1 A bill to be entitled
2 An act relating to the Agency for Health Care
3 Administration; repealing s. 409.904(11), F.S.,
4 which provides eligibility of specified persons
5 for certain optional medical assistance;
6 amending s. 409.904, F.S.; revising standards
7 for eligibility for certain optional medical
8 assistance; amending s. 409.906, F.S.; revising
9 guidelines for payment for certain services;
10 revising eligibility for certain Medicaid
11 services; amending s. 409.9065, F.S.;
12 prescribing enrollment levels with respect to
13 pharmaceutical expense assistance; amending s.
14 409.907, F.S.; authorizing withholding of
15 Medicaid payments in certain circumstances;
16 prescribing additional requirements with
17 respect to providers' submission of
18 information; prescribing additional duties for
19 the agency with respect to provider
20 applications; amending s. 409.908, F.S.;
21 providing temporary authorization for the
22 agency to make special payments to designated
23 Medicaid providers and use intergovernmental
24 transfers for certain payments; revising
25 pharmacy dispensing fees for Medicaid drugs;
26 amending ss. 409.912, 409.9122, F.S.; providing
27 for expanded home delivery of pharmacy
28 products; revising provisions relating to
29 choice counseling for recipients; defining the
30 term "managed care plans"; amending s. 409.913,
31 F.S.; prescribing additional sanctions that may

1 be imposed upon a Medicaid provider;
2 eliminating a limit on costs that may be
3 recovered against a provider; requiring
4 disclosure of certain information before an
5 administrative hearing; providing for
6 withholding payments in cases of Medicaid abuse
7 and in cases subject to administrative
8 proceedings; prescribing agency procedures in
9 cases of overpayment; providing venue for
10 Medicaid overpayment cases; repealing s.
11 414.41(4), F.S., relating to agency procedures
12 in cases of overpayment; repealing s. 400.0225,
13 F.S., relating to consumer-satisfaction
14 surveys; amending s. 400.179, F.S.; declaring
15 liability for overpayment when a nursing
16 facility is sold; amending s. 400.191, F.S.;
17 eliminating a provision relating to
18 consumer-satisfaction and family-satisfaction
19 surveys; amending s. 400.235, F.S.; eliminating
20 a provision relating to participation in the
21 consumer-satisfaction process; amending s.
22 400.071, F.S.; eliminating a provision relating
23 to participation in a
24 consumer-satisfaction-measurement process;
25 amending s. 409.815, F.S.; conforming a
26 cross-reference; amending s. 624.91, F.S.,
27 relating to the Florida Healthy Kids
28 Corporation Act; providing temporary
29 authorization for the agency to revise a local
30 matching requirement; providing effective
31 dates.

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

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~~

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1 ~~in s. 409.903(1), (2), or (3), except that the income or~~
2 ~~assets of such family or person exceed established~~
3 ~~limitations.~~
4
5 For a ~~family or~~ person in this group, medical expenses are
6 deductible from income in accordance with federal requirements
7 in order to make a determination of eligibility. A ~~family or~~
8 person in this group, which group is known as the "medically
9 needy," is eligible to receive the same services as other
10 Medicaid recipients, with the exception of services in skilled
11 nursing facilities and intermediate care facilities for the
12 developmentally disabled.
13 Section 3. Effective July 1, 2002, subsections (1),
14 (12), and (23) of section 409.906, Florida Statutes, are
15 amended to read:
16 409.906 Optional Medicaid services.--Subject to
17 specific appropriations, the agency may make payments for
18 services which are optional to the state under Title XIX of
19 the Social Security Act and are furnished by Medicaid
20 providers to recipients who are determined to be eligible on
21 the dates on which the services were provided. Any optional
22 service that is provided shall be provided only when medically
23 necessary and in accordance with state and federal law.
24 Optional services rendered by providers in mobile units to
25 Medicaid recipients may be restricted or prohibited by the
26 agency. Nothing in this section shall be construed to prevent
27 or limit the agency from adjusting fees, reimbursement rates,
28 lengths of stay, number of visits, or number of services, or
29 making any other adjustments necessary to comply with the
30 availability of moneys and any limitations or directions
31 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.

(e) This subsection is repealed July 1, 2002.

(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.

(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. Subsection (13) of section 409.906, Florida Statutes, is amended to read:

409.906 Optional Medicaid services.--Subject to specific appropriations, the agency may make payments for services which are optional to the state under Title XIX of the Social Security Act and are furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any optional service that is provided shall be provided only when medically necessary and in accordance with state and federal law. Optional services rendered by providers in mobile units to Medicaid recipients may be restricted or prohibited by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. If necessary to safeguard the state's systems of providing services to elderly and disabled persons and subject to the

1 notice and review provisions of s. 216.177, the Governor may
2 direct the Agency for Health Care Administration to amend the
3 Medicaid state plan to delete the optional Medicaid service
4 known as "Intermediate Care Facilities for the Developmentally
5 Disabled." Optional services may include:
6 (13) HOME AND COMMUNITY-BASED SERVICES.--The agency
7 may pay for home-based or community-based services that are
8 rendered to a recipient in accordance with a federally
9 approved waiver program. The agency may limit or eliminate
10 coverage for certain Project AIDS Care Waiver services,
11 preauthorize high-cost or highly utilized services, or make
12 any other adjustments necessary to comply with any limitations
13 or directions provided for in the General Appropriations Act.
14 Section 5. Subsections (3) and (5) of section
15 409.9065, Florida Statutes, are amended to read:
16 409.9065 Pharmaceutical expense assistance.--
17 (3) BENEFITS.--Medications covered under the
18 pharmaceutical expense assistance program are those covered
19 under the Medicaid program in s. 409.906(19)~~s. 409.906(20)~~.
20 Monthly benefit payments shall be limited to $80 per program
21 participant. Participants are required to make a 10-percent
22 coinsurance payment for each prescription purchased through
23 this program.
24 (5) NONENTITLEMENT.--The pharmaceutical expense
25 assistance program established by this section is not an
26 entitlement. Enrollment levels are limited to those authorized
27 by the Legislature in the annual General Appropriations Act.
28 If funds are insufficient to serve all individuals eligible
29 under subsection (2) and seeking coverage, the agency may
30 develop a waiting list based on application dates to use in
31 enrolling individuals in unfilled enrollment slots.

1 Section 6. Effective upon this act becoming a law,
2 subsections (7) and (9) of section 409.907, Florida Statutes,
3 are amended to read:
4 409.907 Medicaid provider agreements.--The agency may
5 make payments for medical assistance and related services
6 rendered to Medicaid recipients only to an individual or
7 entity who has a provider agreement in effect with the agency,
8 who is performing services or supplying goods in accordance
9 with federal, state, and local law, and who agrees that no
10 person shall, on the grounds of handicap, race, color, or
11 national origin, or for any other reason, be subjected to
12 discrimination under any program or activity for which the
13 provider receives payment from the agency.
14 (7) The agency may require, as a condition of
15 participating in the Medicaid program and before entering into
16 the provider agreement, that the provider submit information,
17 in an initial and any required renewal applications,
18 concerning the professional, business, and personal background
19 of the provider and permit an onsite inspection of the
20 provider's service location by agency staff or other personnel
21 designated by the agency to perform this function. As a
22 continuing condition of participation in the Medicaid program,
23 a provider shall immediately notify the agency of any current
24 or pending bankruptcy filing.Before entering into the
25 provider agreement, or as a condition of continuing
26 participation in the Medicaid program, the agency may also
27 require that Medicaid providers reimbursed on a
28 fee-for-services basis or fee schedule basis which is not
29 cost-based, post a surety bond not to exceed $50,000 or the
30 total amount billed by the provider to the program during the
31 current or most recent calendar year, whichever is greater.

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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

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prior violation of the laws, rules, or regulations of any regulatory body of this or any other state.

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

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

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

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

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

1 Section 7. Paragraph (d) is added to subsection (12)
2 of section 409.908, Florida Statutes, and subsection (14) of
3 that section is amended, to read:
4 409.908 Reimbursement of Medicaid providers.--Subject
5 to specific appropriations, the agency shall reimburse
6 Medicaid providers, in accordance with state and federal law,
7 according to methodologies set forth in the rules of the
8 agency and in policy manuals and handbooks incorporated by
9 reference therein. These methodologies may include fee
10 schedules, reimbursement methods based on cost reporting,
11 negotiated fees, competitive bidding pursuant to s. 287.057,
12 and other mechanisms the agency considers efficient and
13 effective for purchasing services or goods on behalf of
14 recipients. Payment for Medicaid compensable services made on
15 behalf of Medicaid eligible persons is subject to the
16 availability of moneys and any limitations or directions
17 provided for in the General Appropriations Act or chapter 216.
18 Further, nothing in this section shall be construed to prevent
19 or limit the agency from adjusting fees, reimbursement rates,
20 lengths of stay, number of visits, or number of services, or
21 making any other adjustments necessary to comply with the
22 availability of moneys and any limitations or directions
23 provided for in the General Appropriations Act, provided the
24 adjustment is consistent with legislative intent.
25 (12)
26 (d) For the 2001-2002 fiscal year only and if
27 necessary to meet the requirements for grants and donations
28 for the special Medicaid payments authorized in the 2001-2002
29 General Appropriations Act, the agency may make special
30 Medicaid payments to qualified Medicaid providers designated
31 by the agency, notwithstanding any provision of this

1 subsection to the contrary, and may use intergovernmental
2 transfers from state entities to serve as the state share of
3 such payments.
4 (14) A provider of prescribed drugs shall be
5 reimbursed the least of the amount billed by the provider, the
6 provider's usual and customary charge, or the Medicaid maximum
7 allowable fee established by the agency, plus a dispensing
8 fee. The agency is directed to implement a variable dispensing
9 fee for payments for prescribed medicines while ensuring
10 continued access for Medicaid recipients. The variable
11 dispensing fee may be based upon, but not limited to, either
12 or both the volume of prescriptions dispensed by a specific
13 pharmacy provider, ~~and~~ the volume of prescriptions dispensed
14 to an individual recipient, and dispensing of
15 preferred-drug-list products. The agency shall increase the
16 pharmacy dispensing fee authorized by statute and in the
17 annual General Appropriations Act by $0.50 for the dispensing
18 of a Medicaid preferred-drug-list product and reduce the
19 pharmacy dispensing fee by $0.50 for the dispensing of a
20 Medicaid product that is not included on the preferred-drug
21 list. The agency is authorized to limit reimbursement for
22 prescribed medicine in order to comply with any limitations or
23 directions provided for in the General Appropriations Act,
24 which may include implementing a prospective or concurrent
25 utilization review program.
26 Section 8. Paragraph (a) of subsection (37) of section
27 409.912, Florida Statutes, is 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

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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 (37)(a) The agency shall implement a Medicaid
20 prescribed-drug spending-control program that includes the
21 following components:
22 1. Medicaid prescribed-drug coverage for brand-name
23 drugs for adult Medicaid recipients is limited to the
24 dispensing of four brand-name drugs per month per recipient.
25 Children are exempt from this restriction. Antiretroviral
26 agents are excluded from this limitation. No requirements for
27 prior authorization or other restrictions on medications used
28 to treat mental illnesses such as schizophrenia, severe
29 depression, or bipolar disorder may be imposed on Medicaid
30 recipients. Medications that will be available without
31 restriction for persons with mental illnesses include atypical

1 antipsychotic medications, conventional antipsychotic
2 medications, selective serotonin reuptake inhibitors, and
3 other medications used for the treatment of serious mental
4 illnesses. The agency shall also limit the amount of a
5 prescribed drug dispensed to no more than a 34-day supply. The
6 agency shall continue to provide unlimited generic drugs,
7 contraceptive drugs and items, and diabetic supplies. Although
8 a drug may be included on the preferred drug formulary, it
9 would not be exempt from the four-brand limit. The agency may
10 authorize exceptions to the brand-name-drug restriction based
11 upon the treatment needs of the patients, only when such
12 exceptions are based on prior consultation provided by the
13 agency or an agency contractor, but the agency must establish
14 procedures to ensure that:
15 a. There will be a response to a request for prior
16 consultation by telephone or other telecommunication device
17 within 24 hours after receipt of a request for prior
18 consultation;
19 b. A 72-hour supply of the drug prescribed will be
20 provided in an emergency or when the agency does not provide a
21 response within 24 hours as required by sub-subparagraph a.;
22 and
23 c. Except for the exception for nursing home residents
24 and other institutionalized adults and except for drugs on the
25 restricted formulary for which prior authorization may be
26 sought by an institutional or community pharmacy, prior
27 authorization for an exception to the brand-name-drug
28 restriction is sought by the prescriber and not by the
29 pharmacy. When prior authorization is granted for a patient in
30 an institutional setting beyond the brand-name-drug
31

1 restriction, such approval is authorized for 12 months and
2 monthly prior authorization is not required for that patient.
3 2. Reimbursement to pharmacies for Medicaid prescribed
4 drugs shall be set at the average wholesale price less 13.25
5 percent.
6 3. The agency shall develop and implement a process
7 for managing the drug therapies of Medicaid recipients who are
8 using significant numbers of prescribed drugs each month. The
9 management process may include, but is not limited to,
10 comprehensive, physician-directed medical-record reviews,
11 claims analyses, and case evaluations to determine the medical
12 necessity and appropriateness of a patient's treatment plan
13 and drug therapies. The agency may contract with a private
14 organization to provide drug-program-management services. The
15 Medicaid drug benefit management program shall include
16 initiatives to manage drug therapies for HIV/AIDS patients,
17 patients using 20 or more unique prescriptions in a 180-day
18 period, and the top 1,000 patients in annual spending.
19 4. The agency may limit the size of its pharmacy
20 network based on need, competitive bidding, price
21 negotiations, credentialing, or similar criteria. The agency
22 shall give special consideration to rural areas in determining
23 the size and location of pharmacies included in the Medicaid
24 pharmacy network. A pharmacy credentialing process may include
25 criteria such as a pharmacy's full-service status, location,
26 size, patient educational programs, patient consultation,
27 disease-management services, and other characteristics. The
28 agency may impose a moratorium on Medicaid pharmacy enrollment
29 when it is determined that it has a sufficient number of
30 Medicaid-participating providers.
31

1 5. The agency shall develop and implement a program
2 that requires Medicaid practitioners who prescribe drugs to
3 use a counterfeit-proof prescription pad for Medicaid
4 prescriptions. The agency shall require the use of
5 standardized counterfeit-proof prescription pads by
6 Medicaid-participating prescribers or prescribers who write
7 prescriptions for Medicaid recipients. The agency may
8 implement the program in targeted geographic areas or
9 statewide.
10 6. The agency may enter into arrangements that require
11 manufacturers of generic drugs prescribed to Medicaid
12 recipients to provide rebates of at least 15.1 percent of the
13 average manufacturer price for the manufacturer's generic
14 products. These arrangements shall require that if a
15 generic-drug manufacturer pays federal rebates for
16 Medicaid-reimbursed drugs at a level below 15.1 percent, the
17 manufacturer must provide a supplemental rebate to the state
18 in an amount necessary to achieve a 15.1-percent rebate level.
19 7. The agency may establish a preferred drug formulary
20 in accordance with 42 U.S.C. s. 1396r-8, and, pursuant to the
21 establishment of such formulary, it is authorized to negotiate
22 supplemental rebates from manufacturers that are in addition
23 to those required by Title XIX of the Social Security Act and
24 at no less than 10 percent of the average manufacturer price
25 as defined in 42 U.S.C. s. 1936 on the last day of a quarter
26 unless the federal or supplemental rebate, or both, equals or
27 exceeds 25 percent. There is no upper limit on the
28 supplemental rebates the agency may negotiate. The agency may
29 determine that specific products, brand-name or generic, are
30 competitive at lower rebate percentages. Agreement to pay the
31 minimum supplemental rebate percentage will guarantee a

1 manufacturer that the Medicaid Pharmaceutical and Therapeutics
2 Committee will consider a product for inclusion on the
3 preferred drug formulary. However, a pharmaceutical
4 manufacturer is not guaranteed placement on the formulary by
5 simply paying the minimum supplemental rebate. Agency
6 decisions will be made on the clinical efficacy of a drug and
7 recommendations of the Medicaid Pharmaceutical and
8 Therapeutics Committee, as well as the price of competing
9 products minus federal and state rebates. The agency is
10 authorized to contract with an outside agency or contractor to
11 conduct negotiations for supplemental rebates. For the
12 purposes of this section, the term "supplemental rebates" may
13 include, at the agency's discretion, cash rebates and other
14 program benefits that offset a Medicaid expenditure. Such
15 other program benefits may include, but are not limited to,
16 disease management programs, drug product donation programs,
17 drug utilization control programs, prescriber and beneficiary
18 counseling and education, fraud and abuse initiatives, and
19 other services or administrative investments with guaranteed
20 savings to the Medicaid program in the same year the rebate
21 reduction is included in the General Appropriations Act. The
22 agency is authorized to seek any federal waivers to implement
23 this initiative.
24 8. The agency shall establish an advisory committee
25 for the purposes of studying the feasibility of using a
26 restricted drug formulary for nursing home residents and other
27 institutionalized adults. The committee shall be comprised of
28 seven members appointed by the Secretary of Health Care
29 Administration. The committee members shall include two
30 physicians licensed under chapter 458 or chapter 459; three
31 pharmacists licensed under chapter 465 and appointed from a

1 list of recommendations provided by the Florida Long-Term Care
2 Pharmacy Alliance; and two pharmacists licensed under chapter
3 465.
4 9. The Agency for Health Care Administration shall
5 expand home delivery of pharmacy products. To assist Medicaid
6 patients in securing their prescriptions and reduce program
7 costs, the agency shall expand its current mail-order-pharmacy
8 diabetes-supply program to include all generic and brand-name
9 drugs used by Medicaid patients with diabetes. Medicaid
10 recipients in the current program may obtain nondiabetes drugs
11 on a voluntary basis. This initiative is limited to the
12 geographic area covered by the current contract. The agency
13 may seek and implement any federal waivers necessary to
14 implement this subparagraph.
15 Section 9. Effective upon this act becoming a law,
16 subsection (26) of section 409.912, Florida Statutes, is
17 amended to read:
18 409.912 Cost-effective purchasing of health care.--The
19 agency shall purchase goods and services for Medicaid
20 recipients in the most cost-effective manner consistent with
21 the delivery of quality medical care. The agency shall
22 maximize the use of prepaid per capita and prepaid aggregate
23 fixed-sum basis services when appropriate and other
24 alternative service delivery and reimbursement methodologies,
25 including competitive bidding pursuant to s. 287.057, designed
26 to facilitate the cost-effective purchase of a case-managed
27 continuum of care. The agency shall also require providers to
28 minimize the exposure of recipients to the need for acute
29 inpatient, custodial, and other institutional care and the
30 inappropriate or unnecessary use of high-cost services. The
31 agency may establish prior authorization requirements for

1 certain populations of Medicaid beneficiaries, certain drug
2 classes, or particular drugs to prevent fraud, abuse, overuse,
3 and possible dangerous drug interactions. The Pharmaceutical
4 and Therapeutics Committee shall make recommendations to the
5 agency on drugs for which prior authorization is required. The
6 agency shall inform the Pharmaceutical and Therapeutics
7 Committee of its decisions regarding drugs subject to prior
8 authorization.
9 (26) The agency shall perform ~~choice counseling,~~
10 enrollments~~,~~ and disenrollments for Medicaid recipients who
11 are eligible for MediPass or managed care plans.
12 Notwithstanding the prohibition contained in paragraph
13 (18)(f), managed care plans may perform preenrollments of
14 Medicaid recipients under the supervision of the agency or its
15 agents. For the purposes of this section, "preenrollment"
16 means the provision of marketing and educational materials to
17 a Medicaid recipient and assistance in completing the
18 application forms, but shall not include actual enrollment
19 into a managed care plan. An application for enrollment shall
20 not be deemed complete until the agency or its agent verifies
21 that the recipient made an informed, voluntary choice. The
22 agency, in cooperation with the Department of Children and
23 Family Services, may test new marketing initiatives to inform
24 Medicaid recipients about their managed care options at
25 selected sites. The agency shall report to the Legislature on
26 the effectiveness of such initiatives. The agency may
27 contract with a third party to perform managed care plan and
28 MediPass ~~choice counseling,~~ enrollment~~,~~ and disenrollment
29 services for Medicaid recipients and is authorized to adopt
30 rules to implement such services. The agency may adjust the
31 capitation rate only to cover the costs of a third-party

1 ~~choice-counseling,~~enrollment~~,~~and disenrollment contract, and
2 for agency supervision and management of the managed care plan
3 ~~choice-counseling,~~enrollment~~,~~and disenrollment contract.
4 Section 10. Effective July 1, 2002, paragraph (e) of
5 subsection (2) of section 409.9122, Florida Statutes, is
6 amended to read:
7 409.9122 Mandatory Medicaid managed care enrollment;
8 programs and procedures.--
9 (2)
10 (e) ~~Prior to requesting a Medicaid recipient who is~~
11 ~~subject to mandatory managed care enrollment to make a choice~~
12 ~~between a managed care plan or MediPass, the agency shall~~
13 ~~contact and provide choice counseling to the recipient.~~
14 Medicaid recipients who are already enrolled in a managed care
15 plan or MediPass shall be offered the opportunity to change
16 managed care plans or MediPass providers on a staggered basis,
17 as defined by the agency. All Medicaid recipients shall have
18 90 days in which to make a choice of managed care plans or
19 MediPass providers. Those Medicaid recipients who do not make
20 a choice shall be assigned to a managed care plan or MediPass
21 in accordance with paragraph (f). To facilitate continuity of
22 care, for a Medicaid recipient who is also a recipient of
23 Supplemental Security Income (SSI), prior to assigning the SSI
24 recipient to a managed care plan or MediPass, the agency shall
25 determine whether the SSI recipient has an ongoing
26 relationship with a MediPass provider or managed care plan,
27 and if so, the agency shall assign the SSI recipient to that
28 MediPass provider or managed care plan. Those SSI recipients
29 who do not have such a provider relationship shall be assigned
30 to a managed care plan or MediPass provider in accordance with
31 paragraph (f).

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1 Section 11. Effective upon this act becoming a law,
2 paragraph (f) of subsection (2) of section 409.9122, Florida
3 Statutes, is amended to read:
4 409.9122 Mandatory Medicaid managed care enrollment;
5 programs and procedures.--
6 (2)
7 (f) When a Medicaid recipient does not choose a
8 managed care plan or MediPass provider, the agency shall
9 assign the Medicaid recipient to a managed care plan or
10 MediPass provider. Medicaid recipients who are subject to
11 mandatory assignment but who fail to make a choice shall be
12 assigned to managed care plans or provider service networks
13 until an equal enrollment of 50 percent in MediPass ~~and~~
14 ~~provider service networks~~ and 50 percent in managed care plans
15 is achieved. Once equal enrollment is achieved, the
16 assignments shall be divided in order to maintain an equal
17 enrollment in MediPass and managed care plans. Thereafter,
18 assignment of Medicaid recipients who fail to make a choice
19 shall be based proportionally on the preferences of recipients
20 who have made a choice in the previous period. Such
21 proportions shall be revised at least quarterly to reflect an
22 update of the preferences of Medicaid recipients. The agency
23 shall also disproportionately assign Medicaid-eligible
24 children in families who are required to but have failed to
25 make a choice of managed care plan or MediPass for their child
26 and who are to be assigned to the MediPass program to
27 children's networks as described in s. 409.912(3)(g) and where
28 available. The disproportionate assignment of children to
29 children's networks shall be made until the agency has
30 determined that the children's networks have sufficient
31 numbers to be economically operated. For purposes of this

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paragraph, when referring to assignment, the term "managed care plans" includes exclusive provider organizations, provider service networks, minority physician networks, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act.When making assignments, the agency shall take into account the following criteria:

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

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

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

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

Section 12. Effective upon this act becoming a law, subsections (15) and (21), paragraph (a) of subsection (22), and paragraph (a) of subsection (24) of section 409.913, Florida Statutes, are amended, and subsections (26) and (27) are added to that section, 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

1 possible, and to recover overpayments and impose sanctions as
2 appropriate.
3 (15) The agency may impose any of the following
4 sanctions on a provider or a person for any of the acts
5 described in subsection (14):
6 (a) Suspension for a specific period of time of not
7 more than 1 year.
8 (b) Termination for a specific period of time of from
9 more than 1 year to 20 years.
10 (c) Imposition of a fine of up to $5,000 for each
11 violation. Each day that an ongoing violation continues, such
12 as refusing to furnish Medicaid-related records or refusing
13 access to records, is considered, for the purposes of this
14 section, to be a separate violation. Each instance of
15 improper billing of a Medicaid recipient; each instance of
16 including an unallowable cost on a hospital or nursing home
17 Medicaid cost report after the provider or authorized
18 representative has been advised in an audit exit conference or
19 previous audit report of the cost unallowability; each
20 instance of furnishing a Medicaid recipient goods or
21 professional services that are inappropriate or of inferior
22 quality as determined by competent peer judgment; each
23 instance of knowingly submitting a materially false or
24 erroneous Medicaid provider enrollment application, request
25 for prior authorization for Medicaid services, drug exception
26 request, or cost report; each instance of inappropriate
27 prescribing of drugs for a Medicaid recipient as determined by
28 competent peer judgment; and each false or erroneous Medicaid
29 claim leading to an overpayment to a provider is considered,
30 for the purposes of this section, to be a separate violation.
31

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1 (d) Immediate suspension, if the agency has received
2 information of patient abuse or neglect or of any act
3 prohibited by s. 409.920. Upon suspension, the agency must
4 issue an immediate final order under s. 120.569(2)(n).
5 (e) A fine, not to exceed $10,000, for a violation of
6 paragraph (14)(i).
7 (f) Imposition of liens against provider assets,
8 including, but not limited to, financial assets and real
9 property, not to exceed the amount of fines or recoveries
10 sought, upon entry of an order determining that such moneys
11 are due or recoverable.
12 (g) Other remedies as permitted by law to effect the
13 recovery of a fine or overpayment.
14 (21) The audit report, supported by agency work
15 papers, showing an overpayment to a provider constitutes
16 evidence of the overpayment. A provider may not present or
17 elicit testimony, either on direct examination or
18 cross-examination in any court or administrative proceeding,
19 regarding the purchase or acquisition by any means of drugs,
20 goods, or supplies; sales or divestment by any means of drugs,
21 goods, or supplies; or inventory of drugs, goods, or supplies,
22 unless such acquisition, sales, divestment, or inventory is
23 documented by written invoices, written inventory records, or
24 other competent written documentary evidence maintained in the
25 normal course of the provider's business. Notwithstanding the
26 applicable rules of discovery, all documentation that will be
27 offered as evidence at an administrative hearing on a Medicaid
28 overpayment must be exchanged by all parties at least 14 days
29 before the administrative hearing or must be excluded from
30 consideration.
31

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(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.~~

(26) When the Agency for Health Care Administration has made a probable cause determination and alleged that an overpayment to a Medicaid provider has occurred, the agency, after notice to the provider, may:

(a) Withhold, and continue to withhold during the pendency of an administrative hearing pursuant to chapter 120, any medical assistance reimbursement payments until such time

1 as the overpayment is recovered, unless within 30 days after
2 receiving notice thereof the provider:
3 1. Makes repayment in full; or
4 2. Establishes a repayment plan that is satisfactory
5 to the Agency for Health Care Administration.
6 (b) Withhold, and continue to withhold during the
7 pendency of an administrative hearing pursuant to chapter 120,
8 medical assistance reimbursement payments if the terms of a
9 repayment plan are not adhered to by the provider.
10
11 If a provider requests an administrative hearing pursuant to
12 chapter 120, such hearing must be conducted within 90 days
13 following receipt by the provider of the final audit report,
14 absent exceptionally good cause shown as determined by the
15 administrative law judge or hearing officer. Upon issuance of
16 a final order, the balance outstanding of the amount
17 determined to constitute the overpayment shall become due.
18 Any withholding of payments by the Agency for Health Care
19 Administration pursuant to this section shall be limited so
20 that the monthly medical assistance payment is not reduced by
21 more than 10 percent.
22 (27) Venue for all Medicaid program integrity
23 overpayment cases shall lie in Leon County, at the discretion
24 of the agency.
25 Section 13. Subsection (4) of section 414.41, Florida
26 Statutes, is repealed.
27 Section 14. Section 400.0225, Florida Statutes, is
28 repealed.
29 Section 15. Paragraph (c) of subsection (5) of section
30 400.179, Florida Statutes, is amended to read:
31

400.179 Sale or transfer of ownership of a nursing facility; liability for Medicaid underpayments and overpayments.--

(5) Because any transfer of a nursing facility may expose the fact that Medicaid may have underpaid or overpaid the transferor, and because in most instances, any such underpayment or overpayment can only be determined following a formal field audit, the liabilities for any such underpayments or overpayments shall be as follows:

(c) Where the facility transfer takes any form of a sale of assets, in addition to the transferor's continuing liability for any such overpayments, if the transferor fails to meet these obligations, the transferee shall be liable for all liabilities that can be readily identifiable 90 days in advance of the transfer. Such liability shall continue in succession until the debt is ultimately paid or otherwise resolved.It shall be the burden of the transferee to determine the amount of all such readily identifiable overpayments from the Agency for Health Care Administration, and the agency shall cooperate in every way with the identification of such amounts. Readily identifiable overpayments shall include overpayments that will result from, but not be limited to:

1. Medicaid rate changes or adjustments;

2. Any depreciation recapture;

3. Any recapture of fair rental value system indexing; or ~~and/or~~

4. Audits completed by the agency.

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

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1 8. The languages spoken by the administrator and staff
2 of each facility.
3 9. Whether or not each facility accepts Medicare or
4 Medicaid recipients or insurance, health maintenance
5 organization, Veterans Administration, CHAMPUS program, or
6 workers' compensation coverage.
7 10. Recreational and other programs available at each
8 facility.
9 11. Special care units or programs offered at each
10 facility.
11 12. Whether the facility is a part of a retirement
12 community that offers other services pursuant to part III,
13 part IV, or part V.
14 ~~13. The results of consumer and family satisfaction~~
15 ~~surveys for each facility, as described in s. 400.0225. The~~
16 ~~results may be converted to a score or scores, which may be~~
17 ~~presented in either numeric or symbolic form for the intended~~
18 ~~consumer audience.~~
19 13.~~14.~~ Survey and deficiency information contained on
20 the Online Survey Certification and Reporting (OSCAR) system
21 of the federal Health Care Financing Administration, including
22 annual survey, revisit, and complaint survey information, for
23 each facility for the past 45 months. For noncertified
24 nursing homes, state survey and deficiency information,
25 including annual survey, revisit, and complaint survey
26 information for the past 45 months shall be provided.
27 14.~~15.~~ A summary of the Online Survey Certification
28 and Reporting (OSCAR) data for each facility over the past 45
29 months. Such summary may include a score, rating, or
30 comparison ranking with respect to other facilities based on
31 the number of citations received by the facility of annual,

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1 revisit, and complaint surveys; the severity and scope of the
2 citations; and the number of annual recertification surveys
3 the facility has had during the past 45 months. The score,
4 rating, or comparison ranking may be presented in either
5 numeric or symbolic form for the intended consumer audience.
6 Section 17. Paragraph (c) of subsection (5) of section
7 400.235, Florida Statutes, is amended to read:
8 400.235 Nursing home quality and licensure status;
9 Gold Seal Program.--
10 (5) Facilities must meet the following additional
11 criteria for recognition as a Gold Seal Program facility:
12 (c) Participate ~~consistently~~ in a ~~the required~~
13 consumer satisfaction process ~~as prescribed by the agency~~, and
14 demonstrate that information is elicited from residents,
15 family members, and guardians about satisfaction with the
16 nursing facility, its environment, the services and care
17 provided, the staff's skills and interactions with residents,
18 attention to resident's needs, and the facility's efforts to
19 act on information gathered from the consumer satisfaction
20 measures.
21
22 A facility assigned a conditional licensure status may not
23 qualify for consideration for the Gold Seal Program until
24 after it has operated for 30 months with no class I or class
25 II deficiencies and has completed a regularly scheduled
26 relicensure survey.
27 Section 18. Section 400.071, Florida Statutes, is
28 amended to read:
29 400.071 Application for license.--
30
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1 (1) An application for a license as required by s.
2 400.062 shall be made to the agency on forms furnished by it
3 and shall be accompanied by the appropriate license fee.
4 (2) The application shall be under oath and shall
5 contain the following:
6 (a) The name, address, and social security number of
7 the applicant if an individual; if the applicant is a firm,
8 partnership, or association, its name, address, and employer
9 identification number (EIN), and the name and address of any
10 controlling interest; and the name by which the facility is to
11 be known.
12 (b) The name of any person whose name is required on
13 the application under the provisions of paragraph (a) and who
14 owns at least a 10-percent interest in any professional
15 service, firm, association, partnership, or corporation
16 providing goods, leases, or services to the facility for which
17 the application is made, and the name and address of the
18 professional service, firm, association, partnership, or
19 corporation in which such interest is held.
20 (c) The location of the facility for which a license
21 is sought and an indication, as in the original application,
22 that such location conforms to the local zoning ordinances.
23 (d) The name of the person or persons under whose
24 management or supervision the facility will be conducted and
25 the name of the administrator.
26 (e) A signed affidavit disclosing any financial or
27 ownership interest that a person or entity described in
28 paragraph (a) or paragraph (d) has held in the last 5 years in
29 any entity licensed by this state or any other state to
30 provide health or residential care which has closed
31 voluntarily or involuntarily; has filed for bankruptcy; has

had a receiver appointed; has had a license denied, suspended, or revoked; or has had an injunction issued against it which was initiated by a regulatory agency. The affidavit must disclose the reason any such entity was closed, whether voluntarily or involuntarily.

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

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

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

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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

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

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

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

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

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

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

(8)~~(9)~~ The agency may not issue a license to a nursing home that fails to receive a certificate of need under the provisions of ss. 408.031-408.045. It is the intent of the Legislature that, in reviewing a certificate-of-need

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application to add beds to an existing nursing home facility, preference be given to the application of a licensee who has been awarded a Gold Seal as provided for in s. 400.235, if the applicant otherwise meets the review criteria specified in s. 408.035.

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

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

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

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

409.815 Health benefits coverage; limitations.--

(2) BENCHMARK BENEFITS.--In order for health benefits coverage to qualify for premium assistance payments for an eligible child under ss. 409.810-409.820, the health benefits

coverage, except for coverage under Medicaid and Medikids, must include the following minimum benefits, as medically necessary.

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

Section 20. 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;

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

1 of the program, and the procedures for enrollment in the
2 program and to maintain public awareness of the corporation
3 and the program;
4 12. Secure staff necessary to properly administer the
5 corporation. Staff costs shall be funded from state and local
6 matching funds and such other private or public funds as
7 become available. The board of directors shall determine the
8 number of staff members necessary to administer the
9 corporation;
10 13. As appropriate, enter into contracts with local
11 school boards or other agencies to provide onsite information,
12 enrollment, and other services necessary to the operation of
13 the corporation;
14 14. Provide a report on an annual basis to the
15 Governor, Insurance Commissioner, Commissioner of Education,
16 Senate President, Speaker of the House of Representatives, and
17 Minority Leaders of the Senate and the House of
18 Representatives;
19 15. Each fiscal year, establish a maximum number of
20 participants by county, on a statewide basis, who may enroll
21 in the program without the benefit of local matching funds.
22 Thereafter, the corporation may establish local matching
23 requirements for supplemental participation in the program.
24 The corporation may vary local matching requirements and
25 enrollment by county depending on factors which may influence
26 the generation of local match, including, but not limited to,
27 population density, per capita income, existing local tax
28 effort, and other factors. The corporation also may accept
29 in-kind match in lieu of cash for the local match requirement
30 to the extent allowed by Title XXI of the Social Security Act;
31 ~~and~~

1 16. Establish eligibility criteria, premium and
2 cost-sharing requirements, and benefit packages which conform
3 to the provisions of the Florida Kidcare program, as created
4 in ss. 409.810-409.820<u>; and</u>~~.~~
5 <u>17. Notwithstanding the requirements of subparagraph</u>
6 <u>15. to the contrary, establish a local matching requirement of</u>
7 <u>$0.00 for the Title XXI program in each county of the state</u>
8 <u>for the 2001-2002 fiscal year. This subparagraph shall take</u>
9 <u>effect upon becoming a law and shall operate retroactively to</u>
10 <u>July 1, 2001. This subparagraph expires July 1, 2002.</u>
11 Section 21. Except as otherwise specifically provided
12 in this act, this act shall take effect January 1, 2002.
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