By Senator Silver

309-502A-02

A bill to be entitled

An act relating to the Agency for Health Care Administration; amending s. 400.23, F.S.; revising the date by which certain rules relating to care for nursing home residents must be adopted; amending s. 409.903, F.S.; revising standards for eligibility for certain mandatory medical assistance; repealing s. 409.904(11), F.S., which provides eligibility of specified persons for certain optional medical assistance; amending s. 409.904, F.S.; revising standards for eligibility for certain optional medical assistance; amending s. 409.906, F.S.; eliminating adult denture services as an optional Medicaid service; limiting provision of certain hearing and visual services to recipients under age 21; revising prescribed drug services and methods of delivering those services; amending s. 409.9065, F.S.; prescribing additional eligibility standards with respect to pharmaceutical expense assistance; amending s. 409.907, F.S.; authorizing withholding of Medicaid payments in certain circumstances; prescribing additional requirements with respect to providers' submission of information; prescribing additional duties for the agency with respect to provider applications; amending s. 409.9116, F.S.; revising the disproportionate share programs for rural hospitals; eliminating financial

assistance program for certain rural hospitals; amending s. 409.912, F.S.; revising the reimbursement rate to pharmacies for Medicaid prescribed drugs; amending s. 409.913, F.S.; prescribing additional sanctions that may be imposed upon a Medicaid provider; eliminating a limit on costs that may be recovered against a provider; amending s. 409.915, F.S.; revising the limit on a county's payment for certain Medicaid costs; amending s. 409.908, F.S.; revising pharmacy dispensing fees for Medicaid drugs; repealing s. 400.0225, F.S., relating to consumer-satisfaction surveys; amending s. 400.191, F.S.; eliminating a provision relating to consumer-satisfaction and family-satisfaction surveys; amending s. 400.235, F.S.; eliminating a provision relating to participation in the consumer-satisfaction process; repealing s. 400.148, F.S., relating to the Medicaid "Up-or-Out" Quality of Care Contract Management Program; amending s. 400.071, F.S.; eliminating a provision relating to participation in a consumer-satisfaction-measurement process; amending s. 409.815, F.S.; conforming a cross-reference; providing effective dates.

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

Section 1. Paragraph (a) of subsection (3) of section 400.23, Florida Statutes, is amended to read:

400.23 Rules; evaluation and deficiencies; licensure status.--

(3)(a) The agency shall adopt rules providing for the minimum staffing requirements for nursing homes. These requirements shall include, for each nursing home facility, a minimum certified nursing assistant staffing of 2.3 hours of direct care per resident per day beginning May ~~January~~ 1, 2002, increasing to 2.6 hours of direct care per resident per day beginning May ~~January~~ 1, 2003, and increasing to 2.9 hours of direct care per resident per day beginning January 1, 2004. Beginning May ~~January~~ 1, 2002, no facility shall staff below one certified nursing assistant per 20 residents, and a minimum licensed nursing staffing of 1.0 hour of direct resident care per resident per day but never below one licensed nurse per 40 residents. Nursing assistants employed under s. 400.211(2) may be included in computing the staffing ratio for certified nursing assistants only if they provide nursing assistance services to residents on a full-time basis. Each nursing home must document compliance with staffing standards as required under this paragraph and post daily the with staffing standards as required under this paragraph and post daily the names of staff on duty for the benefit of facility residents and the public. The agency shall recognize the use of licensed nurses for compliance with minimum staffing requirements for certified nursing assistants, provided that the facility otherwise meets the minimum staffing requirements for licensed nurses and that the licensed nurses so recognized are performing the duties of a certified nursing assistant. Unless otherwise approved by the agency, licensed nurses counted towards the minimum staffing requirements for certified nursing assistants must exclusively

perform the duties of a certified nursing assistant for the entire shift and shall not also be counted towards the minimum staffing requirements for licensed nurses. If the agency approved a facility's request to use a licensed nurse to perform both licensed nursing and certified nursing assistant duties, the facility must allocate the amount of staff time specifically spent on certified nursing assistant duties for the purpose of documenting compliance with minimum staffing requirements for certified and licensed nursing staff. In no event may the hours of a licensed nurse with dual job responsibilities be counted twice.

Section 2. Effective July 1, 2002, subsection (5) of section 409.903, Florida Statutes, is amended to read:

409.903 Mandatory payments for eligible persons.--The agency shall make payments for medical assistance and related services on behalf of the following persons who the department, or the Social Security Administration by contract with the Department of Children and Family Services, determines 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.

(5) A pregnant woman for the duration of her pregnancy and for the postpartum period as defined in federal law and rule, or a child under age 1, if either is living in a family that has an income which is at or below 150 percent of the most current federal poverty level~~, or, effective January 1, 1992, that has an income which is at or below 185 percent of the most current federal poverty level~~. Such a person is not subject to an assets test. Further, a pregnant woman who

applies for eligibility for the Medicaid program through a qualified Medicaid provider must be offered the opportunity, subject to federal rules, to be made presumptively eligible for the Medicaid program.

Section 3. Subsection (11) of section 409.904, Florida Statutes, is repealed.

Section 4. Effective July 1, 2002, subsections (2) and (5) of section 409.904, Florida Statutes, are amended 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.

(2) Pregnant women and children under age 1 who would otherwise qualify for Medicaid under s. 409.903(5) and children under age 18 who would otherwise qualify for Medicaid under subsection (8) and s. 409.903(6) and (7) except for their level of income and whose assets fall within the limits established by the Department of Children and Family Services for the medically needy. Coverage for the medically needy is not available to presumptively eligible pregnant women.~~A family, a pregnant woman, a child under age 18, a person age 65 or over, or a blind or disabled person who would be eligible under any group listed in s. 409.903(1), (2), or (3), except that the income or assets of such family or person exceed established limitations.~~For a family or person in this group, medical expenses are deductible from income in accordance with federal requirements in order to make a

determination of eligibility. A family or person in this group, which group is known as the "medically needy," is eligible to receive the same services as other Medicaid recipients, with the exception of services in skilled nursing facilities and intermediate care facilities for the developmentally disabled.

(5) Subject to specific federal authorization, a postpartum woman living in a family that has an income that is at or below 150 ~~185~~ percent of the most current federal poverty level is eligible for family planning services as specified in s. 409.905(3) for a period of up to 24 months following a pregnancy for which Medicaid paid for pregnancy-related services.

Section 5. Section 409.906, Florida Statutes, is amended 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. Optional services rendered by providers in mobile units to Medicaid recipients may be restricted or prohibited by the agency. 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:

~~(1) ADULT DENTURE SERVICES.--The agency may pay for dentures, the procedures required to seat dentures, and the repair and reline of dentures, provided by or under the direction of a licensed dentist, for a recipient who is age 21 or older. However, Medicaid will not provide reimbursement for dental services provided in a mobile dental unit, except for a mobile dental unit:~~

~~(a) Owned by, operated by, or having a contractual agreement with the Department of Health and complying with Medicaid's county health department clinic services program specifications as a county health department clinic services provider.~~

~~(b) Owned by, operated by, or having a contractual arrangement with a federally qualified health center and complying with Medicaid's federally qualified health center specifications as a federally qualified health center provider.~~

~~(c) Rendering dental services to Medicaid recipients, 21 years of age and older, at nursing facilities.~~

~~(d) Owned by, operated by, or having a contractual agreement with a state-approved dental educational institution.~~

(1)~~(2)~~ ADULT HEALTH SCREENING SERVICES.--The agency may pay for an annual routine physical examination, conducted

by or under the direction of a licensed physician, for a recipient age 21 or older, without regard to medical necessity, in order to detect and prevent disease, disability, or other health condition or its progression.

(2)~~(3)~~ AMBULATORY SURGICAL CENTER SERVICES.--The agency may pay for services provided to a recipient in an ambulatory surgical center licensed under part I of chapter 395, by or under the direction of a licensed physician or dentist.

(3)~~(4)~~ BIRTH CENTER SERVICES.--The agency may pay for examinations and delivery, recovery, and newborn assessment, and related services, provided in a licensed birth center staffed with licensed physicians, certified nurse midwives, and midwives licensed in accordance with chapter 467, to a recipient expected to experience a low-risk pregnancy and delivery.

(4)~~(5)~~ CASE MANAGEMENT SERVICES.--The agency may pay for primary care case management services rendered to a recipient pursuant to a federally approved waiver, and targeted case management services for specific groups of targeted recipients, for which funding has been provided and which are rendered pursuant to federal guidelines. The agency is authorized to limit reimbursement for targeted case management services in order to comply with any limitations or directions provided for in the General Appropriations Act. Notwithstanding s. 216.292, the Department of Children and Family Services may transfer general funds to the Agency for Health Care Administration to fund state match requirements exceeding the amount specified in the General Appropriations Act for targeted case management services.

(5)~~(6)~~ CHILDREN'S DENTAL SERVICES.--The agency may pay for diagnostic, preventive, or corrective procedures, including orthodontia in severe cases, provided to a recipient under age 21, by or under the supervision of a licensed dentist. Services provided under this program include treatment of the teeth and associated structures of the oral cavity, as well as treatment of disease, injury, or impairment that may affect the oral or general health of the individual. However, Medicaid will not provide reimbursement for dental services provided in a mobile dental unit, except for a mobile dental unit:

(a) Owned by, operated by, or having a contractual agreement with the Department of Health and complying with Medicaid's county health department clinic services program specifications as a county health department clinic services provider.

(b) Owned by, operated by, or having a contractual arrangement with a federally qualified health center and complying with Medicaid's federally qualified health center specifications as a federally qualified health center provider.

(c) Rendering dental services to Medicaid recipients, 21 years of age and older, at nursing facilities.

(d) Owned by, operated by, or having a contractual agreement with a state-approved dental educational institution.

(6)~~(7)~~ CHIROPRACTIC SERVICES.--The agency may pay for manual manipulation of the spine and initial services, screening, and X rays provided to a recipient by a licensed chiropractic physician.

(7)~~(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 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.

(8)~~(9)~~ DIALYSIS FACILITY SERVICES.--Subject to specific appropriations being provided for this purpose, the agency may pay a dialysis facility that is approved as a dialysis facility in accordance with Title XVIII of the Social Security Act, for dialysis services that are provided to a Medicaid recipient under the direction of a physician licensed to practice medicine or osteopathic medicine in this state, including dialysis services provided in the recipient's home by a hospital-based or freestanding dialysis facility.

(9)~~(10)~~ DURABLE MEDICAL EQUIPMENT.--The agency may authorize and pay for certain durable medical equipment and supplies provided to a Medicaid recipient as medically necessary.

(10)~~(11)~~ HEALTHY START SERVICES.--The agency may pay for a continuum of risk-appropriate medical and psychosocial services for the Healthy Start program in accordance with a federal waiver. The agency may not implement the federal waiver unless the waiver permits the state to limit enrollment or the amount, duration, and scope of services to ensure that expenditures will not exceed funds appropriated by the Legislature or available from local sources. If the Health

Care Financing Administration does not approve a federal waiver for Healthy Start services, the agency, in consultation with the Department of Health and the Florida Association of Healthy Start Coalitions, is authorized to establish a Medicaid certified-match program for Healthy Start services. Participation in the Healthy Start certified-match program shall be voluntary, and reimbursement shall be limited to the federal Medicaid share to Medicaid-enrolled Healthy Start coalitions for services provided to Medicaid recipients. The agency shall take no action to implement a certified-match program without ensuring that the amendment and review requirements of ss. 216.177 and 216.181 have been met.

(11)~~(12)~~ CHILDREN'S HEARING SERVICES.--The agency may pay for hearing and related services, including hearing evaluations, hearing aid devices, dispensing of the hearing aid, and related repairs, if provided to a recipient under age 21 by a licensed hearing aid specialist, otolaryngologist, otologist, audiologist, or physician.

(12)~~(13)~~ HOME AND COMMUNITY-BASED SERVICES.--The agency may pay for home-based or community-based services that are rendered to a recipient in accordance with a federally approved waiver program.

(13)~~(14)~~ HOSPICE CARE SERVICES.--The agency may pay for all reasonable and necessary services for the palliation or management of a recipient's terminal illness, if the services are provided by a hospice that is licensed under part VI of chapter 400 and meets Medicare certification requirements.

(14)~~(15)~~ INTERMEDIATE CARE FACILITY FOR THE DEVELOPMENTALLY DISABLED SERVICES.--The agency may pay for health-related care and services provided on a 24-hour-a-day

basis by a facility licensed and certified as a Medicaid Intermediate Care Facility for the Developmentally Disabled, for a recipient who needs such care because of a developmental disability.

(15)~~(16)~~ INTERMEDIATE CARE SERVICES.--The agency may pay for 24-hour-a-day intermediate care nursing and rehabilitation services rendered to a recipient in a nursing facility licensed under part II of chapter 400, if the services are ordered by and provided under the direction of a physician.

(16)~~(17)~~ OPTOMETRIC SERVICES.--The agency may pay for services provided to a recipient, including examination, diagnosis, treatment, and management, related to ocular pathology, if the services are provided by a licensed optometrist or physician.

(17)~~(18)~~ PHYSICIAN ASSISTANT SERVICES.--The agency may pay for all services provided to a recipient by a physician assistant licensed under s. 458.347 or s. 459.022. Reimbursement for such services must be not less than 80 percent of the reimbursement that would be paid to a physician who provided the same services.

(18)~~(19)~~ PODIATRIC SERVICES.--The agency may pay for services, including diagnosis and medical, surgical, palliative, and mechanical treatment, related to ailments of the human foot and lower leg, if provided to a recipient by a podiatric physician licensed under state law.

(19)~~(20)~~ PRESCRIBED DRUG SERVICES.--The agency may pay for medications that are prescribed for a recipient by a physician or other licensed practitioner of the healing arts authorized to prescribe medications and that are dispensed to the recipient by a licensed pharmacist or physician in

accordance with applicable state and federal law. For adults eligible through the medically needy program, pharmacies must dispense a generic drug for a product prescribed for a beneficiary if a generic product exists for the product prescribed.

(20)~~(21)~~ REGISTERED NURSE FIRST ASSISTANT SERVICES.--The agency may pay for all services provided to a recipient by a registered nurse first assistant as described in s. 464.027. Reimbursement for such services may not be less than 80 percent of the reimbursement that would be paid to a physician providing the same services.

(21)~~(22)~~ STATE HOSPITAL SERVICES.--The agency may pay for all-inclusive psychiatric inpatient hospital care provided to a recipient age 65 or older in a state mental hospital.

(22)~~(23)~~ CHILDREN'S VISUAL SERVICES.--The agency may pay for visual examinations, eyeglasses, and eyeglass repairs for a recipient under age 21, if they are prescribed by a licensed physician specializing in diseases of the eye or by a licensed optometrist.

(23)~~(24)~~ CHILD-WELFARE-TARGETED CASE MANAGEMENT.--The Agency for Health Care Administration, in consultation with the Department of Children and Family Services, may establish a targeted case-management pilot project in those counties identified by the Department of Children and Family Services and for the community-based child welfare project in Sarasota and Manatee counties, as authorized under s. 409.1671. These projects shall be established for the purpose of determining the impact of targeted case management on the child welfare program and the earnings from the child welfare program. Results of the pilot projects shall be reported to the Child Welfare Estimating Conference and the Social Services

Estimating Conference established under s. 216.136. The number of projects may not be increased until requested by the Department of Children and Family Services, recommended by the Child Welfare Estimating Conference and the Social Services Estimating Conference, and approved by the Legislature. The covered group of individuals who are eligible to receive targeted case management include children who are eligible for Medicaid; who are between the ages of birth through 21; and who are under protective supervision or postplacement supervision, under foster-care supervision, or in shelter care or foster care. The number of individuals who are eligible to receive targeted case management shall be limited to the number for whom the Department of Children and Family Services has available matching funds to cover the costs. The general revenue funds required to match the funds for services provided by the community-based child welfare projects are limited to funds available for services described under s. 409.1671. The Department of Children and Family Services may transfer the general revenue matching funds as billed by the Agency for Health Care Administration.

(24)~~(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 6. Effective April 1, 2002, subsection (19) of section 409.906, Florida Statutes, as amended by this act, is amended 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. Optional services rendered by providers in mobile units to Medicaid recipients may be restricted or prohibited by the agency. 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:

(19) PRESCRIBED DRUG SERVICES.--The agency may pay for medications that are prescribed for a recipient by a physician or other licensed practitioner of the healing arts authorized to prescribe medications and that are dispensed to the recipient by a licensed pharmacist or physician in accordance with applicable state and federal law. <u>The agency may use mail-order pharmacy services for dispensing drugs.</u>For adults eligible through the medically needy program, pharmacies must

dispense a generic drug for a product prescribed for a beneficiary if a generic product exists for the product prescribed.

Section 7. Subsections (3) and (5) of section 409.9065, Florida Statutes, are amended to read:

409.9065 Pharmaceutical expense assistance.--

(3) BENEFITS.--Medications covered under the pharmaceutical expense assistance program are those covered under the Medicaid program in s. 409.906(19)~~s. 409.906(20)~~. Monthly benefit payments shall be limited to $80 per program participant. Participants are required to make a 10-percent coinsurance payment for each prescription purchased through this program.

(5) NONENTITLEMENT.--The pharmaceutical expense assistance program established by this section is not an entitlement. Enrollment levels are limited to those authorized by the Legislature in the annual General Appropriations Act. If funds are insufficient to serve all individuals eligible under subsection (2) and seeking coverage, the agency may develop a waiting list based on application dates to use in enrolling individuals in unfilled enrollment slots.

Section 8. Effective upon this act becoming a law, paragraph (a) of subsection (5) and subsections (7) and (9) of section 409.907, Florida Statutes, are amended to read:

409.907 Medicaid provider agreements.--The agency may make payments for medical assistance and related services rendered to Medicaid recipients only to an individual or entity who has a provider agreement in effect with the agency, who is performing services or supplying goods in accordance with federal, state, and local law, and who agrees that no person shall, on the grounds of handicap, race, color, or

national origin, or for any other reason, be subjected to discrimination under any program or activity for which the provider receives payment from the agency.

(5) The agency:

(a) Is required to make timely payment at the established rate for services or goods furnished to a recipient by the provider upon receipt of a properly completed claim form. The claim form shall require certification that the services or goods have been completely furnished to the recipient and that, with the exception of those services or goods specified by the agency, the amount billed does not exceed the provider's usual and customary charge for the same services or goods. When a provider is under an active fraud or abuse investigation by the agency, the agency may withhold payment to that provider for any pending claim until the conclusion of the investigation. When exercising the provisions of this paragraph, the agency must timely complete its investigation.

(7) The agency may require, as a condition of participating in the Medicaid program and before entering into the provider agreement, that the provider submit information, in an initial and any required renewal applications, concerning the professional, business, and personal background of the provider and permit an onsite inspection of the provider's service location by agency staff or other personnel designated by the agency to perform this function. Before entering into the provider agreement, or as a condition of continuing participation in the Medicaid program, the agency may also require that Medicaid providers reimbursed on a fee-for-services basis or fee schedule basis which is not cost-based, post a surety bond not to exceed $50,000 or the

total amount billed by the provider to the program during the current or most recent calendar year, whichever is greater. For new providers, the amount of the surety bond shall be determined by the agency based on the provider's estimate of its first year's billing. If the provider's billing during the first year exceeds the bond amount, the agency may require the provider to acquire an additional bond equal to the actual billing level of the provider. A provider's bond shall not exceed $50,000 if a physician or group of physicians licensed under chapter 458, chapter 459, or chapter 460 has a 50 percent or greater ownership interest in the provider or if the provider is an assisted living facility licensed under part III of chapter 400. The bonds permitted by this section are in addition to the bonds referenced in s. 400.179(4)(d). If the provider is a corporation, partnership, association, or other entity, the agency may require the provider to submit information concerning the background of that entity and of any principal of the entity, including any partner or shareholder having an ownership interest in the entity equal to 5 percent or greater, and any treating provider who participates in or intends to participate in Medicaid through the entity. The information must include:

(a) Proof of holding a valid license or operating certificate, as applicable, if required by the state or local jurisdiction in which the provider is located or if required by the Federal Government.

(b) Information concerning any prior violation, fine, suspension, termination, or other administrative action taken under the Medicaid laws, rules, or regulations of this state or of any other state or the Federal Government; any prior violation of the laws, rules, or regulations relating to the

Medicare program; any prior violation of the rules or regulations of any other public or private insurer; and any prior violation of the laws, rules, or regulations of any regulatory body of this or any other state.

(c) Full and accurate disclosure of any financial or ownership interest that the provider, or any principal, partner, or major shareholder thereof, may hold in any other Medicaid provider or health care related entity or any other entity that is licensed by the state to provide health or residential care and treatment to persons.

(d) If a group provider, identification of all members of the group and attestation that all members of the group are enrolled in or have applied to enroll in the Medicaid program.

(9) Upon receipt of a completed, signed, and dated application, and completion of any necessary background investigation and criminal history record check, the agency must either:

(a) Enroll the applicant as a Medicaid provider no earlier than the effective date of the approval of the provider application; or

(b) Deny the application if the agency finds that it is in the best interest of the Medicaid program to do so. The agency may consider the factors listed in subsection (10), as well as any other factor that could affect the effective and efficient administration of the program, including, but not limited to, the current availability of medical care, services, or supplies to recipients, taking into account geographic location and reasonable travel time; the number of providers of the same type already enrolled in the same geographic area; and the credentials, experience, success, and

patient outcomes of the provider for the services that it is making application to provide in the Medicaid program.

Section 9. Section 409.9116, Florida Statutes, is amended to read:

409.9116 Disproportionate share ~~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.

(1) The following formula shall be used by the agency to calculate the total amount earned for hospitals that participate in the rural hospital disproportionate share program ~~or the financial assistance program~~:

TAERH = (CCD + MDD)/TPD

Where:

CCD = total charity care-other, plus charity care-Hill-Burton, minus 50 percent of unrestricted tax revenue

from local governments, and restricted funds for indigent care, divided by gross revenue per adjusted patient day; however, if CCD is less than zero, then zero shall be used for CCD.

MDD = Medicaid inpatient days plus Medicaid HMO inpatient days.

TPD = total inpatient days.

TAERH = total amount earned by each rural hospital.

In computing the total amount earned by each rural hospital, the agency must use the most recent actual data reported in accordance with s. 408.061(4)(a).

(2) The agency shall use the following formula for distribution of funds for the disproportionate share ~~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) Any state funds not spent due to an individual hospital's disproportionate-share limit will be redistributed proportionately to those hospitals with an available disproportionate-share limit to maximize available federal funds.

~~(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.~~

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

(3) The Agency for Health Care Administration may recommend to the Legislature a formula to be used in subsequent fiscal years to distribute funds appropriated for this section that includes charity care, uncompensated care to medically indigent patients, and Medicaid inpatient days.

(4) In the event that federal matching funds for the rural hospital disproportionate share program are not available, state matching funds appropriated for the program may be ~~utilized for the Rural Hospital Financial Assistance Program and shall be~~ allocated to rural hospitals based on the formulas in subsections (1) and (2).

(5) In order to receive payments under this section, a hospital must be a rural hospital as defined in s. 395.602 and must meet the following additional requirements:

(a) Agree to conform to all agency requirements to ensure high quality in the provision of services, including criteria adopted by agency rule concerning staffing ratios, medical records, standards of care, equipment, space, and such other standards and criteria as the agency deems appropriate as specified by rule.

(b) Agree to accept all patients, regardless of ability to pay, on a functional space-available basis.

(c) Agree to provide backup and referral services to the county public health departments and other low-income providers within the hospital's service area, including the development of written agreements between these organizations and the hospital.

(d) For any hospital owned by a county government which is leased to a management company, agree to submit on a quarterly basis a report to the agency, in a format specified by the agency, which provides a specific accounting of how all funds dispersed under this act are spent.

~~(6) For the 2000-2001 fiscal year only, the Agency for Health Care Administration shall use the following formula for distribution of the funds in Specific Appropriation 212 of the 2000-2001 General Appropriations Act 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 is then 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.~~

~~(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 determination of the amount of rural disproportionate share hospital funds is calculated by the following formula:~~

~~TDAERH = [(TAERH x ATARH)/STAERH]~~

~~Where:~~

~~TDAERH = total 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) are then added to the results of paragraph (f) to determine the total distribution amount for each rural hospital.~~

~~(h) This subsection is repealed on July 1, 2001.~~

(6)~~(7)~~ This section applies only to hospitals that were defined as statutory rural hospitals, or their successor-in-interest hospital, prior to July 1, 1998. Any additional hospital that is defined as a statutory rural hospital, or its successor-in-interest hospital, on or after July 1, 1998, is not eligible for programs under this section unless additional funds are appropriated each fiscal year specifically to the rural hospital disproportionate share programs ~~and financial assistance programs~~ in an amount necessary to prevent any hospital, or its successor-in-interest hospital, eligible for the programs prior to July 1, 1998, from incurring a reduction in payments because of the eligibility of an additional hospital to participate in the programs. A hospital, or its

successor-in-interest hospital, which received funds pursuant to this section before July 1, 1998, and which qualifies under s. 395.602(2)(e), shall be included in the programs under this section and is not required to seek additional appropriations under this subsection.

Section 10. Paragraph (a) of subsection (37) 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. 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.

(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 is limited to the dispensing of four brand-name drugs per month per recipient. Children 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;

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 15 ~~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.

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; three pharmacists licensed under chapter 465 and appointed from a list of recommendations provided by the Florida Long-Term Care Pharmacy Alliance; and two pharmacists licensed under chapter 465.

Section 11. Effective upon this act becoming a law, subsection (15) and paragraph (a) of subsection (22) of section 409.913, Florida Statutes, are amended to read:

409.913 Oversight of the integrity of the Medicaid program.--The agency shall operate a program to oversee the activities of Florida Medicaid recipients, and providers and their representatives, to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible, and to recover overpayments and impose sanctions as appropriate.

(15) The agency may impose any of the following sanctions on a provider or a person for any of the acts described in subsection (14):

(a) Suspension for a specific period of time of not more than 1 year.

(b) Termination for a specific period of time of from more than 1 year to 20 years.

(c) Imposition of a fine of up to $5,000 for each violation. Each day that an ongoing violation continues, such as refusing to furnish Medicaid-related records or refusing access to records, is considered, for the purposes of this section, to be a separate violation. Each instance of improper billing of a Medicaid recipient; each instance of including an unallowable cost on a hospital or nursing home Medicaid cost report after the provider or authorized representative has been advised in an audit exit conference or previous audit report of the cost unallowability; each instance of furnishing a Medicaid recipient goods or professional services that are inappropriate or of inferior quality as determined by competent peer judgment; each instance of knowingly submitting a materially false or erroneous Medicaid provider enrollment application, request for prior authorization for Medicaid services, drug exception request, or cost report; each instance of inappropriate prescribing of drugs for a Medicaid recipient as determined by competent peer judgment; and each false or erroneous Medicaid claim leading to an overpayment to a provider is considered, for the purposes of this section, to be a separate violation.

(d) Immediate suspension, if the agency has received information of patient abuse or neglect or of any act prohibited by s. 409.920. Upon suspension, the agency must issue an immediate final order under s. 120.569(2)(n).

(e) A fine, not to exceed $10,000, for a violation of paragraph (14)(i).

(f) Imposition of liens against provider assets, including, but not limited to, financial assets and real

property, not to exceed the amount of the fine or recovery sought.

(g) Other remedies as permitted by law to effect the recovery of a fine or overpayment.

(22)(a) In an audit or investigation of a violation committed by a provider which is conducted pursuant to this section, the agency is entitled to recover all ~~up to $15,000 in~~ investigative, legal, and expert witness costs if the agency's findings were not contested by the provider or, if contested, the agency ultimately prevailed.

Section 12. Subsection (2) of section 409.915, Florida Statutes, is 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.

(2) A county's participation must be 35 percent of the total cost, or the applicable discounted cost paid by the state for Medicaid recipients enrolled in health maintenance organizations or prepaid health plans, of providing the items listed in subsection (1), except that the payments for items listed in paragraph (1)(b) may not exceed $90~~$55~~ per month per person.

Section 13. 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. 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 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, and dispensing of preferred-drug-list products. The agency shall 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 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 14. Section 400.0225, Florida Statutes, is repealed.

Section 15. Paragraph (a) of subsection (2) of section 400.191, Florida Statutes, is amended to read:

400.191 Availability, distribution, and posting of reports and records.--

(2) The agency shall provide additional information in consumer-friendly printed and electronic formats to assist consumers and their families in comparing and evaluating nursing home facilities.

(a) The agency shall provide an Internet site which shall include at least the following information either directly or indirectly through a link to another established site or sites of the agency's choosing:

1. A list by name and address of all nursing home facilities in this state.

2. Whether such nursing home facilities are proprietary or nonproprietary.

3. The current owner of the facility's license and the year that that entity became the owner of the license.

4. The name of the owner or owners of each facility and whether the facility is affiliated with a company or other

organization owning or managing more than one nursing facility in this state.

5. The total number of beds in each facility.

6. The number of private and semiprivate rooms in each facility.

7. The religious affiliation, if any, of each facility.

8. The languages spoken by the administrator and staff of each facility.

9. Whether or not each facility accepts Medicare or Medicaid recipients or insurance, health maintenance organization, Veterans Administration, CHAMPUS program, or workers' compensation coverage.

10. Recreational and other programs available at each facility.

11. Special care units or programs offered at each facility.

12. Whether the facility is a part of a retirement community that offers other services pursuant to part III, part IV, or part V.

~~13. The results of consumer and family satisfaction surveys for each facility, as described in s. 400.0225. The results may be converted to a score or scores, which may be presented in either numeric or symbolic form for the intended consumer audience.~~

13.~~14.~~ Survey and deficiency information contained on the Online Survey Certification and Reporting (OSCAR) system of the federal Health Care Financing Administration, including annual survey, revisit, and complaint survey information, for each facility for the past 45 months. For noncertified nursing homes, state survey and deficiency information,

including annual survey, revisit, and complaint survey information for the past 45 months shall be provided.

14.~~15.~~ A summary of the Online Survey Certification and Reporting (OSCAR) data for each facility over the past 45 months. Such summary may include a score, rating, or comparison ranking with respect to other facilities based on the number of citations received by the facility of annual, revisit, and complaint surveys; the severity and scope of the citations; and the number of annual recertification surveys the facility has had during the past 45 months. The score, rating, or comparison ranking may be presented in either numeric or symbolic form for the intended consumer audience.

Section 16. Paragraph (c) of subsection (5) of section 400.235, Florida Statutes, is amended to read:

400.235 Nursing home quality and licensure status; Gold Seal Program.--

(5) Facilities must meet the following additional criteria for recognition as a Gold Seal Program facility:

(c) Participate ~~consistently~~ in a ~~the required~~ consumer satisfaction process ~~as prescribed by the agency~~, and demonstrate that information is elicited from residents, family members, and guardians about satisfaction with the nursing facility, its environment, the services and care provided, the staff's skills and interactions with residents, attention to resident's needs, and the facility's efforts to act on information gathered from the consumer satisfaction measures.

A facility assigned a conditional licensure status may not qualify for consideration for the Gold Seal Program until after it has operated for 30 months with no class I or class

II deficiencies and has completed a regularly scheduled relicensure survey.

Section 17. Section 400.148, Florida Statutes, is repealed.

Section 18. Section 400.071, Florida Statutes, is amended to read:

400.071 Application for license.--

(1) An application for a license as required by s. 400.062 shall be made to the agency on forms furnished by it and shall be accompanied by the appropriate license fee.

(2) The application shall be under oath and shall contain the following:

(a) The name, address, and social security number of the applicant if an individual; if the applicant is a firm, partnership, or association, its name, address, and employer identification number (EIN), and the name and address of any controlling interest; and the name by which the facility is to be known.

(b) The name of any person whose name is required on the application under the provisions of paragraph (a) and who owns at least a 10-percent interest in any professional service, firm, association, partnership, or corporation providing goods, leases, or services to the facility for which the application is made, and the name and address of the professional service, firm, association, partnership, or corporation in which such interest is held.

(c) The location of the facility for which a license is sought and an indication, as in the original application, that such location conforms to the local zoning ordinances.

(d) The name of the person or persons under whose management or supervision the facility will be conducted and the name of the administrator.

(e) A signed affidavit disclosing any financial or ownership interest that a person or entity described in paragraph (a) or paragraph (d) has held in the last 5 years in any entity licensed by this state or any other state to provide health or residential care which has closed voluntarily or involuntarily; has filed for bankruptcy; has had a receiver appointed; has had a license denied, suspended, or revoked; or has had an injunction issued against it which was initiated by a regulatory agency. The affidavit must disclose the reason any such entity was closed, whether voluntarily or involuntarily.

(f) The total number of beds and the total number of Medicare and Medicaid certified beds.

(g) Information relating to the number, experience, and training of the employees of the facility and of the moral character of the applicant and employees which the agency requires by rule, including the name and address of any nursing home with which the applicant or employees have been affiliated through ownership or employment within 5 years of the date of the application for a license and the record of any criminal convictions involving the applicant and any criminal convictions involving an employee if known by the applicant after inquiring of the employee. The applicant must demonstrate that sufficient numbers of qualified staff, by training or experience, will be employed to properly care for the type and number of residents who will reside in the facility.

(h) Copies of any civil verdict or judgment involving the applicant rendered within the 10 years preceding the application, relating to medical negligence, violation of residents' rights, or wrongful death. As a condition of licensure, the licensee agrees to provide to the agency copies of any new verdict or judgment involving the applicant, relating to such matters, within 30 days after filing with the clerk of the court. The information required in this paragraph shall be maintained in the facility's licensure file and in an agency database which is available as a public record.

(3) The applicant shall submit evidence which establishes the good moral character of the applicant, manager, supervisor, and administrator. No applicant, if the applicant is an individual; no member of a board of directors or officer of an applicant, if the applicant is a firm, partnership, association, or corporation; and no licensed nursing home administrator shall have been convicted, or found guilty, regardless of adjudication, of a crime in any jurisdiction which affects or may potentially affect residents in the facility.

(4) Each applicant for licensure must comply with the following requirements:

(a) Upon receipt of a completed, signed, and dated application, the agency shall require background screening of the applicant, in accordance with the level 2 standards for screening set forth in chapter 435. As used in this subsection, the term "applicant" means the facility administrator, or similarly titled individual who is responsible for the day-to-day operation of the licensed facility, and the facility financial officer, or similarly

titled individual who is responsible for the financial operation of the licensed facility.

(b) The agency may require background screening for a member of the board of directors of the licensee or an officer or an individual owning 5 percent or more of the licensee if the agency has probable cause to believe that such individual has been convicted of an offense prohibited under the level 2 standards for screening set forth in chapter 435.

(c) Proof of compliance with the level 2 background screening requirements of chapter 435 which has been submitted within the previous 5 years in compliance with any other health care or assisted living licensure requirements of this state is acceptable in fulfillment of paragraph (a). Proof of compliance with background screening which has been submitted within the previous 5 years to fulfill the requirements of the Department of Insurance pursuant to chapter 651 as part of an application for a certificate of authority to operate a continuing care retirement community is acceptable in fulfillment of the Department of Law Enforcement and Federal Bureau of Investigation background check.

(d) A provisional license may be granted to an applicant when each individual required by this section to undergo background screening has met the standards for the Department of Law Enforcement background check, but the agency has not yet received background screening results from the Federal Bureau of Investigation, or a request for a disqualification exemption has been submitted to the agency as set forth in chapter 435, but a response has not yet been issued. A license may be granted to the applicant upon the agency's receipt of a report of the results of the Federal Bureau of Investigation background screening for each

individual required by this section to undergo background screening which confirms that all standards have been met, or upon the granting of a disqualification exemption by the agency as set forth in chapter 435. Any other person who is required to undergo level 2 background screening may serve in his or her capacity pending the agency's receipt of the report from the Federal Bureau of Investigation; however, the person may not continue to serve if the report indicates any violation of background screening standards and a disqualification exemption has not been requested of and granted by the agency as set forth in chapter 435.

(e) Each applicant must submit to the agency, with its application, a description and explanation of any exclusions, permanent suspensions, or terminations of the applicant from the Medicare or Medicaid programs. Proof of compliance with disclosure of ownership and control interest requirements of the Medicaid or Medicare programs shall be accepted in lieu of this submission.

(f) Each applicant must submit to the agency a description and explanation of any conviction of an offense prohibited under the level 2 standards of chapter 435 by a member of the board of directors of the applicant, its officers, or any individual owning 5 percent or more of the applicant. This requirement shall not apply to a director of a not-for-profit corporation or organization if the director serves solely in a voluntary capacity for the corporation or organization, does not regularly take part in the day-to-day operational decisions of the corporation or organization, receives no remuneration for his or her services on the corporation or organization's board of directors, and has no financial interest and has no family members with a financial

interest in the corporation or organization, provided that the director and the not-for-profit corporation or organization include in the application a statement affirming that the director's relationship to the corporation satisfies the requirements of this paragraph.

(g) An application for license renewal must contain the information required under paragraphs (e) and (f).

(5) The applicant shall furnish satisfactory proof of financial ability to operate and conduct the nursing home in accordance with the requirements of this part and all rules adopted under this part, and the agency shall establish standards for this purpose, including information reported under paragraph (2)(e). The agency also shall establish documentation requirements, to be completed by each applicant, that show anticipated facility revenues and expenditures, the basis for financing the anticipated cash-flow requirements of the facility, and an applicant's access to contingency financing.

(6) If the applicant offers continuing care agreements as defined in chapter 651, proof shall be furnished that such applicant has obtained a certificate of authority as required for operation under that chapter.

(7) As a condition of licensure, each licensee, except one offering continuing care agreements as defined in chapter 651, must agree to accept recipients of Title XIX of the Social Security Act on a temporary, emergency basis. The persons whom the agency may require such licensees to accept are those recipients of Title XIX of the Social Security Act who are residing in a facility in which existing conditions constitute an immediate danger to the health, safety, or security of the residents of the facility.

~~(8) As a condition of licensure, each facility must agree to participate in a consumer satisfaction measurement process as prescribed by the agency.~~

(8)~~(9)~~ The agency may not issue a license to a nursing home that fails to receive a certificate of need under the provisions of ss. 408.031-408.045. It is the intent of the Legislature that, in reviewing a certificate-of-need application to add beds to an existing nursing home facility, preference be given to the application of a licensee who has been awarded a Gold Seal as provided for in s. 400.235, if the applicant otherwise meets the review criteria specified in s. 408.035.

(9)~~(10)~~ The agency may develop an abbreviated survey for licensure renewal applicable to a licensee that has continuously operated as a nursing facility since 1991 or earlier, has operated under the same management for at least the preceding 30 months, and has had during the preceding 30 months no class I or class II deficiencies.

(10)~~(11)~~ The agency may issue an inactive license to a nursing home that will be temporarily unable to provide services but that is reasonably expected to resume services. Such designation may be made for a period not to exceed 12 months but may be renewed by the agency for up to 6 additional months. Any request by a licensee that a nursing home become inactive must be submitted to the agency and approved by the agency prior to initiating any suspension of service or notifying residents. Upon agency approval, the nursing home shall notify residents of any necessary discharge or transfer as provided in s. 400.0255.

(11)~~(12)~~ As a condition of licensure, each facility must establish and submit with its application a plan for quality assurance and for conducting risk management.

Section 19. Paragraph (q) of subsection (2) of section 409.815, Florida Statutes, is amended to read:

409.815 Health benefits coverage; limitations.--

(2) BENCHMARK BENEFITS.--In order for health benefits coverage to qualify for premium assistance payments for an eligible child under ss. 409.810-409.820, the health benefits coverage, except for coverage under Medicaid and Medikids, must include the following minimum benefits, as medically necessary.

(q) Dental services.--Subject to a specific appropriation for this benefit, covered services include those dental services provided to children by the Florida Medicaid program under s. 409.906(5)~~s. 409.906(6)~~.

Section 20. Except as otherwise specifically provided in this act, this act shall take effect January 1, 2002.

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SENATE SUMMARY

Revises and repeals various provisions of law relating to programs administered by the Agency for Health Care Administration. (See bill for details.)