A bill to be entitled

An act relating to the Medicaid program; amending ss. 409.908 and 409.912, F.S.; revising the amount reimbursed to providers and pharmacies for drugs prescribed under the program; creating s. 409.9082, F.S.; providing definitions; requiring the Agency for Health Care Administration to calculate and assess a quality assessment on health care items or services provided by nursing facilities; requiring the agency to seek a waiver of broad-based and uniform provider assessment requirements of federal law; providing for the return of collected assessments under certain circumstances; requiring the agency to adopt rules; providing for the use of moneys in the Grants and Donations Trust Fund and specifying an order of priority; providing for nullification of the quality assessment under certain circumstances; authorizing the agency to impose certain penalties and fines; prohibiting the reversion of moneys in the fund relating to the quality assessment; providing an effective date.

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

Section 1. Subsection (14) of section 409.908, Florida Statutes, is amended 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. If a provider is reimbursed based on cost reporting and submits a cost report late and that cost report would have been used to set a lower reimbursement rate for a rate semester, then the provider's rate for that semester shall be retroactively calculated using the new cost report, and full payment at the recalculated rate shall be effected retroactively. Medicare-granted extensions for filing cost reports, if applicable, shall also apply to Medicaid cost reports. 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.

(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 Medicaid

maximum allowable fee for ingredient cost will be based on the lower of: average wholesale price (AWP) minus 18.4 ~~16.4~~ percent, wholesaler acquisition cost (WAC) plus 2.75 ~~4.75~~ percent, the federal upper limit (FUL), the state maximum allowable cost (SMAC), or the usual and customary (UAC) charge billed by the provider. Medicaid providers are required to dispense generic drugs if available at lower cost and the agency has not determined that the branded product is more cost-effective, unless the prescriber has requested and received approval to require the branded product. 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, the volume of prescriptions dispensed to an individual recipient, and dispensing of preferred-drug-list products. The agency may increase the pharmacy dispensing fee authorized by statute and in the annual General Appropriations Act by $0.50 for the dispensing of a Medicaid preferred-drug-list product and reduce the pharmacy dispensing fee by $0.50 for the dispensing of a Medicaid product that is not included on the preferred drug list. The agency may establish a supplemental pharmaceutical dispensing fee to be paid to providers returning unused unit-dose packaged medications to stock and crediting the Medicaid program for the ingredient cost of those medications if the ingredient costs to be credited exceed the value of the supplemental dispensing fee. 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.

Section 2. Subsection (39) of 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. To ensure that medical services are effectively utilized, the agency may, in any case, require a confirmation or second physician's opinion of the correct diagnosis for purposes of authorizing future services under the Medicaid program. This section does not restrict access to emergency services or poststabilization care services as defined in 42 C.F.R. part 438.114. Such confirmation or second opinion shall be rendered in a manner approved by the agency. 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 shall contract with a vendor to monitor and evaluate the clinical practice patterns of providers in order to identify trends that are outside the normal practice patterns of a provider's professional peers or the national guidelines of a

provider's professional association. The vendor must be able to provide information and counseling to a provider whose practice patterns are outside the norms, in consultation with the agency, to improve patient care and reduce inappropriate utilization. The agency may mandate prior authorization, drug therapy management, or disease management participation 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. The agency is authorized to limit the entities it contracts with or enrolls as Medicaid providers by developing a provider network through provider credentialing. The agency may competitively bid single-source-provider contracts if procurement of goods or services results in demonstrated cost savings to the state without limiting access to care. The agency may limit its network based on the assessment of beneficiary access to care, provider availability, provider quality standards, time and distance standards for access to care, the cultural competence of the provider network, demographic characteristics of Medicaid beneficiaries, practice and provider-to-beneficiary standards, appointment wait times, beneficiary use of services, provider turnover, provider profiling, provider licensure history, previous program integrity investigations and findings, peer review, provider Medicaid policy and billing compliance records, clinical and medical record audits, and other factors. Providers

shall not be entitled to enrollment in the Medicaid provider network. The agency shall determine instances in which allowing Medicaid beneficiaries to purchase durable medical equipment and other goods is less expensive to the Medicaid program than long-term rental of the equipment or goods. The agency may establish rules to facilitate purchases in lieu of long-term rentals in order to protect against fraud and abuse in the Medicaid program as defined in s. 409.913. The agency may seek federal waivers necessary to administer these policies.

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

1. A Medicaid preferred drug list, which shall be a listing of cost-effective therapeutic options recommended by the Medicaid Pharmacy and Therapeutics Committee established pursuant to s. 409.91195 and adopted by the agency for each therapeutic class on the preferred drug list. At the discretion of the committee, and when feasible, the preferred drug list should include at least two products in a therapeutic class. The agency may post the preferred drug list and updates to the preferred drug list on an Internet website without following the rulemaking procedures of chapter 120. Antiretroviral agents are excluded from the preferred drug list. The agency shall also limit the amount of a prescribed drug dispensed to no more than a 34-day supply unless the drug products' smallest marketed package is greater than a 34-day supply, or the drug is determined by the agency to be a maintenance drug in which case a 100-day maximum supply may be authorized. The agency is authorized to seek any federal waivers necessary to implement

these cost-control programs and to continue participation in the federal Medicaid rebate program, or alternatively to negotiate state-only manufacturer rebates. The agency may adopt rules to implement this subparagraph. The agency shall continue to provide unlimited contraceptive drugs and items. The agency must establish procedures to ensure that:

a. There is 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 is provided in an emergency or when the agency does not provide a response within 24 hours as required by sub-subparagraph a.

2. Reimbursement to pharmacies for Medicaid prescribed drugs shall be set at the lesser of: the average wholesale price (AWP) minus 18.4 ~~16.4~~ percent, the wholesaler acquisition cost (WAC) plus 2.75 ~~4.75~~ percent, the federal upper limit (FUL), the state maximum allowable cost (SMAC), or the usual and customary (UAC) charge billed by the provider.

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. The agency shall enroll any Medicaid recipient in the drug benefit management program if he or she meets the specifications of this provision and is not enrolled in a Medicaid health maintenance organization.

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. The agency must allow dispensing practitioners to participate as a part of the Medicaid pharmacy network regardless of the practitioner's proximity to any other entity that is dispensing prescription drugs under the Medicaid program. A dispensing practitioner must meet all credentialing requirements applicable to his or her practice, as determined by the agency.

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.

7. The agency may establish a preferred drug list as described in this subsection, and, pursuant to the establishment of such preferred drug list, 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 14 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 29 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 list. However, a pharmaceutical manufacturer is not guaranteed placement on the preferred drug list 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" means cash rebates. Effective July 1, 2004, value-added programs as a substitution for supplemental rebates are prohibited. The agency is authorized to seek any federal waivers to implement this initiative.

8. The Agency for Health Care Administration shall expand home delivery of pharmacy products. To assist Medicaid patients in securing their prescriptions and reduce program costs, the agency shall expand its current mail-order-pharmacy diabetes-supply program to include all generic and brand-name drugs used by Medicaid patients with diabetes. Medicaid recipients in the current program may obtain nondiabetes drugs on a voluntary basis. This initiative is limited to the geographic area covered by the current contract. The agency may seek and implement any federal waivers necessary to implement this subparagraph.

9. The agency shall limit to one dose per month any drug prescribed to treat erectile dysfunction.

10.a. The agency may implement a Medicaid behavioral drug management system. The agency may contract with a vendor that has experience in operating behavioral drug management systems to implement this program. The agency is authorized to seek federal waivers to implement this program.

b. The agency, in conjunction with the Department of

Children and Family Services, may implement the Medicaid behavioral drug management system that is designed to improve the quality of care and behavioral health prescribing practices based on best practice guidelines, improve patient adherence to medication plans, reduce clinical risk, and lower prescribed drug costs and the rate of inappropriate spending on Medicaid behavioral drugs. The program may include the following elements:

(I) Provide for the development and adoption of best practice guidelines for behavioral health-related drugs such as antipsychotics, antidepressants, and medications for treating bipolar disorders and other behavioral conditions; translate them into practice; review behavioral health prescribers and compare their prescribing patterns to a number of indicators that are based on national standards; and determine deviations from best practice guidelines.

(II) Implement processes for providing feedback to and educating prescribers using best practice educational materials and peer-to-peer consultation.

(III) Assess Medicaid beneficiaries who are outliers in their use of behavioral health drugs with regard to the numbers and types of drugs taken, drug dosages, combination drug therapies, and other indicators of improper use of behavioral health drugs.

(IV) Alert prescribers to patients who fail to refill prescriptions in a timely fashion, are prescribed multiple same-class behavioral health drugs, and may have other potential medication problems.

(V) Track spending trends for behavioral health drugs and

deviation from best practice guidelines.

(VI) Use educational and technological approaches to promote best practices, educate consumers, and train prescribers in the use of practice guidelines.

(VII) Disseminate electronic and published materials.

(VIII) Hold statewide and regional conferences.

(IX) Implement a disease management program with a model quality-based medication component for severely mentally ill individuals and emotionally disturbed children who are high users of care.

11.a. The agency shall implement a Medicaid prescription drug management system. The agency may contract with a vendor that has experience in operating prescription drug management systems in order to implement this system. Any management system that is implemented in accordance with this subparagraph must rely on cooperation between physicians and pharmacists to determine appropriate practice patterns and clinical guidelines to improve the prescribing, dispensing, and use of drugs in the Medicaid program. The agency may seek federal waivers to implement this program.

b. The drug management system must be designed to improve the quality of care and prescribing practices based on best practice guidelines, improve patient adherence to medication plans, reduce clinical risk, and lower prescribed drug costs and the rate of inappropriate spending on Medicaid prescription drugs. The program must:

(I) Provide for the development and adoption of best practice guidelines for the prescribing and use of drugs in the Medicaid program, including translating best practice guidelines

into practice; reviewing prescriber patterns and comparing them to indicators that are based on national standards and practice patterns of clinical peers in their community, statewide, and nationally; and determine deviations from best practice guidelines.

(II) Implement processes for providing feedback to and educating prescribers using best practice educational materials and peer-to-peer consultation.

(III) Assess Medicaid recipients who are outliers in their use of a single or multiple prescription drugs with regard to the numbers and types of drugs taken, drug dosages, combination drug therapies, and other indicators of improper use of prescription drugs.

(IV) Alert prescribers to patients who fail to refill prescriptions in a timely fashion, are prescribed multiple drugs that may be redundant or contraindicated, or may have other potential medication problems.

(V) Track spending trends for prescription drugs and deviation from best practice guidelines.

(VI) Use educational and technological approaches to promote best practices, educate consumers, and train prescribers in the use of practice guidelines.

(VII) Disseminate electronic and published materials.

(VIII) Hold statewide and regional conferences.

(IX) Implement disease management programs in cooperation with physicians and pharmacists, along with a model quality-based medication component for individuals having chronic medical conditions.

12. The agency is authorized to contract for drug rebate

administration, including, but not limited to, calculating rebate amounts, invoicing manufacturers, negotiating disputes with manufacturers, and maintaining a database of rebate collections.

13. The agency may specify the preferred daily dosing form or strength for the purpose of promoting best practices with regard to the prescribing of certain drugs as specified in the General Appropriations Act and ensuring cost-effective prescribing practices.

14. The agency may require prior authorization for Medicaid-covered prescribed drugs. The agency may, but is not required to, prior-authorize the use of a product:

a. For an indication not approved in labeling;

b. To comply with certain clinical guidelines; or

c. If the product has the potential for overuse, misuse, or abuse.

The agency may require the prescribing professional to provide information about the rationale and supporting medical evidence for the use of a drug. The agency may post prior authorization criteria and protocol and updates to the list of drugs that are subject to prior authorization on an Internet website without amending its rule or engaging in additional rulemaking.

15. The agency, in conjunction with the Pharmaceutical and Therapeutics Committee, may require age-related prior authorizations for certain prescribed drugs. The agency may preauthorize the use of a drug for a recipient who may not meet the age requirement or may exceed the length of therapy for use of this product as recommended by the manufacturer and approved

by the Food and Drug Administration. Prior authorization may require the prescribing professional to provide information about the rationale and supporting medical evidence for the use of a drug.

16. The agency shall implement a step-therapy prior authorization approval process for medications excluded from the preferred drug list. Medications listed on the preferred drug list must be used within the previous 12 months prior to the alternative medications that are not listed. The step-therapy prior authorization may require the prescriber to use the medications of a similar drug class or for a similar medical indication unless contraindicated in the Food and Drug Administration labeling. The trial period between the specified steps may vary according to the medical indication. The step-therapy approval process shall be developed in accordance with the committee as stated in s. 409.91195(7) and (8). A drug product may be approved without meeting the step-therapy prior authorization criteria if the prescribing physician provides the agency with additional written medical or clinical documentation that the product is medically necessary because:

a. There is not a drug on the preferred drug list to treat the disease or medical condition which is an acceptable clinical alternative;

b. The alternatives have been ineffective in the treatment of the beneficiary's disease; or

c. Based on historic evidence and known characteristics of the patient and the drug, the drug is likely to be ineffective, or the number of doses have been ineffective.

The agency shall work with the physician to determine the best alternative for the patient. The agency may adopt rules waiving the requirements for written clinical documentation for specific drugs in limited clinical situations.

17. The agency shall implement a return and reuse program for drugs dispensed by pharmacies to institutional recipients, which includes payment of a $5 restocking fee for the implementation and operation of the program. The return and reuse program shall be implemented electronically and in a manner that promotes efficiency. The program must permit a pharmacy to exclude drugs from the program if it is not practical or cost-effective for the drug to be included and must provide for the return to inventory of drugs that cannot be credited or returned in a cost-effective manner. The agency shall determine if the program has reduced the amount of Medicaid prescription drugs which are destroyed on an annual basis and if there are additional ways to ensure more prescription drugs are not destroyed which could safely be reused. The agency's conclusion and recommendations shall be reported to the Legislature by December 1, 2005.

(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 quarterly reports to the Governor, the President of the Senate, and the Speaker of the House of Representatives which must include, but need not be limited to, the progress made in implementing this subsection

and its effect on Medicaid prescribed-drug expenditures.

Section 3. Section 409.9082, Florida Statutes, is created to read:

409.9082 Nursing facility quality assessment; uses of revenues and matching federal funds.—

(1) As used in this section, the term:

(a) "Certain high-volume Medicaid nursing facilities" means the fewest number of facilities necessary and having the highest number of Medicaid days or total patient days annually to meet the statistical redistribution test under 42 C.F.R. s. 433.68(e)(2).

(b) "Medicare Part A resident days" means those patient days funded by the Medicare program or by a Medicare Advantage or special needs plan.

(c) "Net patient service revenue" means gross revenues from services provided to nursing facility patients, less deductions from revenue.

(d) "Deductions from revenue" means reductions from gross revenue resulting from an inability to collect payment of charges. Such reductions include bad debts; contractual adjustments; uncompensated care; administrative, courtesy, and policy discounts and adjustments; and other such revenue deductions.

(e) "Nursing facility" or "nursing home" has the same meaning as the term "nursing home facility" provided in s. 400.021.

(f) "Resident day" means a calendar day of care provided to a nursing facility resident and includes the day of admission and excludes the day of discharge, except that, when admission

and discharge occur on the same day, one day of care is deemed to exist.

(g) "Skilled nursing facility units of acute care hospitals" means the Medicare or Medicare-certified skilled nursing beds located in hospitals licensed by the agency under chapter 395 and defined as such by s. 395.002(10) and (12).

(h) "Fund" means the Grants and Donations Trust Fund of the Agency for Health Care Administration.

(2) Effective May 1, 2009, the agency shall calculate annually the quality assessment rates that nonexempt providers will report and pay on a monthly basis for each non-Medicare patient day. The quality assessment may not exceed 5 percent of the total aggregate net patient service revenue of assessed facilities. The agency shall notify providers of the quality assessment and provide a standardized form to complete and submit with payments. The agency shall collect the quality assessment on health care items or services provided by nursing facilities for the purpose of obtaining federal financial participation under the state's Medicaid program, and shall use these funds to provide reimbursement up to the Medicaid rates of nursing facilities as they existed in accordance with the approved state Medicaid plan in effect on December 31, 2007, so as to ensure continued quality of care in those facilities. The quality assessment and federal matching funds shall be used exclusively for the purposes described in subsection (9).

(3) The quality assessment shall be calculated and paid on the basis of a per-resident day, exclusive of Medicare Part A resident days. The per-resident-day assessment rate shall be the same amount for each affected facility except as prescribed in

subsection (4).

(4) In accordance with the redistribution method set forth in 42 C.F.R. s. 433.68(e)(1) and (2), the agency shall seek a waiver of the broad-based and uniform provider assessment requirements of federal law to exclude certain nursing facilities from the quality assessment and to permit certain high-volume Medicaid nursing facilities or nursing facilities that have a high number of total annual patient days to pay the quality assessment at a lesser amount per non-Medicare resident day.

(a) The agency shall exempt the following nursing facility providers from the quality assessment subject to federal approval under 42 C.F.R. s. 433.68(e)(2):

1. Nursing facilities on the campus of continuing care retirement communities licensed by the agency under chapter 651;

2. Nursing facilities that have 45 or fewer beds; and

3. The skilled nursing facility units of acute care hospitals licensed by the agency under chapter 395.

(b) The agency shall lower the quality assessment for certain high-volume Medicaid nursing facilities or certain facilities that have high patient volumes to meet the redistributive tests of 42 C.F.R. s. 433.68(e)(2).

(5) The collection of the nursing facility quality assessment shall commence no sooner than 10 days after the agency's initial payment of the Medicaid rates containing the elements prescribed in subsection (9).

(6) If the nursing facility quality assessment and the broad-based and uniformity waiver are not approved by the Federal Government, notwithstanding any other provision of this

section, the agency shall return all collected assessment amounts to the nursing facilities that paid them, less any amounts expended by the agency as authorized in the General Appropriations Act for purposes of implementing the assessment, and shall discontinue the imposition, assessment, and collection of the nursing facility quality assessment.

(7) The agency shall collect the nursing facility quality assessment each month and shall collect the assessment from nursing facility providers by no later than the 15th of the next succeeding calendar month. The agency shall require nursing facility providers to report monthly their total number of days of care provided to non-Medicare Part A residents.

(8) The agency shall adopt any rules necessary for the administration and implementation of this section.

(9) The fund and all matching federal funds received for expenditures of the nursing facility quality assessment shall be used only for the following purposes and in the following order of priority:

(a) A pass through to reimburse the Medicaid share of the quality assessment as a Medicaid-allowable cost;

(b) Such increase to each nursing facility's Medicaid rate as needed to bring that rate to the same amount or level as the Medicaid rate for that nursing facility would have been on January 1, 2008, if the approved Medicaid state plan in effect on December 31, 2007, had remained in effect;

(c) Such increase to each nursing facility's Medicaid rates needed to increase rates for the 2008-2009 fiscal year in accordance with the approved state plan in effect on December 31, 2007; and

(d) Such increase to each nursing facility's Medicaid rate accounting for the portion of the total assessment not included in paragraphs (a)-(c) which begins a phase-in to a pricing model for the operating cost component.

(10) The provisions of this section shall become null and void, having no force and effect, if any of the following occur:

(a) The nursing facility quality assessment and the broad-based and uniformity waiver are not approved by the Federal Government;

(b) The Medicaid plan amendment reflecting the payment rates in subsection (9) is not approved by the Federal Government; or

(c) The weighted average Medicaid rate paid to nursing facilities is reduced below the weighted average Medicaid rate to nursing facilities in effect on June 30, 2008, plus any future annual amount of the quality assessment and the applicable matching federal funds.

(11) If this section does not become operative or becomes null and void, all moneys in the fund relating to the assessment shall be returned on a pro rata basis to the nursing facilities that paid the quality assessment.

(12) If the nursing facility fails to make its payments timely, the agency may seek any remedy provided by law, including, but not limited to:

(a) Withholding any medical assistance reimbursement payments until such time as the assessment amount is recovered;

(b) Suspension or revocation of the nursing facility license; or

(c) Imposition of a fine of up to $1,000 per day for each

delinquent payment, not to exceed the amount of the assessment.

(13) Nursing facilities may not create a separate line-item charge for the purpose of passing through the assessment to residents.

(14) Moneys in the fund relating to this assessment will not revert to the General Revenue Fund or to any other state fund at any time.

Section 4. This act shall take effect March 1, 2009.