mental illnesses include atypical antipsychotic medications, conventional antipsychotic medications, selective serotonin reuptake inhibitors, and other medications used for the treatment of serious mental illnesses. The agency shall also limit the amount of a prescribed drug dispensed to no more than a 34-day supply. The agency shall continue to provide unlimited generic drugs, contraceptive drugs and items, and diabetic supplies. Although a drug may be included on the preferred drug formulary, it would not be exempt from the four-brand limit.The agency may authorize exceptions to the brand-name-drug restriction based upon the treatment needs of

the patients, only when such exceptions are based on prior consultation provided by the agency or an agency contractor, but the agency must establish procedures to ensure that:

a. There will be a response to a request for prior consultation by telephone or other telecommunication device within 24 hours after receipt of a request for prior consultation; ~~and~~

b. A 72-hour supply of the drug prescribed will be provided in an emergency or when the agency does not provide a response within 24 hours as required by sub-subparagraph a.; and

c. Except for the exception for nursing home residents and other institutionalized adults and except for drugs on the restricted formulary for which prior authorization may be sought by an institutional or community pharmacy, prior authorization for an exception to the brand-name-drug restriction is sought by the prescriber and not by the pharmacy. When prior authorization is granted for a patient in an institutional setting beyond the brand-name-drug restriction, such approval is authorized for 12 months and monthly prior authorization is not required for that patient.

2. Reimbursement to pharmacies for Medicaid prescribed drugs shall be set at the average wholesale price less 13.25 percent.

3. The agency shall develop and implement a process for managing the drug therapies of Medicaid recipients who are using significant numbers of prescribed drugs each month. The management process may include, but is not limited to, comprehensive, physician-directed medical-record reviews, claims analyses, and case evaluations to determine the medical necessity and appropriateness of a patient's treatment plan

and drug therapies. The agency may contract with a private organization to provide drug-program-management services. The Medicaid drug benefit management program shall include initiatives to manage drug therapies for HIV/AIDS patients, patients using 20 or more unique prescriptions in a 180-day period, and the top 1,000 patients in annual spending.

4. The agency may limit the size of its pharmacy network based on need, competitive bidding, price negotiations, credentialing, or similar criteria. The agency shall give special consideration to rural areas in determining the size and location of pharmacies included in the Medicaid pharmacy network. A pharmacy credentialing process may include criteria such as a pharmacy's full-service status, location, size, patient educational programs, patient consultation, disease-management services, and other characteristics. The agency may impose a moratorium on Medicaid pharmacy enrollment when it is determined that it has a sufficient number of Medicaid-participating providers.

5. The agency shall develop and implement a program that requires Medicaid practitioners who prescribe drugs to use a counterfeit-proof prescription pad for Medicaid prescriptions. The agency shall require the use of standardized counterfeit-proof prescription pads by Medicaid-participating prescribers or prescribers who write prescriptions for Medicaid recipients. The agency may implement the program in targeted geographic areas or statewide.

6. The agency may enter into arrangements that require manufacturers of generic drugs prescribed to Medicaid recipients to provide rebates of at least 15.1 percent of the average manufacturer price for the manufacturer's generic

products. These arrangements shall require that if a generic-drug manufacturer pays federal rebates for Medicaid-reimbursed drugs at a level below 15.1 percent, the manufacturer must provide a supplemental rebate to the state in an amount necessary to achieve a 15.1-percent rebate level. ~~If a generic-drug manufacturer raises its price in excess of the Consumer Price Index (Urban), the excess amount shall be included in the supplemental rebate to the state.~~

7. The agency may establish a preferred drug formulary in accordance with 42 U.S.C. s. 1396r-8, and, pursuant to the establishment of such formulary, it is authorized to negotiate supplemental rebates from manufacturers that are in addition to those required by Title XIX of the Social Security Act and at no less than 10 percent of the average manufacturer price as defined in 42 U.S.C. s. 1936 on the last day of a quarter unless the federal or supplemental rebate, or both, equals or exceeds 25 percent. There is no upper limit on the supplemental rebates the agency may negotiate. The agency may determine that specific products, brand-name or generic, are competitive at lower rebate percentages. Agreement to pay the minimum supplemental rebate percentage will guarantee a manufacturer that the Medicaid Pharmaceutical and Therapeutics Committee will consider a product for inclusion on the preferred drug formulary. However, a pharmaceutical manufacturer is not guaranteed placement on the formulary by simply paying the minimum supplemental rebate. Agency decisions will be made on the clinical efficacy of a drug and recommendations of the Medicaid Pharmaceutical and Therapeutics Committee, as well as the price of competing products minus federal and state rebates. The agency is authorized to contract with an outside agency or contractor to

conduct negotiations for supplemental rebates. For the purposes of this section, the term "supplemental rebates" may include, at the agency's discretion, cash rebates and other program benefits that offset a Medicaid expenditure. Such other program benefits may include, but are not limited to, disease management programs, drug product donation programs, drug utilization control programs, prescriber and beneficiary counseling and education, fraud and abuse initiatives, and other services or administrative investments with guaranteed savings to the Medicaid program in the same year the rebate reduction is included in the General Appropriations Act. The agency is authorized to seek any federal waivers to implement this initiative.

8. The agency shall establish an advisory committee for the purposes of studying the feasibility of using a restricted drug formulary for nursing home residents and other institutionalized adults. The committee shall be comprised of seven members appointed by the Secretary of Health Care Administration. The committee members shall include two physicians licensed under chapter 458 or chapter 459, Florida Statutes; three pharmacists licensed under chapter 465, Florida Statutes, and appointed from a list of recommendations provided by the Florida Long-Term Care Pharmacy Alliance; and two pharmacists licensed under chapter 465, Florida Statutes.

(b) The agency shall implement this subsection to the extent that funds are appropriated to administer the Medicaid prescribed-drug spending-control program. The agency may contract all or any part of this program to private organizations.

(c) The agency shall submit a report to the Governor, the President of the Senate, and the Speaker of the House of

Representatives by January 15 of each year. The report must include, but need not be limited to, the progress made in implementing Medicaid cost-containment measures and their effect on Medicaid prescribed-drug expenditures.

(38) Notwithstanding the provisions of chapter 287, the agency may, at its discretion, renew a contract or contracts for fiscal intermediary services one or more times for such periods as the agency may decide; however, all such renewals may not combine to exceed a total period longer than the term of the original contract.

(39) The agency shall provide for the development of a demonstration project by establishment in Miami-Dade County of a long-term-care facility licensed pursuant to chapter 395 to improve access to health care for a predominantly minority, medically underserved, and medically complex population and to evaluate alternatives to nursing-home care and general acute care for such population. Such project is to be located in a health care condominium and colocated with licensed facilities providing a continuum of care. The establishment of this project is not subject to the provisions of s. 408.036 or s. 408.039. The agency shall report its findings to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 1, 2003.

Section 10. Paragraphs (f) and (k) of subsection (2) of section 409.9122, Florida Statutes, are amended to read:

409.9122 Mandatory Medicaid managed care enrollment; programs and procedures.--

(2)

(f) When a Medicaid recipient does not choose a managed care plan or MediPass provider, the agency shall assign the Medicaid recipient to a managed care plan or

MediPass provider. Medicaid recipients who are subject to mandatory assignment but who fail to make a choice shall be assigned to managed care plans or provider service networks until an equal enrollment of 50 percent in MediPass and provider service networks and 50 percent in managed care plans is achieved. Once equal enrollment is achieved, the assignments shall be divided in order to maintain an equal enrollment in MediPass and managed care plans ~~for the 1998-1999 fiscal year~~. Thereafter, assignment of Medicaid recipients who fail to make a choice shall be based proportionally on the preferences of recipients who have made a choice in the previous period. Such proportions shall be revised at least quarterly to reflect an update of the preferences of Medicaid recipients. The agency shall also disproportionately assign Medicaid-eligible children in families who are required to but have failed to make a choice of managed-care plan or MediPass for their child and who are to be assigned to the MediPass program to children's networks as described in s. 409.912(3)(g) and where available. The disproportionate assignment of children to children's networks shall be made until the agency has determined that the children's networks have sufficient numbers to be economically operated.When making assignments, the agency shall take into account the following criteria:

1. A managed care plan has sufficient network capacity to meet the need of members.

2. The managed care plan or MediPass has previously enrolled the recipient as a member, or one of the managed care plan's primary care providers or MediPass providers has previously provided health care to the recipient.

3. The agency has knowledge that the member has previously expressed a preference for a particular managed care plan or MediPass provider as indicated by Medicaid fee-for-service claims data, but has failed to make a choice.

4. The managed care plan's or MediPass primary care providers are geographically accessible to the recipient's residence.

(k)~~1. Notwithstanding the provisions of paragraph (f), and for the 2000-2001 fiscal year only,~~When a Medicaid recipient does not choose a managed care plan or MediPass provider, the agency shall assign the Medicaid recipient to a managed care plan, except in those counties in which there are fewer than two managed care plans accepting Medicaid enrollees, in which case assignment shall be to a managed care plan or a MediPass provider. Medicaid recipients in counties with fewer than two managed care plans accepting Medicaid enrollees who are subject to mandatory assignment but who fail to make a choice shall be assigned to managed care plans until an equal enrollment of 50 percent in MediPass and provider service networks and 50 percent in managed care plans is achieved. Once equal enrollment is achieved, the assignments shall be divided in order to maintain an equal enrollment in MediPass and managed care plans. When making assignments, the agency shall take into account the following criteria:

1.~~a.~~ A managed care plan has sufficient network capacity to meet the need of members.

2.~~b.~~ The managed care plan or MediPass has previously enrolled the recipient as a member, or one of the managed care plan's primary care providers or MediPass providers has previously provided health care to the recipient.

3.~~c.~~ The agency has knowledge that the member has previously expressed a preference for a particular managed care plan or MediPass provider as indicated by Medicaid fee-for-service claims data, but has failed to make a choice.

4.~~d.~~ The managed care plan's or MediPass primary care providers are geographically accessible to the recipient's residence.

5.~~e.~~ The agency has authority to make mandatory assignments based on quality of service and performance of managed care plans.

~~2. This paragraph is repealed on July 1, 2001.~~

Section 11. Paragraph (a) of subsection (1) and subsection (7) of section 409.915, Florida Statutes, are amended to read:

409.915 County contributions to Medicaid.--Although the state is responsible for the full portion of the state share of the matching funds required for the Medicaid program, in order to acquire a certain portion of these funds, the state shall charge the counties for certain items of care and service as provided in this section.

(1) Each county shall participate in the following items of care and service:

(a) For both health maintenance members and fee-for-service beneficiaries, payments for inpatient hospitalization in excess of 10 ~~12~~ days, but not in excess of 45 days, with the exception of pregnant women and children whose income is in excess of the federal poverty level and who do not participate in the Medicaid medically needy program.

(7) Counties are exempt from contributing toward the cost of new exemptions on inpatient ceilings for statutory teaching hospitals, specialty hospitals, and community

hospital education program hospitals that came into effect July 1, 2000, and for special Medicaid payments that came into effect on or after July 1, 2000.~~Notwithstanding any provision of this section to the contrary, counties are exempt from contributing toward the increased cost of hospital inpatient services due to the elimination of ceilings on Medicaid inpatient reimbursement rates paid to teaching hospitals, specialty hospitals, and community health education program hospitals and for special Medicaid reimbursements to hospitals for which the Legislature has specifically appropriated funds. This subsection is repealed on July 1, 2001.~~

Section 12. Effective upon this act becoming a law, and notwithstanding sections 409.911, 409.9113, and 409.9117, Florida Statutes, from the funds made available under the Medicare program, the Medicaid program, and the State Children's Health Insurance Program Benefits Improvement and Protection Act of 2000 for the 2001 federal fiscal year, disproportionate share program funds shall be distributed as follows: $13,937,997 to Jackson Memorial; $285,298 to Mount Sinai Medical Center; $313,748 to Orlando Regional Medical Center; $2,734,019 to Shands - Jacksonville; $1,060,047 to Shands - University of Florida; $1,683,415 to Tampa General Hospital; and $2,231,910 to North Broward Hospital District. Such funds shall be made available in accordance with a budget amendment and the Medicaid plan amendment submitted prior to the close of the 2001 federal fiscal year. This section does not delay implementation of the budget amendment or the Medicaid plan amendment if such is deemed necessary.

Section 13. From the funds in Specific Appropriation 1002 of the General Appropriations Act for FY 2001-2002,

$1,750,000 in non-recurring County Health Department Trust Funds is provided for the following:

School Health--Hillsborough County	$550,000
School Health--Broward County	$500,000
School Health--Escambia County	$200,000
School Health--Monroe County	$200,000
School Health--Dade County	$300,000

Section 14. The certificate-of-need workgroup created by section 15 of Chapter 2000-318, Laws of Florida, shall review and make recommendations regarding the appropriateness of current regulations on services provided in ambulatory surgical centers. The recommendations shall be based on consideration of:

(1) The consistency of the regulations with federal law and federal reimbursement policies;

(2) The effectiveness of the regulations in protecting the public health and safety, promoting the quality of services provided by ambulatory surgical centers, and encouraging the participation of ambulatory surgical centers in the delivery of essential community services; and

(3) The impact of any change of the current regulations on the health care market, including:

(a) The number and location of facilities and services, whether provided by an ambulatory surgical center or other licensed health care provider;

(b) The financial condition of safety net providers;

(c) The availability of essential community services, including trauma, emergency care and specialty, tertiary services; and

(d) The cost and availability of health care services to all classes of patients, including insured, uninsured, underinsured, and Medicare and Medicaid.

Section 15. Paragraphs (r) and (s) are added to subsection (3) of section 408.036, Florida Statutes, to read:

408.036 Projects subject to review.--

(3) EXEMPTIONS.--Upon request, the following projects are subject to exemption from the provisions of subsection (1):

(r) For the conversion of hospital-based Medicare and Medicaid certified skilled nursing beds to acute care beds, if the conversion does not involve the construction of new facilities.

(s) For fiscal year 2001-2002 only, for transfer by a health care system of existing services and not more than 100 licensed and approved beds from a hospital in district 1, subdistrict 1, to another location within the same subdistrict in order to establish a satellite facility that will improve access to outpatient and inpatient care for residents of the district and subdistrict and that will use new medical technologies, including advanced diagnostics, computer assisted imaging, and telemedicine to improve care. This paragraph is repealed on July 1, 2002.

Section 16. The Legislature determines and declares that this act fulfills an important state interest.

Section 17. It is hereby appropriated for state fiscal year 2001-2002, $713,493 from the General Revenue Fund and $924,837 from the Medical Care Trust Fund to increase the pharmaceutical dispensing fee for prescriptions dispensed to nursing home residents and other institutional residents from $4.23 to $4.73 per prescription.

Section 18. From the funds in Specific Appropriation 500 of the General Appropriations Act for FY 2001-2002, $196,000 in General Revenue is provided for the following:

Public Guardianship Program - Dade County	$150,000
Public Guardianship Program - Collier County	$ 38,000
Public Guardianship Program - Escambia County	$ 8,000

Section 19. Subsection (1) and paragraph (a) of subsection (7) of section 240.4075, Florida Statutes, are amended to read:

240.4075 Nursing Student Loan Forgiveness Program.--

(1) To encourage qualified personnel to seek employment in areas of this state in which critical nursing shortages exist, there is established the Nursing Student Loan Forgiveness Program. The primary function of the program is to increase employment and retention of registered nurses and licensed practical nurses in nursing homes and hospitals in the state and in state-operated medical and health care facilities, birth centers, federally sponsored community health centers, ~~and~~ teaching hospitals, family practice teaching hospitals, and specialty children's hospitals by making repayments toward loans received by students from federal or state programs or commercial lending institutions for the support of postsecondary study in accredited or approved nursing programs.

(7)(a) Funds contained in the Nursing Student Loan Forgiveness Trust Fund which are to be used for loan forgiveness for those nurses employed by hospitals, birth centers, and nursing homes must be matched on a

dollar-for-dollar basis by contributions from the employing institutions, except that this provision shall not apply to state-operated medical and health care facilities, county health departments, federally sponsored community health centers, ~~or~~ teaching hospitals as defined in s. 408.07, family practice teaching hospitals as defined in s. 395.805, or specialty children's hospitals as described in s. 409.9119. If, in any given fiscal quarter, there are insufficient funds in the trust fund to grant all eligible applicants' requests, awards must be based on the following priority by employer: county health departments, federally sponsored community health centers, state-operated medical and health care facilities, teaching hospitals as defined in s. 408.07, family practice teaching hospitals as defined in s. 395.805, specialty children's hospitals as described in s. 409.9119, and other hospitals, birthing centers, or nursing homes where the match is required.

Section 20. Paragraph (b) of subsection (4) of section 240.4076, Florida Statutes, is amended to read:

240.4076 Nursing scholarship program.--

(4) Credit for repayment of a scholarship shall be as follows:

(b) Eligible health care facilities include state-operated medical or health care facilities, county health departments, federally sponsored community health centers, ~~or~~ teaching hospitals as defined in s. 408.07, nursing homes, family practice teaching hospitals as defined in s. 395.805, or specialty children's hospitals as described in s. 409.9119. The recipient shall be encouraged to complete the service obligation at a single employment site. If continuous employment at the same site is not feasible, the

recipient may apply to the department for a transfer to another approved health care facility.

Section 21. All the statutory powers, duties, and functions and the records, personnel, property, and unexpended balances of appropriations, allocations, or other funds of the Nursing Student Loan Forgiveness Program are transferred from the Department of Education to the Department of Health by a type two transfer as defined in section 20.06, Florida Statutes.

Section 22. Except as otherwise expressly provided in this act, this act shall take effect July 1, 2001.