A bill to be entitled

An act relating to health care; amending ss. 409.903 and 409.904, F.S.; revising eligibility categories for optional Medicaid services; amending s. 409.906, F.S.; eliminating Medicaid coverage for adult denture services; limiting coverage for hearing and visual services to children under age 21; authorizing the Agency for Health Care Administration to use mail order pharmacies for drugs prescribed for a Medicaid recipient; amending s. 409.9065, F.S.; revising eligibility for the pharmaceutical expense assistance program; limiting program enrollment levels and authorizing the agency to develop a waiting list; amending s. 409.907, F.S.; authorizing the agency to withhold payments to a Medicaid provider that the agency is investigating for fraud or abuse; providing for inspections and submission of background information as a condition of initial and renewal applications for provider participation in the Medicaid program; clarifying timeframe for enrollment of providers; providing additional considerations for denial of a provider application; amending s. 409.908, F.S.; revising pharmacy provider dispensing fees for products on the preferred drug list and those not so listed; amending ss. 409.912 and 409.9122, F.S.; eliminating requirement that the agency provide enrollment choice counseling to certain Medicaid recipients;

amending s. 409.913, F.S.; specifying additional sanctions which may be imposed by the agency against a Medicaid provider; removing a limitation on certain costs the agency is entitled to recover for provider violations; amending s. 409.915, F.S.; increasing county Medicaid contributions for certain inpatient hospitalization and nursing home and intermediate facilities care; amending ss. 400.071, 400.191, 400.23, 400.235, 409.8132, and 409.815, F.S.; removing references to Medicaid enrollment choice counseling and to nursing facility consumer satisfaction surveys, to conform to the act; correcting cross references; providing that the act fulfills an important state interest; repealing s. 400.0225, F.S., relating to nursing facility consumer satisfaction surveys; repealing s. 400.148, F.S., relating to the Medicaid "Up or Out" Quality of Care Contract Management Program; repealing ss. 464.0195, 464.0196, and 464.0197, F.S., relating to establishment, operation, and funding of the Florida Center for Nursing; providing effective dates.

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

Section 1. Subsection (8) 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.

(8) A person who is age 65 or over or is determined by the agency to be disabled, whose income is at or below 100 percent of the most current federal poverty level and whose assets do not exceed limitations established by the agency. However, the agency may only pay for premiums, coinsurance, and deductibles, as required by federal law~~, unless additional coverage is provided for any or all members of this group by s. 409.904(1)~~.

Section 2. Present 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 <u>85</u> ~~100~~ percent of

federal poverty level, and whose assets do not exceed established limitations.

(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 under subsection (7) or s. 409.903(6) or (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.

Section 3. Present subsections (1), (12), (20), 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 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.~~

(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.

(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. The agency may use mail order pharmacy services for dispensing drugs.

(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.

Section 4. Subsections (2), (3), and (5) of section 409.9065, Florida Statutes, are amended to read:

409.9065 Pharmaceutical expense assistance.--

(2) ELIGIBILITY.--Two groups of individuals are eligible for the program:

(a) Individuals age 65 and older or disabled adults age 21 and older with incomes between 85 and 90 percent of the federal poverty level.

(b) ~~Eligibility for the program is limited to those~~ Individuals who qualify for limited assistance under the Florida Medicaid program as a result of being dually eligible for both Medicare and Medicaid, but whose limited assistance or Medicare coverage does not include any pharmacy benefit. To the extent that funds are appropriated, specifically eligible are low-income senior citizens who:

1.~~(a)~~ Are Florida residents age 65 and over;

2.~~(b)~~ Have an income between 90 and 120 percent of the federal poverty level;

3.~~(c)~~ Are eligible for both Medicare and Medicaid;

4.~~(d)~~ Are not enrolled in a Medicare health maintenance organization that provides a pharmacy benefit; and

5.~~(e)~~ Request to be enrolled in the program.

(3) BENEFITS.--Medications covered under the pharmaceutical expense assistance program are those covered under the Medicaid program in s. 409.906(19)~~(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 appropriation. If there are insufficient funds to serve all individuals eligible under subsection (2)

and seeking coverage, the agency is authorized to develop a waiting list based on application date to use for enrolling individuals in unfilled enrollment slots.

Section 5. Effective upon 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. The agency may withhold payment to a provider for any pending claim if the provider is under an active fraud or abuse investigation by the agency until the conclusion of the investigation by the agency. When exercising the provisions of this paragraph, the agency shall complete its investigation in a timely manner.

(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 for which it is making application to provide in the Medicaid program.

Section 6. Paragraphs (g) and (t) of subsection (3) and subsections (14) and (20) of section 409.908, Florida Statutes, are 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.

(3) Subject to any limitations or directions provided for in the General Appropriations Act, the following Medicaid services and goods may be reimbursed on a fee-for-service basis. For each allowable service or goods furnished in accordance with Medicaid rules, policy manuals, handbooks, and state and federal law, the payment shall be the amount billed by the provider, the provider's usual and customary charge, or the maximum allowable fee established by the agency, whichever amount is less, with the exception of those services or goods for which the agency makes payment using a methodology based on capitation rates, average costs, or negotiated fees.

(g) Children's hearing services.

(t) Children's visual services.

(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 appropriation 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.

(20) A renal dialysis facility that provides dialysis services under s. 409.906(8)~~(9)~~must be reimbursed the lesser of the amount billed by the provider, the provider's usual and customary charge, or the maximum allowable fee established by the agency, whichever amount is less.

Section 7. Subsection (26) 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.

(26) The agency shall perform ~~choice counseling,~~ enrollments~~,~~ and disenrollments for Medicaid recipients who are eligible for MediPass or managed care plans. Notwithstanding the prohibition contained in paragraph (18)(f), managed care plans may perform preenrollments of Medicaid recipients under the supervision of the agency or its agents. For the purposes of this section, "preenrollment" means the provision of marketing and educational materials to a Medicaid recipient and assistance in completing the application forms, but shall not include actual enrollment into a managed care plan. An application for enrollment shall not be deemed complete until the agency or its agent verifies that the recipient made an informed, voluntary choice. The agency, in cooperation with the Department of Children and Family Services, may test new marketing initiatives to inform Medicaid recipients about their managed care options at selected sites. The agency shall report to the Legislature on the effectiveness of such initiatives. The agency may contract with a third party to perform managed care plan and MediPass ~~choice-counseling,~~enrollment~~,~~ and disenrollment services for Medicaid recipients and is authorized to adopt rules to implement such services. The agency may adjust the

capitation rate only to cover the costs of a third-party ~~choice-counseling,~~enrollment~~,~~and disenrollment contract, and for agency supervision and management of the managed care plan ~~choice-counseling,~~enrollment~~,~~and disenrollment contract.

Section 8. Paragraph (e) of subsection (2) of section 409.9122, Florida Statutes, is amended to read:

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

(2)

(e) ~~Prior to requesting a Medicaid recipient who is subject to mandatory managed care enrollment to make a choice between a managed care plan or MediPass, the agency shall contact and provide choice counseling to the recipient.~~ Medicaid recipients who are already enrolled in a managed care plan or MediPass shall be offered the opportunity to change managed care plans or MediPass providers on a staggered basis, as defined by the agency. All Medicaid recipients shall have 90 days in which to make a choice of managed care plans or MediPass providers. Those Medicaid recipients who do not make a choice shall be assigned to a managed care plan or MediPass in accordance with paragraph (f). To facilitate continuity of care, for a Medicaid recipient who is also a recipient of Supplemental Security Income (SSI), prior to assigning the SSI recipient to a managed care plan or MediPass, the agency shall determine whether the SSI recipient has an ongoing relationship with a MediPass provider or managed care plan, and if so, the agency shall assign the SSI recipient to that MediPass provider or managed care plan. Those SSI recipients who do not have such a provider relationship shall be assigned to a managed care plan or MediPass provider in accordance with paragraph (f).

Section 9. Effective upon becoming a law, paragraphs (f) and (g) are added to subsection (15) of section 409.913, Florida Statutes, and paragraph (a) of subsection (22) of said section is 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):

(f) Imposition of liens against the provider's 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 10. Subsections (1) and (2) of section 409.915, Florida Statutes, are amended to read:

409.915 County contributions to Medicaid.--Although the state is responsible for the full portion of the state share of the matching funds required for the Medicaid program,

in order to acquire a certain portion of these funds, the state shall charge the counties for certain items of care and service as provided in this section.

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

(a) For both health maintenance members and fee-for-service beneficiaries, payments for inpatient hospitalization in excess of 9 ~~10~~ days, but not in excess of 45 days, with the exception of pregnant women and children whose income is in excess of the federal poverty level and who do not participate in the Medicaid medically needy program.

(b) Payments for nursing home or intermediate facilities care in excess of $170 per month, with the exception of skilled nursing care for children under age 21.

(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$140~~$55~~ per month per person.

Section 11. Subsection (8) of section 400.071, Florida Statutes, is amended to read:

400.071 Application for license.--

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

Section 12. Paragraphs (a) and (b) of subsection (2) of section 400.191, Florida Statutes, are 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.

(b) The agency shall provide the following information in printed form:

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 or owners of the facility's license and the year that entity became the owner of the license.

4. The total number of beds, and of private and semiprivate rooms, in each facility.

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

6. The name of the owner 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.

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

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

9. Recreational programs, special care units, and other programs available at each facility.

~~10. 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.~~

10.~~11.~~ The Internet address for the site where more detailed information can be seen.

11.~~12.~~ A statement advising consumers that each facility will have its own policies and procedures related to protecting resident property.

12.~~13.~~ 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 on annual, revisit, and complaint surveys; the severity and scope of the citations; the number of 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 13. Paragraph (h) of subsection (2) of section 400.23, Florida Statutes, is amended to read:

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

(2) Pursuant to the intention of the Legislature, the agency, in consultation with the Department of Health and the Department of Elderly Affairs, shall adopt and enforce rules to implement this part, which shall include reasonable and fair criteria in relation to:

(h) ~~The implementation of the consumer satisfaction survey pursuant to s. 400.0225;~~The availability, distribution, and posting of reports and records pursuant to s. 400.191; and the Gold Seal Program pursuant to s. 400.235.

Section 14. 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 in a ~~consistently in 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 15. Subsection (7) of section 409.8132, Florida Statutes, is amended to read:

409.8132 Medikids program component.--

(7) ENROLLMENT.--Enrollment in the Medikids program component may only occur during periodic open enrollment periods as specified by the agency. An applicant may apply for enrollment in the Medikids program component and proceed through the eligibility determination process at any time throughout the year. However, enrollment in Medikids shall not begin until the next open enrollment period; and a child may not receive services under the Medikids program until the child is enrolled in a managed care plan or MediPass. In addition, once determined eligible, an applicant may ~~receive choice counseling and~~ select a managed care plan or MediPass.

The agency may initiate mandatory assignment for a Medikids applicant who has not chosen a managed care plan or MediPass provider after the applicant's voluntary choice period ends. An applicant may select MediPass under the Medikids program component only in counties that have fewer than two managed care plans available to serve Medicaid recipients and only if the federal Health Care Financing Administration determines that MediPass constitutes "health insurance coverage" as defined in Title XXI of the Social Security Act.

Section 16. 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)~~(6)~~.

Section 17. Pursuant to s. 18, Art. VII of the State Constitution, the Legislature finds that this act fulfills an important state interest.

Section 18. Sections 400.0225, 400.148, 464.0195, 464.0196, and 464.0197, Florida Statutes, are repealed.

Section 19. Except as otherwise provided herein, this act shall take effect January 1, 2002.