CHAMBER ACTION

Senate		House
	.	

Senator Silver moved the following amendment:

Senate Amendment (with title amendment)

Delete everything after the enacting clause

and insert:

Section 1. Effective July 1, 2002, subsection (11) of section 409.904, Florida Statutes, is repealed.

Section 2. Effective July 1, 2002, subsections (1) and (2) 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.

(1) A person who is age 65 or older or is determined to be disabled, whose income is at or below 88 ~~100~~ percent of federal poverty level, and whose assets do not exceed

established limitations.

(2)(a) A pregnant woman who would otherwise qualify for Medicaid under s. 409.903(5) except for her level of income and whose assets fall within the limits established by the Department of Children and Family Services for the medically needy. A pregnant woman who applies for medically needy eligibility may not be made presumptively eligible.

(b) A child under age 21 who would otherwise qualify for Medicaid or the Florida Kidcare program except for the family's level of income and whose assets fall within the limits established by the Department of Children and Family Services for the medically needy.~~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.

Section 3. Effective July 1, 2002, subsections (1), (12), and (23) of section 409.906, Florida Statutes, are amended to read:

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

1 services which are optional to the state under Title XIX of
2 the Social Security Act and are furnished by Medicaid
3 providers to recipients who are determined to be eligible on
4 the dates on which the services were provided. Any optional
5 service that is provided shall be provided only when medically
6 necessary and in accordance with state and federal law.
7 Optional services rendered by providers in mobile units to
8 Medicaid recipients may be restricted or prohibited by the
9 agency. Nothing in this section shall be construed to prevent
10 or limit the agency from adjusting fees, reimbursement rates,
11 lengths of stay, number of visits, or number of services, or
12 making any other adjustments necessary to comply with the
13 availability of moneys and any limitations or directions
14 provided for in the General Appropriations Act or chapter 216.
15 If necessary to safeguard the state's systems of providing
16 services to elderly and disabled persons and subject to the
17 notice and review provisions of s. 216.177, the Governor may
18 direct the Agency for Health Care Administration to amend the
19 Medicaid state plan to delete the optional Medicaid service
20 known as "Intermediate Care Facilities for the Developmentally
21 Disabled." Optional services may include:
22 (1) ADULT DENTURE SERVICES.--The agency may pay for
23 dentures, the procedures required to seat dentures, and the
24 repair and reline of dentures, provided by or under the
25 direction of a licensed dentist, for a recipient who is age 21
26 or older. However, Medicaid will not provide reimbursement for
27 dental services provided in a mobile dental unit, except for a
28 mobile dental unit:
29 (a) Owned by, operated by, or having a contractual
30 agreement with the Department of Health and complying with
31 Medicaid's county health department clinic services program

1 specifications as a county health department clinic services
2 provider.
3 (b) Owned by, operated by, or having a contractual
4 arrangement with a federally qualified health center and
5 complying with Medicaid's federally qualified health center
6 specifications as a federally qualified health center
7 provider.
8 (c) Rendering dental services to Medicaid recipients,
9 21 years of age and older, at nursing facilities.
10 (d) Owned by, operated by, or having a contractual
11 agreement with a state-approved dental educational
12 institution.
13 (e) This subsection is repealed July 1, 2002.
14 (12) CHILDREN'S HEARING SERVICES.--The agency may pay
15 for hearing and related services, including hearing
16 evaluations, hearing aid devices, dispensing of the hearing
17 aid, and related repairs, if provided to a recipient under age
18 21 by a licensed hearing aid specialist, otolaryngologist,
19 otologist, audiologist, or physician.
20 (23) CHILDREN'S VISUAL SERVICES.--The agency may pay
21 for visual examinations, eyeglasses, and eyeglass repairs for
22 a recipient under age 21, if they are prescribed by a licensed
23 physician specializing in diseases of the eye or by a licensed
24 optometrist.
25 Section 4. Subsection (13) of section 409.906, Florida
26 Statutes, is amended to read:
27 409.906 Optional Medicaid services.--Subject to
28 specific appropriations, the agency may make payments for
29 services which are optional to the state under Title XIX of
30 the Social Security Act and are furnished by Medicaid
31 providers to recipients who are determined to be eligible on

1 the dates on which the services were provided. Any optional
2 service that is provided shall be provided only when medically
3 necessary and in accordance with state and federal law.
4 Optional services rendered by providers in mobile units to
5 Medicaid recipients may be restricted or prohibited by the
6 agency. Nothing in this section shall be construed to prevent
7 or limit the agency from adjusting fees, reimbursement rates,
8 lengths of stay, number of visits, or number of services, or
9 making any other adjustments necessary to comply with the
10 availability of moneys and any limitations or directions
11 provided for in the General Appropriations Act or chapter 216.
12 If necessary to safeguard the state's systems of providing
13 services to elderly and disabled persons and subject to the
14 notice and review provisions of s. 216.177, the Governor may
15 direct the Agency for Health Care Administration to amend the
16 Medicaid state plan to delete the optional Medicaid service
17 known as "Intermediate Care Facilities for the Developmentally
18 Disabled." Optional services may include:
19 (13) HOME AND COMMUNITY-BASED SERVICES.--The agency
20 may pay for home-based or community-based services that are
21 rendered to a recipient in accordance with a federally
22 approved waiver program. The agency may limit or eliminate
23 coverage for certain Project AIDS Care Waiver services,
24 preauthorize high-cost or highly utilized services, or make
25 any other adjustments necessary to comply with any limitations
26 or directions provided for in the General Appropriations Act.
27 Section 5. Subsections (3) and (5) of section
28 409.9065, Florida Statutes, are amended to read:
29 409.9065 Pharmaceutical expense assistance.--
30 (3) BENEFITS.--Medications covered under the
31 pharmaceutical expense assistance program are those covered

1 under the Medicaid program in s. 409.906(19)~~s. 409.906(20)~~.
2 Monthly benefit payments shall be limited to $80 per program
3 participant. Participants are required to make a 10-percent
4 coinsurance payment for each prescription purchased through
5 this program.
6 (5) NONENTITLEMENT.--The pharmaceutical expense
7 assistance program established by this section is not an
8 entitlement. Enrollment levels are limited to those authorized
9 by the Legislature in the annual General Appropriations Act.
10 If funds are insufficient to serve all individuals eligible
11 under subsection (2) and seeking coverage, the agency may
12 develop a waiting list based on application dates to use in
13 enrolling individuals in unfilled enrollment slots.
14 Section 6. Effective upon this act becoming a law,
15 subsections (7) and (9) of section 409.907, Florida Statutes,
16 are amended to read:
17 409.907 Medicaid provider agreements.--The agency may
18 make payments for medical assistance and related services
19 rendered to Medicaid recipients only to an individual or
20 entity who has a provider agreement in effect with the agency,
21 who is performing services or supplying goods in accordance
22 with federal, state, and local law, and who agrees that no
23 person shall, on the grounds of handicap, race, color, or
24 national origin, or for any other reason, be subjected to
25 discrimination under any program or activity for which the
26 provider receives payment from the agency.
27 (7) The agency may require, as a condition of
28 participating in the Medicaid program and before entering into
29 the provider agreement, that the provider submit information,
30 in an initial and any required renewal applications,
31 concerning the professional, business, and personal background

1 of the provider and permit an onsite inspection of the
2 provider's service location by agency staff or other personnel
3 designated by the agency to perform this function. As a
4 continuing condition of participation in the Medicaid program,
5 a provider shall immediately notify the agency of any current
6 or pending bankruptcy filing.Before entering into the
7 provider agreement, or as a condition of continuing
8 participation in the Medicaid program, the agency may also
9 require that Medicaid providers reimbursed on a
10 fee-for-services basis or fee schedule basis which is not
11 cost-based, post a surety bond not to exceed $50,000 or the
12 total amount billed by the provider to the program during the
13 current or most recent calendar year, whichever is greater.
14 For new providers, the amount of the surety bond shall be
15 determined by the agency based on the provider's estimate of
16 its first year's billing. If the provider's billing during the
17 first year exceeds the bond amount, the agency may require the
18 provider to acquire an additional bond equal to the actual
19 billing level of the provider. A provider's bond shall not
20 exceed $50,000 if a physician or group of physicians licensed
21 under chapter 458, chapter 459, or chapter 460 has a 50
22 percent or greater ownership interest in the provider or if
23 the provider is an assisted living facility licensed under
24 part III of chapter 400. The bonds permitted by this section
25 are in addition to the bonds referenced in s. 400.179(4)(d).
26 If the provider is a corporation, partnership, association, or
27 other entity, the agency may require the provider to submit
28 information concerning the background of that entity and of
29 any principal of the entity, including any partner or
30 shareholder having an ownership interest in the entity equal
31 to 5 percent or greater, and any treating provider who

1 participates in or intends to participate in Medicaid through
2 the entity. The information must include:
3 (a) Proof of holding a valid license or operating
4 certificate, as applicable, if required by the state or local
5 jurisdiction in which the provider is located or if required
6 by the Federal Government.
7 (b) Information concerning any prior violation, fine,
8 suspension, termination, or other administrative action taken
9 under the Medicaid laws, rules, or regulations of this state
10 or of any other state or the Federal Government; any prior
11 violation of the laws, rules, or regulations relating to the
12 Medicare program; any prior violation of the rules or
13 regulations of any other public or private insurer; and any
14 prior violation of the laws, rules, or regulations of any
15 regulatory body of this or any other state.
16 (c) Full and accurate disclosure of any financial or
17 ownership interest that the provider, or any principal,
18 partner, or major shareholder thereof, may hold in any other
19 Medicaid provider or health care related entity or any other
20 entity that is licensed by the state to provide health or
21 residential care and treatment to persons.
22 (d) If a group provider, identification of all members
23 of the group and attestation that all members of the group are
24 enrolled in or have applied to enroll in the Medicaid program.
25 (9) Upon receipt of a completed, signed, and dated
26 application, and completion of any necessary background
27 investigation and criminal history record check, the agency
28 must either:
29 (a) Enroll the applicant as a Medicaid provider no
30 earlier than the effective date of the approval of the
31 provider application; or

1 (b) Deny the application if the agency finds that it
2 is in the best interest of the Medicaid program to do so. The
3 agency may consider the factors listed in subsection (10), as
4 well as any other factor that could affect the effective and
5 efficient administration of the program, including, but not
6 limited to, the current availability of medical care,
7 services, or supplies to recipients, taking into account
8 geographic location and reasonable travel time; the number of
9 providers of the same type already enrolled in the same
10 geographic area; and the credentials, experience, success, and
11 patient outcomes of the provider for the services that it is
12 making application to provide in the Medicaid program.
13 Section 7. Paragraph (d) is added to subsection (12)
14 of section 409.908, Florida Statutes, and subsection (14) of
15 that section is amended, to read:
16 409.908 Reimbursement of Medicaid providers.--Subject
17 to specific appropriations, the agency shall reimburse
18 Medicaid providers, in accordance with state and federal law,
19 according to methodologies set forth in the rules of the
20 agency and in policy manuals and handbooks incorporated by
21 reference therein. These methodologies may include fee
22 schedules, reimbursement methods based on cost reporting,
23 negotiated fees, competitive bidding pursuant to s. 287.057,
24 and other mechanisms the agency considers efficient and
25 effective for purchasing services or goods on behalf of
26 recipients. Payment for Medicaid compensable services made on
27 behalf of Medicaid eligible persons is subject to the
28 availability of moneys and any limitations or directions
29 provided for in the General Appropriations Act or chapter 216.
30 Further, nothing in this section shall be construed to prevent
31 or limit the agency from adjusting fees, reimbursement rates,

1 lengths of stay, number of visits, or number of services, or
2 making any other adjustments necessary to comply with the
3 availability of moneys and any limitations or directions
4 provided for in the General Appropriations Act, provided the
5 adjustment is consistent with legislative intent.
6 (12)
7 (d) For the 2001-2002 fiscal year only and if
8 necessary to meet the requirements for grants and donations
9 for the special Medicaid payments authorized in the 2001-2002
10 General Appropriations Act, the agency may make special
11 Medicaid payments to qualified Medicaid providers designated
12 by the agency, notwithstanding any provision of this
13 subsection to the contrary, and may use intergovernmental
14 transfers from state entities to serve as the state share of
15 such payments.
16 (14) A provider of prescribed drugs shall be
17 reimbursed the least of the amount billed by the provider, the
18 provider's usual and customary charge, or the Medicaid maximum
19 allowable fee established by the agency, plus a dispensing
20 fee. The agency is directed to implement a variable dispensing
21 fee for payments for prescribed medicines while ensuring
22 continued access for Medicaid recipients. The variable
23 dispensing fee may be based upon, but not limited to, either
24 or both the volume of prescriptions dispensed by a specific
25 pharmacy provider, ~~and~~ the volume of prescriptions dispensed
26 to an individual recipient, and dispensing of
27 preferred-drug-list products. The agency shall increase the
28 pharmacy dispensing fee authorized by statute and in the
29 annual General Appropriations Act by $0.50 for the dispensing
30 of a Medicaid preferred-drug-list product and reduce the
31 pharmacy dispensing fee by $0.50 for the dispensing of a

1 Medicaid product that is not included on the preferred-drug
2 list.The agency is authorized to limit reimbursement for
3 prescribed medicine in order to comply with any limitations or
4 directions provided for in the General Appropriations Act,
5 which may include implementing a prospective or concurrent
6 utilization review program.
7 Section 8. Paragraph (a) of subsection (37) of section
8 409.912, Florida Statutes, is amended to read:
9 409.912 Cost-effective purchasing of health care.--The
10 agency shall purchase goods and services for Medicaid
11 recipients in the most cost-effective manner consistent with
12 the delivery of quality medical care. The agency shall
13 maximize the use of prepaid per capita and prepaid aggregate
14 fixed-sum basis services when appropriate and other
15 alternative service delivery and reimbursement methodologies,
16 including competitive bidding pursuant to s. 287.057, designed
17 to facilitate the cost-effective purchase of a case-managed
18 continuum of care. The agency shall also require providers to
19 minimize the exposure of recipients to the need for acute
20 inpatient, custodial, and other institutional care and the
21 inappropriate or unnecessary use of high-cost services. The
22 agency may establish prior authorization requirements for
23 certain populations of Medicaid beneficiaries, certain drug
24 classes, or particular drugs to prevent fraud, abuse, overuse,
25 and possible dangerous drug interactions. The Pharmaceutical
26 and Therapeutics Committee shall make recommendations to the
27 agency on drugs for which prior authorization is required. The
28 agency shall inform the Pharmaceutical and Therapeutics
29 Committee of its decisions regarding drugs subject to prior
30 authorization.
31 (37)(a) The agency shall implement a Medicaid

1 prescribed-drug spending-control program that includes the
2 following components:
3 1. Medicaid prescribed-drug coverage for brand-name
4 drugs for adult Medicaid recipients is limited to the
5 dispensing of four brand-name drugs per month per recipient.
6 Children are exempt from this restriction. Antiretroviral
7 agents are excluded from this limitation. No requirements for
8 prior authorization or other restrictions on medications used
9 to treat mental illnesses such as schizophrenia, severe
10 depression, or bipolar disorder may be imposed on Medicaid
11 recipients. Medications that will be available without
12 restriction for persons with mental illnesses include atypical
13 antipsychotic medications, conventional antipsychotic
14 medications, selective serotonin reuptake inhibitors, and
15 other medications used for the treatment of serious mental
16 illnesses. The agency shall also limit the amount of a
17 prescribed drug dispensed to no more than a 34-day supply. The
18 agency shall continue to provide unlimited generic drugs,
19 contraceptive drugs and items, and diabetic supplies. Although
20 a drug may be included on the preferred drug formulary, it
21 would not be exempt from the four-brand limit. The agency may
22 authorize exceptions to the brand-name-drug restriction based
23 upon the treatment needs of the patients, only when such
24 exceptions are based on prior consultation provided by the
25 agency or an agency contractor, but the agency must establish
26 procedures to ensure that:
27 a. There will be a response to a request for prior
28 consultation by telephone or other telecommunication device
29 within 24 hours after receipt of a request for prior
30 consultation;
31 b. A 72-hour supply of the drug prescribed will be

1 provided in an emergency or when the agency does not provide a
2 response within 24 hours as required by sub-subparagraph a.;
3 and
4 c. Except for the exception for nursing home residents
5 and other institutionalized adults and except for drugs on the
6 restricted formulary for which prior authorization may be
7 sought by an institutional or community pharmacy, prior
8 authorization for an exception to the brand-name-drug
9 restriction is sought by the prescriber and not by the
10 pharmacy. When prior authorization is granted for a patient in
11 an institutional setting beyond the brand-name-drug
12 restriction, such approval is authorized for 12 months and
13 monthly prior authorization is not required for that patient.
14 2. Reimbursement to pharmacies for Medicaid prescribed
15 drugs shall be set at the average wholesale price less 13.25
16 percent.
17 3. The agency shall develop and implement a process
18 for managing the drug therapies of Medicaid recipients who are
19 using significant numbers of prescribed drugs each month. The
20 management process may include, but is not limited to,
21 comprehensive, physician-directed medical-record reviews,
22 claims analyses, and case evaluations to determine the medical
23 necessity and appropriateness of a patient's treatment plan
24 and drug therapies. The agency may contract with a private
25 organization to provide drug-program-management services. The
26 Medicaid drug benefit management program shall include
27 initiatives to manage drug therapies for HIV/AIDS patients,
28 patients using 20 or more unique prescriptions in a 180-day
29 period, and the top 1,000 patients in annual spending.
30 4. The agency may limit the size of its pharmacy
31 network based on need, competitive bidding, price

1 negotiations, credentialing, or similar criteria. The agency
2 shall give special consideration to rural areas in determining
3 the size and location of pharmacies included in the Medicaid
4 pharmacy network. A pharmacy credentialing process may include
5 criteria such as a pharmacy's full-service status, location,
6 size, patient educational programs, patient consultation,
7 disease-management services, and other characteristics. The
8 agency may impose a moratorium on Medicaid pharmacy enrollment
9 when it is determined that it has a sufficient number of
10 Medicaid-participating providers.
11 5. The agency shall develop and implement a program
12 that requires Medicaid practitioners who prescribe drugs to
13 use a counterfeit-proof prescription pad for Medicaid
14 prescriptions. The agency shall require the use of
15 standardized counterfeit-proof prescription pads by
16 Medicaid-participating prescribers or prescribers who write
17 prescriptions for Medicaid recipients. The agency may
18 implement the program in targeted geographic areas or
19 statewide.
20 6. The agency may enter into arrangements that require
21 manufacturers of generic drugs prescribed to Medicaid
22 recipients to provide rebates of at least 15.1 percent of the
23 average manufacturer price for the manufacturer's generic
24 products. These arrangements shall require that if a
25 generic-drug manufacturer pays federal rebates for
26 Medicaid-reimbursed drugs at a level below 15.1 percent, the
27 manufacturer must provide a supplemental rebate to the state
28 in an amount necessary to achieve a 15.1-percent rebate level.
29 7. The agency may establish a preferred drug formulary
30 in accordance with 42 U.S.C. s. 1396r-8, and, pursuant to the
31 establishment of such formulary, it is authorized to negotiate

1 supplemental rebates from manufacturers that are in addition
2 to those required by Title XIX of the Social Security Act and
3 at no less than 10 percent of the average manufacturer price
4 as defined in 42 U.S.C. s. 1936 on the last day of a quarter
5 unless the federal or supplemental rebate, or both, equals or
6 exceeds 25 percent. There is no upper limit on the
7 supplemental rebates the agency may negotiate. The agency may
8 determine that specific products, brand-name or generic, are
9 competitive at lower rebate percentages. Agreement to pay the
10 minimum supplemental rebate percentage will guarantee a
11 manufacturer that the Medicaid Pharmaceutical and Therapeutics
12 Committee will consider a product for inclusion on the
13 preferred drug formulary. However, a pharmaceutical
14 manufacturer is not guaranteed placement on the formulary by
15 simply paying the minimum supplemental rebate. Agency
16 decisions will be made on the clinical efficacy of a drug and
17 recommendations of the Medicaid Pharmaceutical and
18 Therapeutics Committee, as well as the price of competing
19 products minus federal and state rebates. The agency is
20 authorized to contract with an outside agency or contractor to
21 conduct negotiations for supplemental rebates. For the
22 purposes of this section, the term "supplemental rebates" may
23 include, at the agency's discretion, cash rebates and other
24 program benefits that offset a Medicaid expenditure. Such
25 other program benefits may include, but are not limited to,
26 disease management programs, drug product donation programs,
27 drug utilization control programs, prescriber and beneficiary
28 counseling and education, fraud and abuse initiatives, and
29 other services or administrative investments with guaranteed
30 savings to the Medicaid program in the same year the rebate
31 reduction is included in the General Appropriations Act. The

1 agency is authorized to seek any federal waivers to implement
2 this initiative.
3 8. The agency shall establish an advisory committee
4 for the purposes of studying the feasibility of using a
5 restricted drug formulary for nursing home residents and other
6 institutionalized adults. The committee shall be comprised of
7 seven members appointed by the Secretary of Health Care
8 Administration. The committee members shall include two
9 physicians licensed under chapter 458 or chapter 459; three
10 pharmacists licensed under chapter 465 and appointed from a
11 list of recommendations provided by the Florida Long-Term Care
12 Pharmacy Alliance; and two pharmacists licensed under chapter
13 465.
14 9. The Agency for Health Care Administration shall
15 expand home delivery of pharmacy products. To assist Medicaid
16 patients in securing their prescriptions and reduce program
17 costs, the agency shall expand its current mail-order-pharmacy
18 diabetes-supply program to include all generic and brand-name
19 drugs used by Medicaid patients with diabetes. Medicaid
20 recipients in the current program may obtain nondiabetes drugs
21 on a voluntary basis. This initiative is limited to the
22 geographic area covered by the current contract. The agency
23 may seek and implement any federal waivers necessary to
24 implement this subparagraph.
25 Section 9. Effective upon this act becoming a law,
26 subsection (26) of section 409.912, Florida Statutes, is
27 amended to read:
28 409.912 Cost-effective purchasing of health care.--The
29 agency shall purchase goods and services for Medicaid
30 recipients in the most cost-effective manner consistent with
31 the delivery of quality medical care. The agency shall

1 maximize the use of prepaid per capita and prepaid aggregate
2 fixed-sum basis services when appropriate and other
3 alternative service delivery and reimbursement methodologies,
4 including competitive bidding pursuant to s. 287.057, designed
5 to facilitate the cost-effective purchase of a case-managed
6 continuum of care. The agency shall also require providers to
7 minimize the exposure of recipients to the need for acute
8 inpatient, custodial, and other institutional care and the
9 inappropriate or unnecessary use of high-cost services. The
10 agency may establish prior authorization requirements for
11 certain populations of Medicaid beneficiaries, certain drug
12 classes, or particular drugs to prevent fraud, abuse, overuse,
13 and possible dangerous drug interactions. The Pharmaceutical
14 and Therapeutics Committee shall make recommendations to the
15 agency on drugs for which prior authorization is required. The
16 agency shall inform the Pharmaceutical and Therapeutics
17 Committee of its decisions regarding drugs subject to prior
18 authorization.
19 (26) The agency shall perform ~~choice counseling,~~
20 enrollments~~,~~ and disenrollments for Medicaid recipients who
21 are eligible for MediPass or managed care plans.
22 Notwithstanding the prohibition contained in paragraph
23 (18)(f), managed care plans may perform preenrollments of
24 Medicaid recipients under the supervision of the agency or its
25 agents. For the purposes of this section, "preenrollment"
26 means the provision of marketing and educational materials to
27 a Medicaid recipient and assistance in completing the
28 application forms, but shall not include actual enrollment
29 into a managed care plan. An application for enrollment shall
30 not be deemed complete until the agency or its agent verifies
31 that the recipient made an informed, voluntary choice. The

1 agency, in cooperation with the Department of Children and
2 Family Services, may test new marketing initiatives to inform
3 Medicaid recipients about their managed care options at
4 selected sites. The agency shall report to the Legislature on
5 the effectiveness of such initiatives. The agency may
6 contract with a third party to perform managed care plan and
7 MediPass ~~choice-counseling,~~enrollment~~,~~and disenrollment
8 services for Medicaid recipients and is authorized to adopt
9 rules to implement such services. The agency may adjust the
10 capitation rate only to cover the costs of a third-party
11 ~~choice-counseling,~~enrollment~~,~~and disenrollment contract, and
12 for agency supervision and management of the managed care plan
13 ~~choice-counseling,~~enrollment~~,~~and disenrollment contract.
14 Section 10. Effective July 1, 2002, paragraph (e) of
15 subsection (2) of section 409.9122, Florida Statutes, is
16 amended to read:
17 409.9122 Mandatory Medicaid managed care enrollment;
18 programs and procedures.--
19 (2)
20 (e) ~~Prior to requesting a Medicaid recipient who is~~
21 ~~subject to mandatory managed care enrollment to make a choice~~
22 ~~between a managed care plan or MediPass, the agency shall~~
23 ~~contact and provide choice counseling to the recipient.~~
24 Medicaid recipients who are already enrolled in a managed care
25 plan or MediPass shall be offered the opportunity to change
26 managed care plans or MediPass providers on a staggered basis,
27 as defined by the agency. All Medicaid recipients shall have
28 90 days in which to make a choice of managed care plans or
29 MediPass providers. Those Medicaid recipients who do not make
30 a choice shall be assigned to a managed care plan or MediPass
31 in accordance with paragraph (f). To facilitate continuity of

1 care, for a Medicaid recipient who is also a recipient of
2 Supplemental Security Income (SSI), prior to assigning the SSI
3 recipient to a managed care plan or MediPass, the agency shall
4 determine whether the SSI recipient has an ongoing
5 relationship with a MediPass provider or managed care plan,
6 and if so, the agency shall assign the SSI recipient to that
7 MediPass provider or managed care plan. Those SSI recipients
8 who do not have such a provider relationship shall be assigned
9 to a managed care plan or MediPass provider in accordance with
10 paragraph (f).
11 Section 11. Effective upon this act becoming a law,
12 paragraph (f) of subsection (2) of section 409.9122, Florida
13 Statutes, is amended to read:
14 409.9122 Mandatory Medicaid managed care enrollment;
15 programs and procedures.--
16 (2)
17 (f) When a Medicaid recipient does not choose a
18 managed care plan or MediPass provider, the agency shall
19 assign the Medicaid recipient to a managed care plan or
20 MediPass provider. Medicaid recipients who are subject to
21 mandatory assignment but who fail to make a choice shall be
22 assigned to managed care plans or provider service networks
23 until an equal enrollment of 50 percent in MediPass ~~and~~
24 ~~provider service networks~~ and 50 percent in managed care plans
25 is achieved. Once equal enrollment is achieved, the
26 assignments shall be divided in order to maintain an equal
27 enrollment in MediPass and managed care plans. Thereafter,
28 assignment of Medicaid recipients who fail to make a choice
29 shall be based proportionally on the preferences of recipients
30 who have made a choice in the previous period. Such
31 proportions shall be revised at least quarterly to reflect an

1 update of the preferences of Medicaid recipients. The agency
2 shall also disproportionately assign Medicaid-eligible
3 children in families who are required to but have failed to
4 make a choice of managed care plan or MediPass for their child
5 and who are to be assigned to the MediPass program to
6 children's networks as described in s. 409.912(3)(g) and where
7 available. The disproportionate assignment of children to
8 children's networks shall be made until the agency has
9 determined that the children's networks have sufficient
10 numbers to be economically operated. For purposes of this
11 paragraph, when referring to assignment, the term "managed
12 care plans" includes exclusive provider organizations,
13 provider service networks, minority physician networks, and
14 pediatric emergency department diversion programs authorized
15 by this chapter or the General Appropriations Act.When making
16 assignments, the agency shall take into account the following
17 criteria:
18 1. A managed care plan has sufficient network capacity
19 to meet the need of members.
20 2. The managed care plan or MediPass has previously
21 enrolled the recipient as a member, or one of the managed care
22 plan's primary care providers or MediPass providers has
23 previously provided health care to the recipient.
24 3. The agency has knowledge that the member has
25 previously expressed a preference for a particular managed
26 care plan or MediPass provider as indicated by Medicaid
27 fee-for-service claims data, but has failed to make a choice.
28 4. The managed care plan's or MediPass primary care
29 providers are geographically accessible to the recipient's
30 residence.
31 Section 12. Effective upon this act becoming a law,

1 subsections (15) and (21), paragraph (a) of subsection (22),
2 and paragraph (a) of subsection (24) of section 409.913,
3 Florida Statutes, are amended, and subsections (26) and (27)
4 are added to that section, to read:
5 409.913 Oversight of the integrity of the Medicaid
6 program.--The agency shall operate a program to oversee the
7 activities of Florida Medicaid recipients, and providers and
8 their representatives, to ensure that fraudulent and abusive
9 behavior and neglect of recipients occur to the minimum extent
10 possible, and to recover overpayments and impose sanctions as
11 appropriate.
12 (15) The agency may impose any of the following
13 sanctions on a provider or a person for any of the acts
14 described in subsection (14):
15 (a) Suspension for a specific period of time of not
16 more than 1 year.
17 (b) Termination for a specific period of time of from
18 more than 1 year to 20 years.
19 (c) Imposition of a fine of up to $5,000 for each
20 violation. Each day that an ongoing violation continues, such
21 as refusing to furnish Medicaid-related records or refusing
22 access to records, is considered, for the purposes of this
23 section, to be a separate violation. Each instance of
24 improper billing of a Medicaid recipient; each instance of
25 including an unallowable cost on a hospital or nursing home
26 Medicaid cost report after the provider or authorized
27 representative has been advised in an audit exit conference or
28 previous audit report of the cost unallowability; each
29 instance of furnishing a Medicaid recipient goods or
30 professional services that are inappropriate or of inferior
31 quality as determined by competent peer judgment; each

1 instance of knowingly submitting a materially false or
2 erroneous Medicaid provider enrollment application, request
3 for prior authorization for Medicaid services, drug exception
4 request, or cost report; each instance of inappropriate
5 prescribing of drugs for a Medicaid recipient as determined by
6 competent peer judgment; and each false or erroneous Medicaid
7 claim leading to an overpayment to a provider is considered,
8 for the purposes of this section, to be a separate violation.
9 (d) Immediate suspension, if the agency has received
10 information of patient abuse or neglect or of any act
11 prohibited by s. 409.920. Upon suspension, the agency must
12 issue an immediate final order under s. 120.569(2)(n).
13 (e) A fine, not to exceed $10,000, for a violation of
14 paragraph (14)(i).
15 (f) Imposition of liens against provider assets,
16 including, but not limited to, financial assets and real
17 property, not to exceed the amount of fines or recoveries
18 sought, upon entry of an order determining that such moneys
19 are due or recoverable.
20 (g) Other remedies as permitted by law to effect the
21 recovery of a fine or overpayment.
22 (21) The audit report, supported by agency work
23 papers, showing an overpayment to a provider constitutes
24 evidence of the overpayment. A provider may not present or
25 elicit testimony, either on direct examination or
26 cross-examination in any court or administrative proceeding,
27 regarding the purchase or acquisition by any means of drugs,
28 goods, or supplies; sales or divestment by any means of drugs,
29 goods, or supplies; or inventory of drugs, goods, or supplies,
30 unless such acquisition, sales, divestment, or inventory is
31 documented by written invoices, written inventory records, or

other competent written documentary evidence maintained in the normal course of the provider's business. Notwithstanding the applicable rules of discovery, all documentation that will be offered as evidence at an administrative hearing on a Medicaid overpayment must be exchanged by all parties at least 14 days before the administrative hearing or must be excluded from consideration.

(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.

(24)(a) The agency may withhold Medicaid payments, in whole or in part, to a provider upon receipt of reliable evidence that the circumstances giving rise to the need for a withholding of payments involve fraud, ~~or~~ willful misrepresentation, or abuse under the Medicaid program, or a crime committed while rendering goods or services to Medicaid recipients, pending completion of legal proceedings. If it is determined that fraud, willful misrepresentation, abuse, or a crime did not occur, the payments withheld must be paid to the provider within 14 days after such determination with interest at the rate of 10 percent a year. Any money withheld in accordance with this paragraph shall be placed in a suspended account, readily accessible to the agency, so that any payment ultimately due the provider shall be made within 14 days. ~~Furthermore, the authority to withhold payments under this paragraph shall not apply to physicians whose alleged overpayments are being determined by administrative proceedings pursuant to chapter 120.~~

1 (26) When the Agency for Health Care Administration
2 has made a probable cause determination and alleged that an
3 overpayment to a Medicaid provider has occurred, the agency,
4 after notice to the provider, may:
5 (a) Withhold, and continue to withhold during the
6 pendency of an administrative hearing pursuant to chapter 120,
7 any medical assistance reimbursement payments until such time
8 as the overpayment is recovered, unless within 30 days after
9 receiving notice thereof the provider:
10 1. Makes repayment in full; or
11 2. Establishes a repayment plan that is satisfactory
12 to the Agency for Health Care Administration.
13 (b) Withhold, and continue to withhold during the
14 pendency of an administrative hearing pursuant to chapter 120,
15 medical assistance reimbursement payments if the terms of a
16 repayment plan are not adhered to by the provider.
17
18 If a provider requests an administrative hearing pursuant to
19 chapter 120, such hearing must be conducted within 90 days
20 following receipt by the provider of the final audit report,
21 absent exceptionally good cause shown as determined by the
22 administrative law judge or hearing officer. Upon issuance of
23 a final order, the balance outstanding of the amount
24 determined to constitute the overpayment shall become due.
25 Any withholding of payments by the Agency for Health Care
26 Administration pursuant to this section shall be limited so
27 that the monthly medical assistance payment is not reduced by
28 more than 10 percent.
29 (27) Venue for all Medicaid program integrity
30 overpayment cases shall lie in Leon County, at the discretion
31 of the agency.

1 Section 13. Subsection (4) of section 414.41, Florida
2 Statutes, is repealed.
3 Section 14. Section 400.0225, Florida Statutes, is
4 repealed.
5 Section 15. Paragraph (c) of subsection (5) of section
6 400.179, Florida Statutes, is amended to read:
7 400.179 Sale or transfer of ownership of a nursing
8 facility; liability for Medicaid underpayments and
9 overpayments.--
10 (5) Because any transfer of a nursing facility may
11 expose the fact that Medicaid may have underpaid or overpaid
12 the transferor, and because in most instances, any such
13 underpayment or overpayment can only be determined following a
14 formal field audit, the liabilities for any such underpayments
15 or overpayments shall be as follows:
16 (c) Where the facility transfer takes any form of a
17 sale of assets, in addition to the transferor's continuing
18 liability for any such overpayments, if the transferor fails
19 to meet these obligations, the transferee shall be liable for
20 all liabilities that can be readily identifiable 90 days in
21 advance of the transfer. Such liability shall continue in
22 succession until the debt is ultimately paid or otherwise
23 resolved.It shall be the burden of the transferee to
24 determine the amount of all such readily identifiable
25 overpayments from the Agency for Health Care Administration,
26 and the agency shall cooperate in every way with the
27 identification of such amounts. Readily identifiable
28 overpayments shall include overpayments that will result from,
29 but not be limited to:
30 1. Medicaid rate changes or adjustments;
31 2. Any depreciation recapture;

1 3. Any recapture of fair rental value system indexing;
2 or ~~and/or~~
3 4. Audits completed by the agency.
4
5 The transferor shall remain liable for any such Medicaid
6 overpayments that were not readily identifiable 90 days in
7 advance of the nursing facility transfer.
8 Section 16. Paragraph (a) of subsection (2) of section
9 400.191, Florida Statutes, is amended to read:
10 400.191 Availability, distribution, and posting of
11 reports and records.--
12 (2) The agency shall provide additional information in
13 consumer-friendly printed and electronic formats to assist
14 consumers and their families in comparing and evaluating
15 nursing home facilities.
16 (a) The agency shall provide an Internet site which
17 shall include at least the following information either
18 directly or indirectly through a link to another established
19 site or sites of the agency's choosing:
20 1. A list by name and address of all nursing home
21 facilities in this state.
22 2. Whether such nursing home facilities are
23 proprietary or nonproprietary.
24 3. The current owner of the facility's license and the
25 year that that entity became the owner of the license.
26 4. The name of the owner or owners of each facility
27 and whether the facility is affiliated with a company or other
28 organization owning or managing more than one nursing facility
29 in this state.
30 5. The total number of beds in each facility.
31 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 17. 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 18. Section 400.071, Florida Statutes, is amended to read:

1 400.071 Application for license.--
2 (1) An application for a license as required by s.
3 400.062 shall be made to the agency on forms furnished by it
4 and shall be accompanied by the appropriate license fee.
5 (2) The application shall be under oath and shall
6 contain the following:
7 (a) The name, address, and social security number of
8 the applicant if an individual; if the applicant is a firm,
9 partnership, or association, its name, address, and employer
10 identification number (EIN), and the name and address of any
11 controlling interest; and the name by which the facility is to
12 be known.
13 (b) The name of any person whose name is required on
14 the application under the provisions of paragraph (a) and who
15 owns at least a 10-percent interest in any professional
16 service, firm, association, partnership, or corporation
17 providing goods, leases, or services to the facility for which
18 the application is made, and the name and address of the
19 professional service, firm, association, partnership, or
20 corporation in which such interest is held.
21 (c) The location of the facility for which a license
22 is sought and an indication, as in the original application,
23 that such location conforms to the local zoning ordinances.
24 (d) The name of the person or persons under whose
25 management or supervision the facility will be conducted and
26 the name of the administrator.
27 (e) A signed affidavit disclosing any financial or
28 ownership interest that a person or entity described in
29 paragraph (a) or paragraph (d) has held in the last 5 years in
30 any entity licensed by this state or any other state to
31 provide health or residential care which has closed

1 voluntarily or involuntarily; has filed for bankruptcy; has
2 had a receiver appointed; has had a license denied, suspended,
3 or revoked; or has had an injunction issued against it which
4 was initiated by a regulatory agency. The affidavit must
5 disclose the reason any such entity was closed, whether
6 voluntarily or involuntarily.
7 (f) The total number of beds and the total number of
8 Medicare and Medicaid certified beds.
9 (g) Information relating to the number, experience,
10 and training of the employees of the facility and of the moral
11 character of the applicant and employees which the agency
12 requires by rule, including the name and address of any
13 nursing home with which the applicant or employees have been
14 affiliated through ownership or employment within 5 years of
15 the date of the application for a license and the record of
16 any criminal convictions involving the applicant and any
17 criminal convictions involving an employee if known by the
18 applicant after inquiring of the employee. The applicant must
19 demonstrate that sufficient numbers of qualified staff, by
20 training or experience, will be employed to properly care for
21 the type and number of residents who will reside in the
22 facility.
23 (h) Copies of any civil verdict or judgment involving
24 the applicant rendered within the 10 years preceding the
25 application, relating to medical negligence, violation of
26 residents' rights, or wrongful death. As a condition of
27 licensure, the licensee agrees to provide to the agency copies
28 of any new verdict or judgment involving the applicant,
29 relating to such matters, within 30 days after filing with the
30 clerk of the court. The information required in this
31 paragraph shall be maintained in the facility's licensure file

1 and in an agency database which is available as a public
2 record.
3 (3) The applicant shall submit evidence which
4 establishes the good moral character of the applicant,
5 manager, supervisor, and administrator. No applicant, if the
6 applicant is an individual; no member of a board of directors
7 or officer of an applicant, if the applicant is a firm,
8 partnership, association, or corporation; and no licensed
9 nursing home administrator shall have been convicted, or found
10 guilty, regardless of adjudication, of a crime in any
11 jurisdiction which affects or may potentially affect residents
12 in the facility.
13 (4) Each applicant for licensure must comply with the
14 following requirements:
15 (a) Upon receipt of a completed, signed, and dated
16 application, the agency shall require background screening of
17 the applicant, in accordance with the level 2 standards for
18 screening set forth in chapter 435. As used in this
19 subsection, the term "applicant" means the facility
20 administrator, or similarly titled individual who is
21 responsible for the day-to-day operation of the licensed
22 facility, and the facility financial officer, or similarly
23 titled individual who is responsible for the financial
24 operation of the licensed facility.
25 (b) The agency may require background screening for a
26 member of the board of directors of the licensee or an officer
27 or an individual owning 5 percent or more of the licensee if
28 the agency has probable cause to believe that such individual
29 has been convicted of an offense prohibited under the level 2
30 standards for screening set forth in chapter 435.
31 (c) Proof of compliance with the level 2 background

1 screening requirements of chapter 435 which has been submitted
2 within the previous 5 years in compliance with any other
3 health care or assisted living licensure requirements of this
4 state is acceptable in fulfillment of paragraph (a). Proof of
5 compliance with background screening which has been submitted
6 within the previous 5 years to fulfill the requirements of the
7 Department of Insurance pursuant to chapter 651 as part of an
8 application for a certificate of authority to operate a
9 continuing care retirement community is acceptable in
10 fulfillment of the Department of Law Enforcement and Federal
11 Bureau of Investigation background check.
12 (d) A provisional license may be granted to an
13 applicant when each individual required by this section to
14 undergo background screening has met the standards for the
15 Department of Law Enforcement background check, but the agency
16 has not yet received background screening results from the
17 Federal Bureau of Investigation, or a request for a
18 disqualification exemption has been submitted to the agency as
19 set forth in chapter 435, but a response has not yet been
20 issued. A license may be granted to the applicant upon the
21 agency's receipt of a report of the results of the Federal
22 Bureau of Investigation background screening for each
23 individual required by this section to undergo background
24 screening which confirms that all standards have been met, or
25 upon the granting of a disqualification exemption by the
26 agency as set forth in chapter 435. Any other person who is
27 required to undergo level 2 background screening may serve in
28 his or her capacity pending the agency's receipt of the report
29 from the Federal Bureau of Investigation; however, the person
30 may not continue to serve if the report indicates any
31 violation of background screening standards and a

1 disqualification exemption has not been requested of and
2 granted by the agency as set forth in chapter 435.
3 (e) Each applicant must submit to the agency, with its
4 application, a description and explanation of any exclusions,
5 permanent suspensions, or terminations of the applicant from
6 the Medicare or Medicaid programs. Proof of compliance with
7 disclosure of ownership and control interest requirements of
8 the Medicaid or Medicare programs shall be accepted in lieu of
9 this submission.
10 (f) Each applicant must submit to the agency a
11 description and explanation of any conviction of an offense
12 prohibited under the level 2 standards of chapter 435 by a
13 member of the board of directors of the applicant, its
14 officers, or any individual owning 5 percent or more of the
15 applicant. This requirement shall not apply to a director of a
16 not-for-profit corporation or organization if the director
17 serves solely in a voluntary capacity for the corporation or
18 organization, does not regularly take part in the day-to-day
19 operational decisions of the corporation or organization,
20 receives no remuneration for his or her services on the
21 corporation or organization's board of directors, and has no
22 financial interest and has no family members with a financial
23 interest in the corporation or organization, provided that the
24 director and the not-for-profit corporation or organization
25 include in the application a statement affirming that the
26 director's relationship to the corporation satisfies the
27 requirements of this paragraph.
28 (g) An application for license renewal must contain
29 the information required under paragraphs (e) and (f).
30 (5) The applicant shall furnish satisfactory proof of
31 financial ability to operate and conduct the nursing home in

1 accordance with the requirements of this part and all rules
2 adopted under this part, and the agency shall establish
3 standards for this purpose, including information reported
4 under paragraph (2)(e). The agency also shall establish
5 documentation requirements, to be completed by each applicant,
6 that show anticipated facility revenues and expenditures, the
7 basis for financing the anticipated cash-flow requirements of
8 the facility, and an applicant's access to contingency
9 financing.
10 (6) If the applicant offers continuing care agreements
11 as defined in chapter 651, proof shall be furnished that such
12 applicant has obtained a certificate of authority as required
13 for operation under that chapter.
14 (7) As a condition of licensure, each licensee, except
15 one offering continuing care agreements as defined in chapter
16 651, must agree to accept recipients of Title XIX of the
17 Social Security Act on a temporary, emergency basis. The
18 persons whom the agency may require such licensees to accept
19 are those recipients of Title XIX of the Social Security Act
20 who are residing in a facility in which existing conditions
21 constitute an immediate danger to the health, safety, or
22 security of the residents of the facility.
23 ~~(8) As a condition of licensure, each facility must~~
24 ~~agree to participate in a consumer satisfaction measurement~~
25 ~~process as prescribed by the agency.~~
26 (8)~~(9)~~ The agency may not issue a license to a nursing
27 home that fails to receive a certificate of need under the
28 provisions of ss. 408.031-408.045. It is the intent of the
29 Legislature that, in reviewing a certificate-of-need
30 application to add beds to an existing nursing home facility,
31 preference be given to the application of a licensee who has

1 been awarded a Gold Seal as provided for in s. 400.235, if the
2 applicant otherwise meets the review criteria specified in s.
3 408.035.
4 (9)~~(10)~~ The agency may develop an abbreviated survey
5 for licensure renewal applicable to a licensee that has
6 continuously operated as a nursing facility since 1991 or
7 earlier, has operated under the same management for at least
8 the preceding 30 months, and has had during the preceding 30
9 months no class I or class II deficiencies.
10 (10)~~(11)~~ The agency may issue an inactive license to a
11 nursing home that will be temporarily unable to provide
12 services but that is reasonably expected to resume services.
13 Such designation may be made for a period not to exceed 12
14 months but may be renewed by the agency for up to 6 additional
15 months. Any request by a licensee that a nursing home become
16 inactive must be submitted to the agency and approved by the
17 agency prior to initiating any suspension of service or
18 notifying residents. Upon agency approval, the nursing home
19 shall notify residents of any necessary discharge or transfer
20 as provided in s. 400.0255.
21 (11)~~(12)~~ As a condition of licensure, each facility
22 must establish and submit with its application a plan for
23 quality assurance and for conducting risk management.
24 Section 19. Paragraph (q) of subsection (2) of section
25 409.815, Florida Statutes, is amended to read:
26 409.815 Health benefits coverage; limitations.--
27 (2) BENCHMARK BENEFITS.--In order for health benefits
28 coverage to qualify for premium assistance payments for an
29 eligible child under ss. 409.810-409.820, the health benefits
30 coverage, except for coverage under Medicaid and Medikids,
31 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. Paragraph (b) of subsection (4) of section 624.91, Florida Statutes, is amended to read:

624.91 The Florida Healthy Kids Corporation Act.--

(4) CORPORATION AUTHORIZATION, DUTIES, POWERS.--

(b) The Florida Healthy Kids Corporation shall phase in a program to:

1. Organize school children groups to facilitate the provision of comprehensive health insurance coverage to children;

2. Arrange for the collection of any family, local contributions, or employer payment or premium, in an amount to be determined by the board of directors, to provide for payment of premiums for comprehensive insurance coverage and for the actual or estimated administrative expenses;

3. Establish the administrative and accounting procedures for the operation of the corporation;

4. Establish, with consultation from appropriate professional organizations, standards for preventive health services and providers and comprehensive insurance benefits appropriate to children; provided that such standards for rural areas shall not limit primary care providers to board-certified pediatricians;

5. Establish eligibility criteria which children must meet in order to participate in the program;

6. Establish procedures under which applicants to and participants in the program may have grievances reviewed by an

1 impartial body and reported to the board of directors of the
2 corporation;
3 7. Establish participation criteria and, if
4 appropriate, contract with an authorized insurer, health
5 maintenance organization, or insurance administrator to
6 provide administrative services to the corporation;
7 8. Establish enrollment criteria which shall include
8 penalties or waiting periods of not fewer than 60 days for
9 reinstatement of coverage upon voluntary cancellation for
10 nonpayment of family premiums;
11 9. If a space is available, establish a special open
12 enrollment period of 30 days' duration for any child who is
13 enrolled in Medicaid or Medikids if such child loses Medicaid
14 or Medikids eligibility and becomes eligible for the Florida
15 Healthy Kids program;
16 10. Contract with authorized insurers or any provider
17 of health care services, meeting standards established by the
18 corporation, for the provision of comprehensive insurance
19 coverage to participants. Such standards shall include
20 criteria under which the corporation may contract with more
21 than one provider of health care services in program sites.
22 Health plans shall be selected through a competitive bid
23 process. The selection of health plans shall be based
24 primarily on quality criteria established by the board. The
25 health plan selection criteria and scoring system, and the
26 scoring results, shall be available upon request for
27 inspection after the bids have been awarded;
28 11. Develop and implement a plan to publicize the
29 Florida Healthy Kids Corporation, the eligibility requirements
30 of the program, and the procedures for enrollment in the
31 program and to maintain public awareness of the corporation

and the program;

12. Secure staff necessary to properly administer the corporation. Staff costs shall be funded from state and local matching funds and such other private or public funds as become available. The board of directors shall determine the number of staff members necessary to administer the corporation;

13. As appropriate, enter into contracts with local school boards or other agencies to provide onsite information, enrollment, and other services necessary to the operation of the corporation;

14. Provide a report on an annual basis to the Governor, Insurance Commissioner, Commissioner of Education, Senate President, Speaker of the House of Representatives, and Minority Leaders of the Senate and the House of Representatives;

15. Each fiscal year, establish a maximum number of participants by county, on a statewide basis, who may enroll in the program without the benefit of local matching funds. Thereafter, the corporation may establish local matching requirements for supplemental participation in the program. The corporation may vary local matching requirements and enrollment by county depending on factors which may influence the generation of local match, including, but not limited to, population density, per capita income, existing local tax effort, and other factors. The corporation also may accept in-kind match in lieu of cash for the local match requirement to the extent allowed by Title XXI of the Social Security Act; ~~and~~

16. Establish eligibility criteria, premium and cost-sharing requirements, and benefit packages which conform

1 to the provisions of the Florida Kidcare program, as created
2 in ss. 409.810-409.820; and.
3 17. Notwithstanding the requirements of subparagraph
4 15. to the contrary, establish a local matching requirement of
5 $0.00 for the Title XXI program in each county of the state
6 for the 2001-2002 fiscal year. This subparagraph shall take
7 effect upon becoming a law and shall operate retroactively to
8 July 1, 2001. This subparagraph expires July 1, 2002.
9 Section 21. Except as otherwise specifically provided
10 in this act, this act shall take effect January 1, 2002.
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12
13 =============== T I T L E A M E N D M E N T ===============
14 And the title is amended as follows:
15 Delete everything before the enacting clause
16
17 and insert:
18 A bill to be entitled
19 An act relating to the Agency for Health Care
20 Administration; repealing s. 409.904(11), F.S.,
21 which provides eligibility of specified persons
22 for certain optional medical assistance;
23 amending s. 409.904, F.S.; revising standards
24 for eligibility for certain optional medical
25 assistance; amending s. 409.906, F.S.; revising
26 guidelines for payment for certain services;
27 revising eligibility for certain Medicaid
28 services; amending s. 409.9065, F.S.;
29 prescribing enrollment levels with respect to
30 pharmaceutical expense assistance; amending s.
31 409.907, F.S.; authorizing withholding of

1 Medicaid payments in certain circumstances;
2 prescribing additional requirements with
3 respect to providers' submission of
4 information; prescribing additional duties for
5 the agency with respect to provider
6 applications; amending s. 409.908, F.S.;
7 providing temporary authorization for the
8 agency to make special payments to designated
9 Medicaid providers and use intergovernmental
10 transfers for certain payments; revising
11 pharmacy dispensing fees for Medicaid drugs;
12 amending ss. 409.912, 409.9122, F.S.; providing
13 for expanded home delivery of pharmacy
14 products; revising provisions relating to
15 choice counseling for recipients; defining the
16 term "managed care plans"; amending s. 409.913,
17 F.S.; prescribing additional sanctions that may
18 be imposed upon a Medicaid provider;
19 eliminating a limit on costs that may be
20 recovered against a provider; requiring
21 disclosure of certain information before an
22 administrative hearing; providing for
23 withholding payments in cases of Medicaid abuse
24 and in cases subject to administrative
25 proceedings; prescribing agency procedures in
26 cases of overpayment; providing venue for
27 Medicaid overpayment cases; repealing s.
28 414.41(4), F.S., relating to agency procedures
29 in cases of overpayment; repealing s. 400.0225,
30 F.S., relating to consumer-satisfaction
31 surveys; amending s. 400.179, F.S.; declaring

1 liability for overpayment when a nursing
2 facility is sold; amending s. 400.191, F.S.;
3 eliminating a provision relating to
4 consumer-satisfaction and family-satisfaction
5 surveys; amending s. 400.235, F.S.; eliminating
6 a provision relating to participation in the
7 consumer-satisfaction process; amending s.
8 400.071, F.S.; eliminating a provision relating
9 to participation in a
10 consumer-satisfaction-measurement process;
11 amending s. 409.815, F.S.; conforming a
12 cross-reference; amending s. 624.91, F.S.,
13 relating to the Florida Healthy Kids
14 Corporation Act; providing temporary
15 authorization for the agency to revise a local
16 matching requirement; providing effective
17 dates.
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