1
2 An act relating to health care; amending s.
3 16.59, F.S.; specifying additional requirements
4 for the Medicaid Fraud Control Unit of the
5 Department of Legal Affairs and the Medicaid
6 program integrity program; amending s.
7 240.4075, F.S.; revising priority of awards
8 under the Nursing Student Loan Forgiveness
9 Program; amending s. 395.002, F.S.; redefining
10 "premises" for purposes of hospital licensing
11 and regulation; amending s. 395.003, F.S.;
12 revising provisions relating to such licensing,
13 including licensing of teaching hospitals;
14 amending s. 112.3187, F.S.; revising procedures
15 and requirements relating to whistle-blower
16 protection for reporting Medicaid fraud or
17 abuse; amending s. 400.141, F.S.; requiring
18 licensed nursing home facilities to maintain
19 general and professional liability insurance
20 coverage; requiring facilities to submit
21 information to the Agency for Health Care
22 Administration which shall provide reports
23 regarding facilities' litigation, complaints,
24 and deficiencies; amending s. 400.147, F.S.;
25 revising reporting requirements under facility
26 internal risk management and quality assurance
27 programs; providing for funding to expedite the
28 availability of nursing home liability
29 insurance; amending s. 400.179, F.S.; providing
30 an alternative to certain bond requirements for
31 protection against nursing home Medicaid

1 overpayments; providing for review and
2 rulemaking authority of the Agency for Health
3 Care Administration; providing for future
4 repeal; requiring a study and report; amending
5 s. 400.925, F.S.; eliminating the regulation of
6 certain home medical equipment by the Agency
7 for Health Care Administration; creating s.
8 408.831, F.S.; allowing the Agency for Health
9 Care Administration to take action against a
10 licensee in certain circumstances; reenacting
11 s. 409.8132(4), F.S., to incorporate amendments
12 to ss. 409.902, 409.907, 409.908, and 409.913,
13 F.S., in references thereto; amending s.
14 409.8177, F.S.; requiring the agency to
15 contract for evaluation of the Florida Kidcare
16 program; amending s. 409.902, F.S.; requiring
17 consent for release of medical records to the
18 agency and the Medicaid Fraud Control Unit as a
19 condition of Medicaid eligibility; amending s.
20 409.904, F.S.; revising eligibility standards
21 for certain Medicaid optional medical
22 assistance; amending s. 409.905, F.S.;
23 providing additional criteria for the agency to
24 adjust a hospital's inpatient per diem rate for
25 Medicaid; amending s. 409.906, F.S.;
26 authorizing the agency to make payments for
27 specified services which are optional under
28 Title XIX of the Social Security Act; amending
29 s. 409.9065, F.S.; providing a program name;
30 revising standards for pharmaceutical expense
31 assistance; amending s. 409.907, F.S.;

1 prescribing additional requirements with
2 respect to provider enrollment; requiring that
3 the Agency for Health Care Administration deny
4 a provider's application under certain
5 circumstances; amending s. 409.908, F.S.;
6 requiring retroactive calculation of cost
7 report if requirements for cost reporting are
8 not met; revising provisions relating to rate
9 adjustments to offset the cost of general and
10 professional liability insurance for nursing
11 homes; extending authorization for special
12 Medicaid payments to qualified providers;
13 providing for intergovernmental transfer of
14 payments; amending s. 409.911, F.S.; expanding
15 application of definitions; amending s.
16 409.9116, F.S.; revising the disproportionate
17 share/financial assistance program for rural
18 hospitals; amending s. 409.91195, F.S.;
19 granting interested parties opportunity to
20 present public testimony before the Medicaid
21 Pharmaceutical and Therapeutics Committee;
22 amending s. 409.912, F.S.; providing
23 requirements for contracts for Medicaid
24 behavioral health care services; revising
25 provisions governing the purchase of goods and
26 services for Medicaid recipients; providing for
27 quarterly reports to the Governor and presiding
28 officers of the Legislature; amending s.
29 409.9122, F.S.; revising procedures relating to
30 assignment of a Medicaid recipient to a managed
31 care plan or MediPass provider; granting agency

1 discretion to renew contracts; amending s.
2 409.913, F.S.; requiring that the agency and
3 Medicaid Fraud Control Unit annually submit a
4 report to the Legislature; defining
5 "complaint"; specifying additional requirements
6 for the Medicaid program integrity program and
7 the Medicaid Fraud Control Unit of the
8 Department of Legal Affairs; requiring
9 imposition of sanctions or disincentives,
10 except under certain circumstances; providing
11 additional sanctions and disincentives;
12 providing additional grounds under which the
13 agency may terminate a provider's participation
14 in the Medicaid program; providing additional
15 requirements for administrative hearings;
16 providing additional grounds for withholding
17 payments to a provider; authorizing the agency
18 and the Medicaid Fraud Control Unit to review
19 certain records; requiring review by the
20 Attorney General of certain settlements;
21 requiring review by the Auditor General of
22 certain cost reports; amending s. 409.920,
23 F.S.; providing additional duties of the
24 Medicaid Fraud Control Unit; amending s.
25 624.91, F.S.; revising duties of the Florida
26 Healthy Kids Corporation with respect to annual
27 determination of participation in the Healthy
28 Kids program; prescribing duties of the
29 corporation in establishing local match
30 requirements; revising composition of the board
31 of directors; amending s. 627.6425, F.S.;

1 revising requirements for nonrenewal or
2 discontinuance of individual health insurance
3 coverage; amending s. 766.110, F.S.; removing
4 certain restrictions on the authority of
5 licensed hospitals to provide self-insurance
6 coverage for hospital medical staff; amending
7 s. 393.063, F.S.; authorizing licensure of
8 certain comprehensive transitional education
9 programs for persons with developmental
10 disabilities; revising definition of
11 "intermediate care facility for the
12 developmentally disabled"; amending ss. 400.965
13 and 400.968, F.S.; providing penalties for
14 violation of pt. XI of ch. 400, F.S., relating
15 to intermediate care facilities for
16 developmentally disabled persons; amending s.
17 499.012, F.S.; redefining "wholesale
18 distribution" with respect to regulation of
19 distribution of prescription drugs; requiring
20 the Department of Children and Family Services
21 to develop and implement a comprehensive
22 redesign of the home and community-based
23 services delivery system for persons with
24 developmental disabilities; restricting certain
25 release of funds; providing an implementation
26 schedule; requiring the Agency for Health Care
27 Administration to conduct a study of health
28 care services provided to children who are
29 medically fragile or dependent on medical
30 technology; requiring the Agency for Health
31 Care Administration to conduct a pilot program

1 for a subacute pediatric transitional care
2 center; requiring background screening of
3 center personnel; requiring the agency to amend
4 the Medicaid state plan and seek federal
5 waivers as necessary; requiring the center to
6 have an advisory board; providing for
7 membership on the advisory board; providing
8 requirements for the admission, transfer, and
9 discharge of a child to the center; requiring
10 the agency to submit certain reports to the
11 Legislature; providing guidelines for the
12 agency regarding distribution of
13 disproportionate share funds during the
14 2002-2003 fiscal year; authorizing the Agency
15 for Health Care Administration to conduct a
16 pilot project on overnight stays in an
17 ambulatory surgical center; directing the
18 Office of Program Policy Analysis and
19 Government Accountability to perform a study of
20 county contributions to Medicaid nursing home
21 costs; requiring a report and recommendations;
22 transferring to the Department of Health the
23 powers, duties, functions, and assets that
24 relate to the consumer complaint services,
25 investigations, and prosecutorial services
26 performed by the Agency for Health Care
27 Administration under contract with the
28 department; transferring full-time equivalent
29 positions and the practitioner regulation
30 component from the agency to the department;
31 terminating an interagency agreement;

authorizing the department to contract with the Department of Legal Affairs; amending s. 20.43, F.S.; deleting the provision authorizing the department to enter into such contract with the agency, to conform; repealing s. 456.047, F.S., relating to standardized credentialing for health care practitioners; repealing s. 414.41(5), F.S., relating to interest imposed upon the recovery amount of medical assistance overpayments; providing severability; providing for construction of laws enacted at the 2002 Regular Session in relation to this act; providing effective dates.

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

Section 1. Section 16.59, Florida Statutes, is amended to read:

16.59 Medicaid fraud control.--There is created in the Department of Legal Affairs the Medicaid Fraud Control Unit, which may investigate all violations of s. 409.920 and any criminal violations discovered during the course of those investigations. The Medicaid Fraud Control Unit may refer any criminal violation so uncovered to the appropriate prosecuting authority. Offices of the Medicaid Fraud Control Unit and the offices of the Agency for Health Care Administration Medicaid program integrity program shall, to the extent possible, be collocated. The agency and the Department of Legal Affairs shall conduct joint training and other joint activities designed to increase communication and coordination in recovering overpayments.

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1 Section 2. Subsections (3), (5), and (7) of section
2 112.3187, Florida Statutes, are amended to read:
3 112.3187 Adverse action against employee for
4 disclosing information of specified nature prohibited;
5 employee remedy and relief.--
6 (3) DEFINITIONS.--As used in this act, unless
7 otherwise specified, the following words or terms shall have
8 the meanings indicated:
9 (a) "Agency" means any state, regional, county, local,
10 or municipal government entity, whether executive, judicial,
11 or legislative; any official, officer, department, division,
12 bureau, commission, authority, or political subdivision
13 therein; or any public school, community college, or state
14 university.
15 (b) "Employee" means a person who performs services
16 for, and under the control and direction of, or contracts
17 with, an agency or independent contractor for wages or other
18 remuneration.
19 (c) "Adverse personnel action" means the discharge,
20 suspension, transfer, or demotion of any employee or the
21 withholding of bonuses, the reduction in salary or benefits,
22 or any other adverse action taken against an employee within
23 the terms and conditions of employment by an agency or
24 independent contractor.
25 (d) "Independent contractor" means a person, other
26 than an agency, engaged in any business and who enters into a
27 contract, including a provider agreement, with an agency.
28 (e) "Gross mismanagement" means a continuous pattern
29 of managerial abuses, wrongful or arbitrary and capricious
30 actions, or fraudulent or criminal conduct which may have a
31 substantial adverse economic impact.

1 (5) NATURE OF INFORMATION DISCLOSED.--The information
2 disclosed under this section must include:
3 (a) Any violation or suspected violation of any
4 federal, state, or local law, rule, or regulation committed by
5 an employee or agent of an agency or independent contractor
6 which creates and presents a substantial and specific danger
7 to the public's health, safety, or welfare.
8 (b) Any act or suspected act of gross mismanagement,
9 malfeasance, misfeasance, gross waste of public funds,
10 suspected or actual Medicaid fraud or abuse, or gross neglect
11 of duty committed by an employee or agent of an agency or
12 independent contractor.
13 (7) EMPLOYEES AND PERSONS PROTECTED.--This section
14 protects employees and persons who disclose information on
15 their own initiative in a written and signed complaint; who
16 are requested to participate in an investigation, hearing, or
17 other inquiry conducted by any agency or federal government
18 entity; who refuse to participate in any adverse action
19 prohibited by this section; or who initiate a complaint
20 through the whistle-blower's hotline or the hotline of the
21 Medicaid Fraud Control Unit of the Department of Legal
22 Affairs; or employees who file any written complaint to their
23 supervisory officials or employees who submit a complaint to
24 the Chief Inspector General in the Executive Office of the
25 Governor, to the employee designated as agency inspector
26 general under s. 112.3189(1), or to the Florida Commission on
27 Human Relations. The provisions of this section may not be
28 used by a person while he or she is under the care, custody,
29 or control of the state correctional system or, after release
30 from the care, custody, or control of the state correctional
31 system, with respect to circumstances that occurred during any

period of incarceration. No remedy or other protection under ss. 112.3187-112.31895 applies to any person who has committed or intentionally participated in committing the violation or suspected violation for which protection under ss. 112.3187-112.31895 is being sought.

Section 3. Paragraph (a) of subsection (7) of section 240.4075, Florida Statutes, is amended to read:

240.4075 Nursing Student Loan Forgiveness Program.--

(7)(a) Funds contained in the Nursing Student Loan Forgiveness Trust Fund which are to be used for loan forgiveness for those nurses employed by hospitals, birth centers, and nursing homes must be matched on a dollar-for-dollar basis by contributions from the employing institutions, except that this provision shall not apply to state-operated medical and health care facilities, public schools, county health departments, federally sponsored community health centers, teaching hospitals as defined in s. 408.07, family practice teaching hospitals as defined in s. 395.805, or specialty hospitals for children as used in s. 409.9119. An estimate of the annual trust fund dollars shall be made at the beginning of the fiscal year based on historic expenditures from the trust fund. Applicant requests shall be reviewed on a quarterly basis, and applicant awards shall be based on the following priority of employer until all such estimated trust funds are awarded: state-operated medical and health care facilities; public schools;~~If in any given fiscal quarter there are insufficient funds in the trust fund to grant all eligible applicant requests, awards shall be based on the following priority of employer:~~county health departments; federally sponsored community health centers; ~~state-operated medical and health care facilities; public~~

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~~schools;~~teaching hospitals as defined in s. 408.07; family practice teaching hospitals as defined in s. 395.805; specialty hospitals for children as used in s. 409.9119; and other hospitals, birth centers, and nursing homes.

Section 4. Subsection (24) of section 395.002, Florida Statutes, is amended to read:

395.002 Definitions.--As used in this chapter:

(24) "Premises" means those buildings, beds, and equipment located at the address of the licensed facility and all other buildings, beds, and equipment for the provision of hospital, ambulatory surgical, or mobile surgical care located in such reasonable proximity to the address of the licensed facility as to appear to the public to be under the dominion and control of the licensee. For any licensee that is a teaching hospital as defined in s. 408.07(44), reasonable proximity includes any buildings, beds, services, programs, and equipment under the dominion and control of the licensee that are located at a site with a main address that is within 1 mile of the main address of the licensed facility; and all such buildings, beds, and equipment may, at the request of a licensee or applicant, be included on the facility license as a single premises.

Section 5. Subsection (2) of section 395.003, Florida Statutes, is amended to read:

395.003 Licensure; issuance, renewal, denial, and revocation.--

(2)(a) Upon the receipt of an application for a license and the license fee, the agency shall issue a license if the applicant and facility have received all approvals required by law and meet the requirements established under

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1 this part and in rules. Such license shall include all beds
2 and services located on the premises of the facility.
3 (b) A provisional license may be issued to a new
4 facility or a facility that is in substantial compliance with
5 this part and with the rules of the agency. A provisional
6 license shall be granted for a period of no more than 1 year
7 and shall expire automatically at the end of its term. A
8 provisional license may not be renewed.
9 (c) A license, unless sooner suspended or revoked,
10 shall automatically expire 2 years from the date of issuance
11 and shall be renewable biennially upon application for renewal
12 and payment of the fee prescribed by s. 395.004(2), provided
13 the applicant and licensed facility meet the requirements
14 established under this part and in rules. An application for
15 renewal of a license shall be made 90 days prior to expiration
16 of the license, on forms provided by the agency.
17 (d) The agency shall, at the request of a licensee,
18 issue a single license to a licensee for facilities located on
19 separate premises. Such a license shall specifically state
20 the location of the facilities, the services, and the licensed
21 beds available on each separate premises. If a licensee
22 requests a single license, the licensee shall designate which
23 facility or office is responsible for receipt of information,
24 payment of fees, service of process, and all other activities
25 necessary for the agency to carry out the provisions of this
26 part.
27 (e) The agency shall, at the request of a licensee
28 that is a teaching hospital as defined in s. 408.07(44), issue
29 a single license to a licensee for facilities that have been
30 previously licensed as separate premises, provided such
31 separately licensed facilities, taken together, constitute the

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same premises as defined in s. 395.002(24). Such license for the single premises shall include all of the beds, services, and programs that were previously included on the licenses for the separate premises. The granting of a single license under this paragraph shall not in any manner reduce the number of beds, services, or programs operated by the licensee.

(f)~~(e)~~ Intensive residential treatment programs for children and adolescents which have received accreditation from the Joint Commission on Accreditation of Healthcare Organizations and which meet the minimum standards developed by rule of the agency for such programs shall be licensed by the agency under this part.

Section 6. Subsection (20) of section 400.141, Florida Statutes, is amended to read:

400.141 Administration and management of nursing home facilities.--Every licensed facility shall comply with all applicable standards and rules of the agency and shall:

(20) Maintain general and professional liability insurance coverage that is in force at all times.

Section 7. (1) For the period beginning June 30, 2001, and ending June 30, 2005, the Agency for Health Care Administration shall provide a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives with respect to nursing homes. The first report shall be submitted no later than December 30, 2002, and subsequent reports shall be submitted every 6 months thereafter. The report shall identify facilities based on their ownership characteristics, size, business structure, for-profit or not-for-profit status, and any other characteristics the agency determines useful in analyzing the

1 varied segments of the nursing home industry and shall
2 report:
3 (a) The number of Notices of Intent to litigate
4 received by each facility each month.
5 (b) The number of complaints on behalf of a resident
6 or resident legal representative that were filed with the
7 clerk of the court each month.
8 (c) The month in which the injury which is the basis
9 for the suit occurred or was discovered or, if unavailable,
10 the dates of residency of the resident involved, beginning
11 with the date of initial admission and latest discharge date.
12 (d) Information regarding deficiencies cited,
13 including information used to develop the Nursing Home Guide
14 WATCH LIST pursuant to s. 400.191, Florida Statutes, and
15 applicable rules, a summary of data generated on nursing homes
16 by Centers for Medicare and Medicaid Services Nursing Home
17 Quality Information Project, and information collected
18 pursuant to s. 400.147(9), Florida Statutes, relating to
19 litigation.
20 (2) Facilities subject to part II of chapter 400,
21 Florida Statutes, must submit the information necessary to
22 compile this report each month on existing forms, as modified,
23 provided by the agency.
24 (3) The agency shall delineate the available
25 information on a monthly basis.
26 Section 8. Subsection (9) of section 400.147, Florida
27 Statutes, is amended to read:
28 400.147 Internal risk management and quality assurance
29 program.--
30 (9) By the 10th of each month,each facility subject
31 to this section shall report ~~monthly~~ any notice received

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pursuant to s. 400.0233(2) and each initial complaint that was filed with the clerk of the court and served on the facility during the previous month by a resident or a resident's family member, guardian, conservator, or personal legal representative ~~liability claim filed against it~~. The report must include the name of the resident, the resident's date of birth and social security number, the Medicaid identification number for Medicaid-eligible persons,the date or dates of the incident leading to the claim or dates of residency, if applicable, and the type of injury or violation of rights alleged to have occurred. Each facility shall also submit a copy of the notices received pursuant to s. 400.0233(2) and complaints filed with the clerk of the court. This report is confidential as provided by law and is not discoverable or admissible in any civil or administrative action, except in such actions brought by the agency to enforce the provisions of this part.

Section 9. In order to expedite the availability of general and professional liability insurance for nursing homes, the Agency for Health Care Administration, subject to appropriations included in the General Appropriation Act, shall advance $6 million for the purpose of capitalizing the risk retention group. The terms of repayment may not extend beyond 3 years from the date of funding. For purposes of this project, notwithstanding the provisions of s. 631.271, Florida Statutes, the agency's claim shall be considered a class 3 claim.

Section 10. Effective upon becoming a law and applicable to any pending license renewal, paragraph (d) of subsection (5) of section 400.179, Florida Statutes, is amended to read:

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:

(d) Where the transfer involves a facility that has been leased by the transferor:

1. The transferee shall, as a condition to being issued a license by the agency, acquire, maintain, and provide proof to the agency of a bond with a term of 30 months, renewable annually, in an amount not less than the total of 3 months Medicaid payments to the facility computed on the basis of the preceding 12-month average Medicaid payments to the facility.

2. A leasehold licensee may meet the requirements of subparagraph 1. by payment of a nonrefundable fee, paid at initial licensure, paid at the time of any subsequent change of ownership, and paid at the time of any subsequent annual license renewal, in the amount of 2 percent of the total of 3 months' Medicaid payments to the facility computed on the basis of the preceding 12-month average Medicaid payments to the facility. If a preceding 12-month average is not available, projected Medicaid payments may be used. The fee shall be deposited into the Health Care Trust Fund and shall be accounted for separately as a Medicaid nursing home overpayment account. These fees shall be used at the sole discretion of the agency to repay nursing home Medicaid

1 overpayments. Payment of this fee shall not release the
2 licensee from any liability for any Medicaid overpayments, nor
3 shall payment bar the agency from seeking to recoup
4 overpayments from the licensee and any other liable party. As
5 a condition of exercising this lease bond alternative,
6 licensees paying this fee must maintain an existing lease bond
7 through the end of the 30-month term period of that bond. The
8 agency is herein granted specific authority to promulgate all
9 rules pertaining to the administration and management of this
10 account, including withdrawals from the account, subject to
11 federal review and approval. This subparagraph is repealed on
12 June 30, 2003. This provision shall take effect upon becoming
13 law and shall apply to any leasehold license application.
14 a. The financial viability of the Medicaid nursing
15 home overpayment account shall be determined by the agency
16 through annual review of the account balance and the amount of
17 total outstanding, unpaid Medicaid overpayments owing from
18 leasehold licensees to the agency as determined by final
19 agency audits.
20 b. The agency, in consultation with the Florida Health
21 Care Association and the Florida Association of Homes for the
22 Aging, shall study and make recommendations on the minimum
23 amount to be held in reserve to protect against Medicaid
24 overpayments to leasehold licensees and on the issue of
25 successor liability for Medicaid overpayments upon sale or
26 transfer of ownership of a nursing facility. The agency shall
27 submit the findings and recommendations of the study to the
28 Governor, the President of the Senate, and the Speaker of the
29 House of Representatives by January 1, 2003.
30 3.~~2.~~ The leasehold licensee ~~operator~~ may meet the bond
31 requirement through other arrangements acceptable to the

agency ~~Department~~. The agency is herein granted specific authority to promulgate rules pertaining to lease bond arrangements.

4.~~3.~~ All existing nursing facility licensees, operating the facility as a leasehold, shall acquire, maintain, and provide proof to the agency of the 30-month bond required in subparagraph 1., above, on and after July 1, 1993, for each license renewal.

5.~~4.~~ It shall be the responsibility of all nursing facility operators, operating the facility as a leasehold, to renew the 30-month bond and to provide proof of such renewal to the agency annually at the time of application for license renewal.

6.~~5.~~ Any failure of the nursing facility operator to acquire, maintain, renew annually, or provide proof to the agency shall be grounds for the agency to deny, cancel, revoke, or suspend the facility license to operate such facility and to take any further action, including, but not limited to, enjoining the facility, asserting a moratorium, or applying for a receiver, deemed necessary to ensure compliance with this section and to safeguard and protect the health, safety, and welfare of the facility's residents.

Section 11. Subsection (8) of section 400.925, Florida Statutes, is amended to read:

400.925 Definitions.--As used in this part, the term:

(8) "Home medical equipment" includes any product as defined by the Federal Drug Administration's Drugs, Devices and Cosmetics Act, any products reimbursed under the Medicare Part B Durable Medical Equipment benefits, or any products reimbursed under the Florida Medicaid durable medical equipment program. Home medical equipment includes~~, but is not~~

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~~limited to,~~oxygen and related respiratory equipment; manual, motorized, or~~. Home medical equipment includes~~ customized wheelchairs and related seating and positioning, but does not include prosthetics or orthotics or any splints, braces, or aids custom fabricated by a licensed health care practitioner;~~. Home medical equipment includes assistive technology devices, including: manual wheelchairs, motorized wheelchairs,~~motorized scooters;~~, voice-synthesized computer modules, optical scanners, talking software, braille printers, environmental control devices for use by person with quadriplegia, motor vehicle adaptive transportation aids, devices that enable persons with severe speech disabilities to in effect speak,~~personal transfer systems;and specialty beds, ~~including demonstrator,~~for use by a person with a medical need.

Section 12. Section 408.831, Florida Statutes, is created to read:

408.831 Denial, suspension, or revocation of a license, registration, certificate, or application.--

(1) In addition to any other remedies provided by law, the agency may deny each application or suspend or revoke each license, registration, or certificate of entities regulated or licensed by it:

(a) If the applicant, licensee, registrant, or certificateholder, or, in the case of a corporation, partnership, or other business entity, if any officer, director, agent, or managing employee of that business entity or any affiliated person, partner, or shareholder having an ownership interest equal to 5 percent or greater in that business entity, has failed to pay all outstanding fines, liens, or overpayments assessed by final order of the agency

1 or final order of the Centers for Medicare and Medicaid
2 Services, not subject to further appeal, unless a repayment
3 plan is approved by the agency; or
4 (b) For failure to comply with any repayment plan.
5 (2) This section provides standards of enforcement
6 applicable to all entities licensed or regulated by the Agency
7 for Health Care Administration. This section controls over any
8 conflicting provisions of chapters 39, 381, 383, 390, 391,
9 393, 394, 395, 400, 408, 468, 483, and 641 or rules adopted
10 pursuant to those chapters.
11 Section 13. For the purpose of incorporating the
12 amendments made by this act to sections 409.902, 409.907,
13 409.908, and 409.913, Florida Statutes, in references thereto,
14 subsection (4) of section 409.8132, Florida Statutes, is
15 reenacted to read:
16 409.8132 Medikids program component.--
17 (4) APPLICABILITY OF LAWS RELATING TO MEDICAID.--The
18 provisions of ss. 409.902, 409.905, 409.906, 409.907, 409.908,
19 409.912, 409.9121, 409.9122, 409.9123, 409.9124, 409.9127,
20 409.9128, 409.913, 409.916, 409.919, 409.920, and 409.9205
21 apply to the administration of the Medikids program component
22 of the Florida Kidcare program, except that s. 409.9122
23 applies to Medikids as modified by the provisions of
24 subsection (7).
25 Section 14. Section 409.8177, Florida Statutes, is
26 amended to read:
27 409.8177 Program evaluation.--
28 (1) The agency, in consultation with the Department of
29 Health, the Department of Children and Family Services, and
30 the Florida Healthy Kids Corporation, shall contract for an
31 evaluation of the Florida Kidcare program and shall by January

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1 of each year submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives a report of the ~~Florida Kidcare~~ program. In addition to the items specified under s. 2108 of Title XXI of the Social Security Act, the report shall include an assessment of crowd-out and access to health care, as well as the following:

(a)~~(1)~~ An assessment of the operation of the program, including the progress made in reducing the number of uncovered low-income children.

(b)~~(2)~~ An assessment of the effectiveness in increasing the number of children with creditable health coverage, including an assessment of the impact of outreach.

(c)~~(3)~~ The characteristics of the children and families assisted under the program, including ages of the children, family income, and access to or coverage by other health insurance prior to the program and after disenrollment from the program.

(d)~~(4)~~ The quality of health coverage provided, including the types of benefits provided.

(e)~~(5)~~ The amount and level, including payment of part or all of any premium, of assistance provided.

(f)~~(6)~~ The average length of coverage of a child under the program.

(g)~~(7)~~ The program's choice of health benefits coverage and other methods used for providing child health assistance.

(h)~~(8)~~ The sources of nonfederal funding used in the program.

(i)~~(9)~~ An assessment of the effectiveness of Medikids, Children's Medical Services network, and other public and private programs in the state in increasing the availability

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of affordable quality health insurance and health care for children.

(j)~~(10)~~ A review and assessment of state activities to coordinate the program with other public and private programs.

(k)~~(11)~~ An analysis of changes and trends in the state that affect the provision of health insurance and health care to children.

(l)~~(12)~~ A description of any plans the state has for improving the availability of health insurance and health care for children.

(m)~~(13)~~ Recommendations for improving the program.

(n)~~(14)~~ Other studies as necessary.

(2) The agency shall ~~also~~ submit each month to the Governor, the President of the Senate, and the Speaker of the House of Representatives a report of enrollment for each program component of the Florida Kidcare program.

Section 15. Section 409.902, Florida Statutes, is amended to read:

409.902 Designated single state agency; payment requirements; program title; release of medical records.--The Agency for Health Care Administration is designated as the single state agency authorized to make payments for medical assistance and related services under Title XIX of the Social Security Act. These payments shall be made, subject to any limitations or directions provided for in the General Appropriations Act, only for services included in the program, shall be made only on behalf of eligible individuals, and shall be made only to qualified providers in accordance with federal requirements for Title XIX of the Social Security Act and the provisions of state law. This program of medical assistance is designated the "Medicaid program." The

Department of Children and Family Services is responsible for Medicaid eligibility determinations, including, but not limited to, policy, rules, and the agreement with the Social Security Administration for Medicaid eligibility determinations for Supplemental Security Income recipients, as well as the actual determination of eligibility. As a condition of Medicaid eligibility, subject to federal approval, the Agency for Health Care Administration and the Department of Children and Family Services shall ensure that each recipient of Medicaid consents to the release of her or his medical records to the Agency for Health Care Administration and the Medicaid Fraud Control Unit of the Department of Legal Affairs.

Section 16. Effective July 1, 2002, subsection (2) of section 409.904, Florida Statutes, as amended by section 2 of chapter 2001-377, Laws of Florida, is amended to read:

409.904 Optional payments for eligible persons.--The agency may make payments for medical assistance and related services on behalf of the following persons who are determined to be eligible subject to the income, assets, and categorical eligibility tests set forth in federal and state law. Payment on behalf of these Medicaid eligible persons is subject to the availability of moneys and any limitations established by the General Appropriations Act or chapter 216.

(2)~~(a)~~ A caretaker relative or parent, a pregnant woman, a child under age 19 who would otherwise qualify for Florida Kidcare Medicaid, a child up to age 21 who would otherwise qualify under s. 409.903(1), a person age 65 or over, or a blind or disabled person, who would otherwise be eligible for Florida Medicaid, except that the income or assets of such family or person exceed established

limitations.~~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.~~

For a family or person in one of these coverage groups ~~this group~~, medical expenses are deductible from income in accordance with federal requirements in order to make a determination of eligibility. Expenses used to meet spend-down liability are not reimbursable by Medicaid. Effective May 1, 2003, when determining the eligibility of a pregnant woman, a child, or an aged, blind, or disabled individual, $270 shall be deducted from the countable income of the filing unit. When determining the eligibility of the parent or caretaker relative as defined by Title XIX of the Social Security Act, the additional income disregard of $270 does not apply.A family or person eligible under the coverage ~~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 17. Subsection (10) of section 409.904, Florida Statutes, is 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.

(10)~~(a)~~ Eligible women with incomes at or below 200 percent of the federal poverty level and under age 65, for cancer treatment pursuant to the federal Breast and Cervical Cancer Prevention and Treatment Act of 2000, screened through the Mary Brogan ~~National~~ Breast and Cervical Cancer Early Detection Program established under s. 381.93.

~~(b) A woman who has not attained 65 years of age and who has been screened for breast or cervical cancer by a qualified entity under the Mary Brogan Breast and Cervical Cancer Early Detection Program of the Department of Health and needs treatment for breast or cervical cancer and is not otherwise covered under creditable coverage, as defined in s. 2701(c) of the Public Health Service Act. For purposes of this subsection, the term "qualified entity" means a county public health department or other entity that has contracted with the Department of Health to provide breast and cervical cancer screening services paid for under this act. In determining the eligibility of such a woman, an assets test is not required. A presumptive eligibility period begins on the date on which all eligibility criteria appear to be met and ends on the date determination is made with respect to the eligibility of such woman for services under the state plan or, in the case of such a woman who does not file an application, by the last day~~

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1 ~~of the month following the month in which the presumptive~~
2 ~~eligibility determination is made. A woman is eligible until~~
3 ~~she gains creditable coverage, until treatment is no longer~~
4 ~~necessary, or until attainment of 65 years of age.~~
5 Section 18. Paragraph (c) of subsection (5) of section
6 409.905, Florida Statutes, is amended to read:
7 409.905 Mandatory Medicaid services.--The agency may
8 make payments for the following services, which are required
9 of the state by Title XIX of the Social Security Act,
10 furnished by Medicaid providers to recipients who are
11 determined to be eligible on the dates on which the services
12 were provided. Any service under this section shall be
13 provided only when medically necessary and in accordance with
14 state and federal law. Mandatory services rendered by
15 providers in mobile units to Medicaid recipients may be
16 restricted by the agency. Nothing in this section shall be
17 construed to prevent or limit the agency from adjusting fees,
18 reimbursement rates, lengths of stay, number of visits, number
19 of services, or any other adjustments necessary to comply with
20 the availability of moneys and any limitations or directions
21 provided for in the General Appropriations Act or chapter 216.
22 (5) HOSPITAL INPATIENT SERVICES.--The agency shall pay
23 for all covered services provided for the medical care and
24 treatment of a recipient who is admitted as an inpatient by a
25 licensed physician or dentist to a hospital licensed under
26 part I of chapter 395. However, the agency shall limit the
27 payment for inpatient hospital services for a Medicaid
28 recipient 21 years of age or older to 45 days or the number of
29 days necessary to comply with the General Appropriations Act.
30 (c) Agency for Health Care Administration shall adjust
31 a hospital's current inpatient per diem rate to reflect the

cost of serving the Medicaid population at that institution if:

1. The hospital experiences an increase in Medicaid caseload by more than 25 percent in any year, primarily resulting from the closure of a hospital in the same service area occurring after July 1, 1995; ~~or~~

2. The hospital's Medicaid per diem rate is at least 25 percent below the Medicaid per patient cost for that year; or~~.~~

3. The hospital is located in a county that has five or fewer hospitals, began offering obstetrical services on or after September 1999, and has submitted a request in writing to the agency for a rate adjustment after July 1, 2000, but before September 30, 2000, in which case such hospital's Medicaid inpatient per diem rate shall be adjusted to cost, effective July 1, 2002.

No later than October 1 of each year ~~November 1, 2001~~, the agency must provide estimated costs for any adjustment in a hospital inpatient per diem pursuant to this paragraph to the Executive Office of the Governor, the House of Representatives General Appropriations Committee, and the Senate Appropriations Committee. Before the agency implements a change in a hospital's inpatient per diem rate pursuant to this paragraph, the Legislature must have specifically appropriated sufficient funds in the General Appropriations Act to support the increase in cost as estimated by the agency.

Section 19. Effective July 1, 2002, subsections (1), (12), and (23) of section 409.906, Florida Statutes, as

amended by section 3 of chapter 2001-377, Laws of Florida, 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 DENTAL ~~DENTURE~~ SERVICES.--The agency may pay for medically necessary, emergency dental procedures to alleviate pain or infection. Emergency dental care shall be limited to emergency oral examinations, necessary radiographs, extractions, and incision and drainage of abscess ~~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

1 physician specializing in diseases of the eye or by a licensed
2 optometrist.
3 Section 20. Subsections (1) and (2) of section
4 409.9065, Florida Statutes, as amended by section 5 of chapter
5 2001-377, Laws of Florida, are amended to read:
6 409.9065 Pharmaceutical expense assistance.--
7 (1) PROGRAM ESTABLISHED.--There is established a
8 program to provide pharmaceutical expense assistance to
9 certain low-income elderly individuals, which shall be known
10 as the "Ron Silver Senior Drug Program."
11 (2) ELIGIBILITY.--Eligibility for the program is
12 limited to those individuals who qualify for limited
13 assistance under the Florida Medicaid program as a result of
14 being dually eligible for both Medicare and Medicaid, but
15 whose limited assistance or Medicare coverage does not include
16 any pharmacy benefit. To the extent funds are appropriated,
17 specifically eligible individuals are individuals ~~low-income~~
18 ~~senior citizens~~ who:
19 (a) Are Florida residents age 65 and over;
20 (b) Have an income:
21 1. Between 88 ~~90~~ and 120 percent of the federal
22 poverty level;
23 2. Between 88 and 150 percent of the federal poverty
24 level if the Federal Government increases the federal Medicaid
25 match for persons between 100 and 150 percent of the federal
26 poverty level; or
27 3. Between 88 percent of the federal poverty level and
28 a level that can be supported with funds provided in the
29 General Appropriations Act for the program offered under this
30 section along with federal matching funds approved by the
31 Federal Government under a s. 1115 waiver. The agency is

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1 authorized to submit and implement a federal waiver pursuant
2 to this subparagraph. The agency shall design a pharmacy
3 benefit that includes annual per-member benefit limits and
4 cost-sharing provisions and limits enrollment to available
5 appropriations and matching federal funds. Prior to
6 implementing this program, the agency must submit a budget
7 amendment pursuant to chapter 216;
8 (c) Are eligible for both Medicare and Medicaid;
9 (d) Are not enrolled in a Medicare health maintenance
10 organization that provides a pharmacy benefit; and
11 (e) Request to be enrolled in the program.
12 Section 21. Subsections (7) and (9) of section
13 409.907, Florida Statutes, as amended by section 6 of chapter
14 2001-377, Laws of Florida, are amended to read:
15 409.907 Medicaid provider agreements.--The agency may
16 make payments for medical assistance and related services
17 rendered to Medicaid recipients only to an individual or
18 entity who has a provider agreement in effect with the agency,
19 who is performing services or supplying goods in accordance
20 with federal, state, and local law, and who agrees that no
21 person shall, on the grounds of handicap, race, color, or
22 national origin, or for any other reason, be subjected to
23 discrimination under any program or activity for which the
24 provider receives payment from the agency.
25 (7) The agency may require, as a condition of
26 participating in the Medicaid program and before entering into
27 the provider agreement, that the provider submit information,
28 in an initial and any required renewal applications,
29 concerning the professional, business, and personal background
30 of the provider and permit an onsite inspection of the
31 provider's service location by agency staff or other personnel

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designated by the agency to perform this function. The agency shall perform a random onsite inspection, within 60 days after receipt of a fully complete new provider's application, of the provider's service location prior to making its first payment to the provider for Medicaid services to determine the applicant's ability to provide the services that the applicant is proposing to provide for Medicaid reimbursement. The agency is not required to perform an onsite inspection of a provider or program that is licensed by the agency, that provides services under waiver programs for home and community-based services, or that is licensed as a medical foster home by the Department of Children and Family Services.As a continuing condition of participation in the Medicaid program, a provider shall immediately notify the agency of any current or pending bankruptcy filing. 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.

1 (d) If a group provider, identification of all members
2 of the group and attestation that all members of the group are
3 enrolled in or have applied to enroll in the Medicaid program.
4 (9) Upon receipt of a completed, signed, and dated
5 application, and completion of any necessary background
6 investigation and criminal history record check, the agency
7 must either:
8 (a) Enroll the applicant as a Medicaid provider no
9 earlier than the effective date of the approval of the
10 provider application. With respect to providers who were
11 recently granted a change of ownership and those who primarily
12 provide emergency medical services transportation or emergency
13 services and care pursuant to s. 401.45 or s. 395.1041, and
14 out-of-state providers, upon approval of the provider
15 application, the effective date of approval is considered to
16 be the date the agency receives the provider application; or
17 (b) Deny the application if the agency finds that it
18 is in the best interest of the Medicaid program to do so. The
19 agency may consider the factors listed in subsection (10), as
20 well as any other factor that could affect the effective and
21 efficient administration of the program, including, but not
22 limited to, the applicant's demonstrated ability to provide
23 services, conduct business, and operate a financially viable
24 concern;the current availability of medical care, services,
25 or supplies to recipients, taking into account geographic
26 location and reasonable travel time; the number of providers
27 of the same type already enrolled in the same geographic area;
28 and the credentials, experience, success, and patient outcomes
29 of the provider for the services that it is making application
30 to provide in the Medicaid program. The agency shall deny the
31 application if the agency finds that a provider; any officer,

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1 director, agent, managing employee, or affiliated person; or
2 any partner or shareholder having an ownership interest equal
3 to 5 percent or greater in the provider if the provider is a
4 corporation, partnership, or other business entity, has failed
5 to pay all outstanding fines or overpayments assessed by final
6 order of the agency or final order of the Centers for Medicare
7 and Medicaid Services, not subject to further appeal, unless
8 the provider agrees to a repayment plan that includes
9 withholding Medicaid reimbursement until the amount due is
10 paid in full.
11 Section 22. Section 409.908, Florida Statutes, as
12 amended by section 7 of chapter 2001-377, Laws of Florida, is
13 amended to read:
14 409.908 Reimbursement of Medicaid providers.--Subject
15 to specific appropriations, the agency shall reimburse
16 Medicaid providers, in accordance with state and federal law,
17 according to methodologies set forth in the rules of the
18 agency and in policy manuals and handbooks incorporated by
19 reference therein. These methodologies may include fee
20 schedules, reimbursement methods based on cost reporting,
21 negotiated fees, competitive bidding pursuant to s. 287.057,
22 and other mechanisms the agency considers efficient and
23 effective for purchasing services or goods on behalf of
24 recipients. If a provider is reimbursed based on cost
25 reporting and submits a cost report late and that cost report
26 would have been used to set a lower reimbursement rate for a
27 rate semester, then the provider's rate for that semester
28 shall be retroactively calculated using the new cost report,
29 and full payment at the recalculated rate shall be affected
30 retroactively. Medicare-granted extensions for filing cost
31 reports, if applicable, shall also apply to Medicaid cost

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reports.Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(1) Reimbursement to hospitals licensed under part I of chapter 395 must be made prospectively or on the basis of negotiation.

(a) Reimbursement for inpatient care is limited as provided for in s. 409.905(5), except for:

1. The raising of rate reimbursement caps, excluding rural hospitals.

2. Recognition of the costs of graduate medical education.

3. Other methodologies recognized in the General Appropriations Act.

4. Hospital inpatient rates shall be reduced by 6 percent effective July 1, 2001, and restored effective April 1, 2002.

During the years funds are transferred from the Department of Health, any reimbursement supported by such funds shall be subject to certification by the Department of Health that the hospital has complied with s. 381.0403. The agency is authorized to receive funds from state entities, including,

1 but not limited to, the Department of Health, local
2 governments, and other local political subdivisions, for the
3 purpose of making special exception payments, including
4 federal matching funds, through the Medicaid inpatient
5 reimbursement methodologies. Funds received from state
6 entities or local governments for this purpose shall be
7 separately accounted for and shall not be commingled with
8 other state or local funds in any manner. The agency may
9 certify all local governmental funds used as state match under
10 Title XIX of the Social Security Act, to the extent that the
11 identified local health care provider that is otherwise
12 entitled to and is contracted to receive such local funds is
13 the benefactor under the state's Medicaid program as
14 determined under the General Appropriations Act and pursuant
15 to an agreement between the Agency for Health Care
16 Administration and the local governmental entity. The local
17 governmental entity shall use a certification form prescribed
18 by the agency. At a minimum, the certification form shall
19 identify the amount being certified and describe the
20 relationship between the certifying local governmental entity
21 and the local health care provider. The agency shall prepare
22 an annual statement of impact which documents the specific
23 activities undertaken during the previous fiscal year pursuant
24 to this paragraph, to be submitted to the Legislature no later
25 than January 1, annually.
26 (b) Reimbursement for hospital outpatient care is
27 limited to $1,500 per state fiscal year per recipient, except
28 for:
29 1. Such care provided to a Medicaid recipient under
30 age 21, in which case the only limitation is medical
31 necessity.

2. Renal dialysis services.
3. Other exceptions made by the agency.

The agency is authorized to receive funds from state entities, including, but not limited to, the Department of Health, the Board of Regents, local governments, and other local political subdivisions, for the purpose of making payments, including federal matching funds, through the Medicaid outpatient reimbursement methodologies. Funds received from state entities and local governments for this purpose shall be separately accounted for and shall not be commingled with other state or local funds in any manner.

(c) Hospitals that provide services to a disproportionate share of low-income Medicaid recipients, or that participate in the regional perinatal intensive care center program under chapter 383, or that participate in the statutory teaching hospital disproportionate share program may receive additional reimbursement. The total amount of payment for disproportionate share hospitals shall be fixed by the General Appropriations Act. The computation of these payments must be made in compliance with all federal regulations and the methodologies described in ss. 409.911, 409.9112, and 409.9113.

(d) The agency is authorized to limit inflationary increases for outpatient hospital services as directed by the General Appropriations Act.

(2)(a)1. Reimbursement to nursing homes licensed under part II of chapter 400 and state-owned-and-operated intermediate care facilities for the developmentally disabled licensed under chapter 393 must be made prospectively.

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2. Unless otherwise limited or directed in the General Appropriations Act, reimbursement to hospitals licensed under part I of chapter 395 for the provision of swing-bed nursing home services must be made on the basis of the average statewide nursing home payment, and reimbursement to a hospital licensed under part I of chapter 395 for the provision of skilled nursing services must be made on the basis of the average nursing home payment for those services in the county in which the hospital is located. When a hospital is located in a county that does not have any community nursing homes, reimbursement must be determined by averaging the nursing home payments, in counties that surround the county in which the hospital is located. Reimbursement to hospitals, including Medicaid payment of Medicare copayments, for skilled nursing services shall be limited to 30 days, unless a prior authorization has been obtained from the agency. Medicaid reimbursement may be extended by the agency beyond 30 days, and approval must be based upon verification by the patient's physician that the patient requires short-term rehabilitative and recuperative services only, in which case an extension of no more than 15 days may be approved. Reimbursement to a hospital licensed under part I of chapter 395 for the temporary provision of skilled nursing services to nursing home residents who have been displaced as the result of a natural disaster or other emergency may not exceed the average county nursing home payment for those services in the county in which the hospital is located and is limited to the period of time which the agency considers necessary for continued placement of the nursing home residents in the hospital.

(b) Subject to any limitations or directions provided for in the General Appropriations Act, the agency shall establish and implement a Florida Title XIX Long-Term Care Reimbursement Plan (Medicaid) for nursing home care in order to provide care and services in conformance with the applicable state and federal laws, rules, regulations, and quality and safety standards and to ensure that individuals eligible for medical assistance have reasonable geographic access to such care.

1. Changes of ownership or of licensed operator do not qualify for increases in reimbursement rates associated with the change of ownership or of licensed operator. The agency shall amend the Title XIX Long Term Care Reimbursement Plan to provide that the initial nursing home reimbursement rates, for the operating, patient care, and MAR components, associated with related and unrelated party changes of ownership or licensed operator filed on or after September 1, 2001, are equivalent to the previous owner's reimbursement rate.

2. The agency shall amend the long-term care reimbursement plan and cost reporting system to create direct care and indirect care subcomponents of the patient care component of the per diem rate. These two subcomponents together shall equal the patient care component of the per diem rate. Separate cost-based ceilings shall be calculated for each patient care subcomponent. The direct care subcomponent of the per diem rate shall be limited by the cost-based class ceiling, and the indirect care subcomponent shall be limited by the lower of the cost-based class ceiling, by the target rate class ceiling, or by the individual provider target. The agency shall adjust the patient care component effective January 1, 2002. The cost to adjust the

direct care subcomponent shall be net of the total funds previously allocated for the case mix add-on. The agency shall make the required changes to the nursing home cost reporting forms to implement this requirement effective January 1, 2002.

3. The direct care subcomponent shall include salaries and benefits of direct care staff providing nursing services including registered nurses, licensed practical nurses, and certified nursing assistants who deliver care directly to residents in the nursing home facility. This excludes nursing administration, MDS, and care plan coordinators, staff development, and staffing coordinator.

4. All other patient care costs shall be included in the indirect care cost subcomponent of the patient care per diem rate. There shall be no costs directly or indirectly allocated to the direct care subcomponent from a home office or management company.

5. On July 1 of each year, the agency shall report to the Legislature direct and indirect care costs, including average direct and indirect care costs per resident per facility and direct care and indirect care salaries and benefits per category of staff member per facility.

6. In order to offset the cost of general and professional liability insurance, the agency shall amend ~~Under~~ the plan to allow for~~,~~interim rate adjustments ~~shall not be granted~~ to reflect increases in the cost of general or professional liability insurance for nursing homes ~~unless the following criteria are met: have at least a 65 percent Medicaid utilization in the most recent cost report submitted to the agency, and the increase in general or professional liability costs to the facility for the most recent policy period affects the total Medicaid per diem by at least 5~~

~~percent. This rate adjustment shall not result in the per diem exceeding the class ceiling~~. This provision shall be implemented to the extent existing appropriations are available.

It is the intent of the Legislature that the reimbursement plan achieve the goal of providing access to health care for nursing home residents who require large amounts of care while encouraging diversion services as an alternative to nursing home care for residents who can be served within the community. The agency shall base the establishment of any maximum rate of payment, whether overall or component, on the available moneys as provided for in the General Appropriations Act. The agency may base the maximum rate of payment on the results of scientifically valid analysis and conclusions derived from objective statistical data pertinent to the particular maximum rate of payment.

(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.

(a) Advanced registered nurse practitioner services.

(b) Birth center services.

(c) Chiropractic services.

1 (d) Community mental health services.
2 (e) Dental services, including oral and maxillofacial
3 surgery.
4 (f) Durable medical equipment.
5 (g) Hearing services.
6 (h) Occupational therapy for Medicaid recipients under
7 age 21.
8 (i) Optometric services.
9 (j) Orthodontic services.
10 (k) Personal care for Medicaid recipients under age
11 21.
12 (l) Physical therapy for Medicaid recipients under age
13 21.
14 (m) Physician assistant services.
15 (n) Podiatric services.
16 (o) Portable X-ray services.
17 (p) Private-duty nursing for Medicaid recipients under
18 age 21.
19 (q) Registered nurse first assistant services.
20 (r) Respiratory therapy for Medicaid recipients under
21 age 21.
22 (s) Speech therapy for Medicaid recipients under age
23 21.
24 (t) Visual services.
25 (4) Subject to any limitations or directions provided
26 for in the General Appropriations Act, alternative health
27 plans, health maintenance organizations, and prepaid health
28 plans shall be reimbursed a fixed, prepaid amount negotiated,
29 or competitively bid pursuant to s. 287.057, by the agency and
30 prospectively paid to the provider monthly for each Medicaid
31 recipient enrolled. The amount may not exceed the average

amount the agency determines it would have paid, based on claims experience, for recipients in the same or similar category of eligibility. The agency shall calculate capitation rates on a regional basis and, beginning September 1, 1995, shall include age-band differentials in such calculations. Effective July 1, 2001, the cost of exempting statutory teaching hospitals, specialty hospitals, and community hospital education program hospitals from reimbursement ceilings and the cost of special Medicaid payments shall not be included in premiums paid to health maintenance organizations or prepaid health care plans. Each rate semester, the agency shall calculate and publish a Medicaid hospital rate schedule that does not reflect either special Medicaid payments or the elimination of rate reimbursement ceilings, to be used by hospitals and Medicaid health maintenance organizations, in order to determine the Medicaid rate referred to in ss. 409.912(16), 409.9128(5), and 641.513(6).

(5) An ambulatory surgical center shall be reimbursed the lesser of the amount billed by the provider or the Medicare-established allowable amount for the facility.

(6) A provider of early and periodic screening, diagnosis, and treatment services to Medicaid recipients who are children under age 21 shall be reimbursed using an all-inclusive rate stipulated in a fee schedule established by the agency. A provider of the visual, dental, and hearing components of such services shall be reimbursed the lesser of the amount billed by the provider or the Medicaid maximum allowable fee established by the agency.

(7) A provider of family planning services shall be reimbursed the lesser of the amount billed by the provider or

1 an all-inclusive amount per type of visit for physicians and
2 advanced registered nurse practitioners, as established by the
3 agency in a fee schedule.
4 (8) A provider of home-based or community-based
5 services rendered pursuant to a federally approved waiver
6 shall be reimbursed based on an established or negotiated rate
7 for each service. These rates shall be established according
8 to an analysis of the expenditure history and prospective
9 budget developed by each contract provider participating in
10 the waiver program, or under any other methodology adopted by
11 the agency and approved by the Federal Government in
12 accordance with the waiver. Effective July 1, 1996, privately
13 owned and operated community-based residential facilities
14 which meet agency requirements and which formerly received
15 Medicaid reimbursement for the optional intermediate care
16 facility for the mentally retarded service may participate in
17 the developmental services waiver as part of a
18 home-and-community-based continuum of care for Medicaid
19 recipients who receive waiver services.
20 (9) A provider of home health care services or of
21 medical supplies and appliances shall be reimbursed on the
22 basis of competitive bidding or for the lesser of the amount
23 billed by the provider or the agency's established maximum
24 allowable amount, except that, in the case of the rental of
25 durable medical equipment, the total rental payments may not
26 exceed the purchase price of the equipment over its expected
27 useful life or the agency's established maximum allowable
28 amount, whichever amount is less.
29 (10) A hospice shall be reimbursed through a
30 prospective system for each Medicaid hospice patient at
31 Medicaid rates using the methodology established for hospice

1 reimbursement pursuant to Title XVIII of the federal Social
2 Security Act.
3 (11) A provider of independent laboratory services
4 shall be reimbursed on the basis of competitive bidding or for
5 the least of the amount billed by the provider, the provider's
6 usual and customary charge, or the Medicaid maximum allowable
7 fee established by the agency.
8 (12)(a) A physician shall be reimbursed the lesser of
9 the amount billed by the provider or the Medicaid maximum
10 allowable fee established by the agency.
11 (b) The agency shall adopt a fee schedule, subject to
12 any limitations or directions provided for in the General
13 Appropriations Act, based on a resource-based relative value
14 scale for pricing Medicaid physician services. Under this fee
15 schedule, physicians shall be paid a dollar amount for each
16 service based on the average resources required to provide the
17 service, including, but not limited to, estimates of average
18 physician time and effort, practice expense, and the costs of
19 professional liability insurance. The fee schedule shall
20 provide increased reimbursement for preventive and primary
21 care services and lowered reimbursement for specialty services
22 by using at least two conversion factors, one for cognitive
23 services and another for procedural services. The fee
24 schedule shall not increase total Medicaid physician
25 expenditures unless moneys are available, and shall be phased
26 in over a 2-year period beginning on July 1, 1994. The Agency
27 for Health Care Administration shall seek the advice of a
28 16-member advisory panel in formulating and adopting the fee
29 schedule. The panel shall consist of Medicaid physicians
30 licensed under chapters 458 and 459 and shall be composed of
31

1 50 percent primary care physicians and 50 percent specialty
2 care physicians.
3 (c) Notwithstanding paragraph (b), reimbursement fees
4 to physicians for providing total obstetrical services to
5 Medicaid recipients, which include prenatal, delivery, and
6 postpartum care, shall be at least $1,500 per delivery for a
7 pregnant woman with low medical risk and at least $2,000 per
8 delivery for a pregnant woman with high medical risk. However,
9 reimbursement to physicians working in Regional Perinatal
10 Intensive Care Centers designated pursuant to chapter 383, for
11 services to certain pregnant Medicaid recipients with a high
12 medical risk, may be made according to obstetrical care and
13 neonatal care groupings and rates established by the agency.
14 Nurse midwives licensed under part I of chapter 464 or
15 midwives licensed under chapter 467 shall be reimbursed at no
16 less than 80 percent of the low medical risk fee. The agency
17 shall by rule determine, for the purpose of this paragraph,
18 what constitutes a high or low medical risk pregnant woman and
19 shall not pay more based solely on the fact that a caesarean
20 section was performed, rather than a vaginal delivery. The
21 agency shall by rule determine a prorated payment for
22 obstetrical services in cases where only part of the total
23 prenatal, delivery, or postpartum care was performed. The
24 Department of Health shall adopt rules for appropriate
25 insurance coverage for midwives licensed under chapter 467.
26 Prior to the issuance and renewal of an active license, or
27 reactivation of an inactive license for midwives licensed
28 under chapter 467, such licensees shall submit proof of
29 coverage with each application.
30 (d) For fiscal years 2001-2002 and 2002-2003 ~~the~~
31 ~~2001-2002 fiscal year~~ only and if necessary to meet the

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requirements for grants and donations for the special Medicaid payments authorized in the 2001-2002 and 2002-2003 General Appropriations Acts ~~Act~~, the agency may make special Medicaid payments to qualified Medicaid providers designated by the agency, notwithstanding any provision of this subsection to the contrary, and may use intergovernmental transfers from state entities or other governmental entities to serve as the state share of such payments.

(13) Medicare premiums for persons eligible for both Medicare and Medicaid coverage shall be paid at the rates established by Title XVIII of the Social Security Act. For Medicare services rendered to Medicaid-eligible persons, Medicaid shall pay Medicare deductibles and coinsurance as follows:

(a) Medicaid shall make no payment toward deductibles and coinsurance for any service that is not covered by Medicaid.

(b) Medicaid's financial obligation for deductibles and coinsurance payments shall be based on Medicare allowable fees, not on a provider's billed charges.

(c) Medicaid will pay no portion of Medicare deductibles and coinsurance when payment that Medicare has made for the service equals or exceeds what Medicaid would have paid if it had been the sole payor. The combined payment of Medicare and Medicaid shall not exceed the amount Medicaid would have paid had it been the sole payor. The Legislature finds that there has been confusion regarding the reimbursement for services rendered to dually eligible Medicare beneficiaries. Accordingly, the Legislature clarifies that it has always been the intent of the Legislature before and after 1991 that, in reimbursing in accordance with fees

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1 established by Title XVIII for premiums, deductibles, and
2 coinsurance for Medicare services rendered by physicians to
3 Medicaid eligible persons, physicians be reimbursed at the
4 lesser of the amount billed by the physician or the Medicaid
5 maximum allowable fee established by the Agency for Health
6 Care Administration, as is permitted by federal law. It has
7 never been the intent of the Legislature with regard to such
8 services rendered by physicians that Medicaid be required to
9 provide any payment for deductibles, coinsurance, or
10 copayments for Medicare cost sharing, or any expenses incurred
11 relating thereto, in excess of the payment amount provided for
12 under the State Medicaid plan for such service. This payment
13 methodology is applicable even in those situations in which
14 the payment for Medicare cost sharing for a qualified Medicare
15 beneficiary with respect to an item or service is reduced or
16 eliminated. This expression of the Legislature is in
17 clarification of existing law and shall apply to payment for,
18 and with respect to provider agreements with respect to, items
19 or services furnished on or after the effective date of this
20 act. This paragraph applies to payment by Medicaid for items
21 and services furnished before the effective date of this act
22 if such payment is the subject of a lawsuit that is based on
23 the provisions of this section, and that is pending as of, or
24 is initiated after, the effective date of this act.
25 (d) Notwithstanding paragraphs (a)-(c):
26 1. Medicaid payments for Nursing Home Medicare part A
27 coinsurance shall be the lesser of the Medicare coinsurance
28 amount or the Medicaid nursing home per diem rate.
29 2. Medicaid shall pay all deductibles and coinsurance
30 for Medicare-eligible recipients receiving freestanding end
31 stage renal dialysis center services.

1 3. Medicaid payments for general hospital inpatient
2 services shall be limited to the Medicare deductible per spell
3 of illness. Medicaid shall make no payment toward coinsurance
4 for Medicare general hospital inpatient services.
5 4. Medicaid shall pay all deductibles and coinsurance
6 for Medicare emergency transportation services provided by
7 ambulances licensed pursuant to chapter 401.
8 (14) A provider of prescribed drugs shall be
9 reimbursed the least of the amount billed by the provider, the
10 provider's usual and customary charge, or the Medicaid maximum
11 allowable fee established by the agency, plus a dispensing
12 fee. The agency is directed to implement a variable dispensing
13 fee for payments for prescribed medicines while ensuring
14 continued access for Medicaid recipients. The variable
15 dispensing fee may be based upon, but not limited to, either
16 or both the volume of prescriptions dispensed by a specific
17 pharmacy provider, the volume of prescriptions dispensed to an
18 individual recipient, and dispensing of preferred-drug-list
19 products. The agency shall increase the pharmacy dispensing
20 fee authorized by statute and in the annual General
21 Appropriations Act by $0.50 for the dispensing of a Medicaid
22 preferred-drug-list product and reduce the pharmacy dispensing
23 fee by $0.50 for the dispensing of a Medicaid product that is
24 not included on the preferred-drug list. The agency is
25 authorized to limit reimbursement for prescribed medicine in
26 order to comply with any limitations or directions provided
27 for in the General Appropriations Act, which may include
28 implementing a prospective or concurrent utilization review
29 program.
30 (15) A provider of primary care case management
31 services rendered pursuant to a federally approved waiver

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1 shall be reimbursed by payment of a fixed, prepaid monthly sum
2 for each Medicaid recipient enrolled with the provider.
3 (16) A provider of rural health clinic services and
4 federally qualified health center services shall be reimbursed
5 a rate per visit based on total reasonable costs of the
6 clinic, as determined by the agency in accordance with federal
7 regulations.
8 (17) A provider of targeted case management services
9 shall be reimbursed pursuant to an established fee, except
10 where the Federal Government requires a public provider be
11 reimbursed on the basis of average actual costs.
12 (18) Unless otherwise provided for in the General
13 Appropriations Act, a provider of transportation services
14 shall be reimbursed the lesser of the amount billed by the
15 provider or the Medicaid maximum allowable fee established by
16 the agency, except when the agency has entered into a direct
17 contract with the provider, or with a community transportation
18 coordinator, for the provision of an all-inclusive service, or
19 when services are provided pursuant to an agreement negotiated
20 between the agency and the provider. The agency, as provided
21 for in s. 427.0135, shall purchase transportation services
22 through the community coordinated transportation system, if
23 available, unless the agency determines a more cost-effective
24 method for Medicaid clients. Nothing in this subsection shall
25 be construed to limit or preclude the agency from contracting
26 for services using a prepaid capitation rate or from
27 establishing maximum fee schedules, individualized
28 reimbursement policies by provider type, negotiated fees,
29 prior authorization, competitive bidding, increased use of
30 mass transit, or any other mechanism that the agency considers
31 efficient and effective for the purchase of services on behalf

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1 of Medicaid clients, including implementing a transportation
2 eligibility process. The agency shall not be required to
3 contract with any community transportation coordinator or
4 transportation operator that has been determined by the
5 agency, the Department of Legal Affairs Medicaid Fraud Control
6 Unit, or any other state or federal agency to have engaged in
7 any abusive or fraudulent billing activities. The agency is
8 authorized to competitively procure transportation services or
9 make other changes necessary to secure approval of federal
10 waivers needed to permit federal financing of Medicaid
11 transportation services at the service matching rate rather
12 than the administrative matching rate.
13 (19) County health department services may be
14 reimbursed a rate per visit based on total reasonable costs of
15 the clinic, as determined by the agency in accordance with
16 federal regulations under the authority of 42 C.F.R. s.
17 431.615.
18 (20) A renal dialysis facility that provides dialysis
19 services under s. 409.906(9) must be reimbursed the lesser of
20 the amount billed by the provider, the provider's usual and
21 customary charge, or the maximum allowable fee established by
22 the agency, whichever amount is less.
23 (21) The agency shall reimburse school districts which
24 certify the state match pursuant to ss. 236.0812 and 409.9071
25 for the federal portion of the school district's allowable
26 costs to deliver the services, based on the reimbursement
27 schedule. The school district shall determine the costs for
28 delivering services as authorized in ss. 236.0812 and 409.9071
29 for which the state match will be certified. Reimbursement of
30 school-based providers is contingent on such providers being
31 enrolled as Medicaid providers and meeting the qualifications

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contained in 42 C.F.R. s. 440.110, unless otherwise waived by the federal Health Care Financing Administration. Speech therapy providers who are certified through the Department of Education pursuant to rule 6A-4.0176, Florida Administrative Code, are eligible for reimbursement for services that are provided on school premises. Any employee of the school district who has been fingerprinted and has received a criminal background check in accordance with Department of Education rules and guidelines shall be exempt from any agency requirements relating to criminal background checks.

(22) The agency shall request and implement Medicaid waivers from the federal Health Care Financing Administration to advance and treat a portion of the Medicaid nursing home per diem as capital for creating and operating a risk-retention group for self-insurance purposes, consistent with federal and state laws and rules.

Section 23. Subsection (1) of section 409.911, Florida Statutes, is amended to read:

409.911 Disproportionate share program.--Subject to specific allocations established within the General Appropriations Act and any limitations established pursuant to chapter 216, the agency shall distribute, pursuant to this section, moneys to hospitals providing a disproportionate share of Medicaid or charity care services by making quarterly Medicaid payments as required. Notwithstanding the provisions of s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients.

(1) Definitions.--As used in this section,~~and~~ s. 409.9112, and the Florida Hospital Uniform Reporting System manual:

(a) "Adjusted patient days" means the sum of acute care patient days and intensive care patient days as reported to the Agency for Health Care Administration, divided by the ratio of inpatient revenues generated from acute, intensive, ambulatory, and ancillary patient services to gross revenues.

(b) "Actual audited data" or "actual audited experience" means data reported to the Agency for Health Care Administration which has been audited in accordance with generally accepted auditing standards by the agency or representatives under contract with the agency.

(c) "Base Medicaid per diem" means the hospital's Medicaid per diem rate initially established by the Agency for Health Care Administration on January 1, 1999. The base Medicaid per diem rate shall not include any additional per diem increases received as a result of the disproportionate share distribution.

(d) "Charity care" or "uncompensated charity care" means that portion of hospital charges reported to the Agency for Health Care Administration for which there is no compensation, other than restricted or unrestricted revenues provided to a hospital by local governments or tax districts regardless of the method of payment, for care provided to a patient whose family income for the 12 months preceding the determination is less than or equal to 200 percent of the federal poverty level, unless the amount of hospital charges due from the patient exceeds 25 percent of the annual family income. However, in no case shall the hospital charges for a patient whose family income exceeds four times the federal poverty level for a family of four be considered charity.

(e) "Charity care days" means the sum of the deductions from revenues for charity care minus 50 percent of

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1 restricted and unrestricted revenues provided to a hospital by
2 local governments or tax districts, divided by gross revenues
3 per adjusted patient day.
4 (f) "Disproportionate share percentage" means a rate
5 of increase in the Medicaid per diem rate as calculated under
6 this section.
7 (g) "Hospital" means a health care institution
8 licensed as a hospital pursuant to chapter 395, but does not
9 include ambulatory surgical centers.
10 (h) "Medicaid days" means the number of actual days
11 attributable to Medicaid patients as determined by the Agency
12 for Health Care Administration.
13 Section 24. Subsection (7) of section 409.9116,
14 Florida Statutes, is amended to read:
15 409.9116 Disproportionate share/financial assistance
16 program for rural hospitals.--In addition to the payments made
17 under s. 409.911, the Agency for Health Care Administration
18 shall administer a federally matched disproportionate share
19 program and a state-funded financial assistance program for
20 statutory rural hospitals. The agency shall make
21 disproportionate share payments to statutory rural hospitals
22 that qualify for such payments and financial assistance
23 payments to statutory rural hospitals that do not qualify for
24 disproportionate share payments. The disproportionate share
25 program payments shall be limited by and conform with federal
26 requirements. Funds shall be distributed quarterly in each
27 fiscal year for which an appropriation is made.
28 Notwithstanding the provisions of s. 409.915, counties are
29 exempt from contributing toward the cost of this special
30 reimbursement for hospitals serving a disproportionate share
31 of low-income patients.

(7) This section applies only to hospitals that were defined as statutory rural hospitals, or their successor-in-interest hospital, prior to January 1, 2001 ~~July 1, 1998~~. Any additional hospital that is defined as a statutory rural hospital, or its successor-in-interest hospital, on or after January 1, 2001 ~~July 1, 1998~~, is not eligible for programs under this section unless additional funds are appropriated each fiscal year specifically to the rural hospital disproportionate share and financial assistance programs in an amount necessary to prevent any hospital, or its successor-in-interest hospital, eligible for the programs prior to January 1, 2001 ~~July 1, 1998~~, from incurring a reduction in payments because of the eligibility of an additional hospital to participate in the programs. A hospital, or its successor-in-interest hospital, which received funds pursuant to this section before January 1, 2001 ~~July 1, 1998~~, and which qualifies under s. 395.602(2)(e), shall be included in the programs under this section and is not required to seek additional appropriations under this subsection.

Section 25. Subsection (7) of section 409.91195, Florida Statutes, is amended to read:

409.91195 Medicaid Pharmaceutical and Therapeutics Committee.--There is created a Medicaid Pharmaceutical and Therapeutics Committee within the Agency for Health Care Administration for the purpose of developing a preferred drug formulary pursuant to 42 U.S.C. s. 1396r-8.

(7) The committee shall ensure that interested parties, including pharmaceutical manufacturers agreeing to provide a supplemental rebate as outlined in this chapter, have an opportunity to present public testimony to the

committee with information or evidence supporting inclusion of a product on the preferred drug list. Such public testimony shall occur prior to any recommendations made by the committee for inclusion or exclusion from the preferred drug list. Upon timely notice, the agency shall ensure that any drug that has been approved or had any of its particular uses approved by the United States Food and Drug Administration under a priority review classification will be reviewed by the Medicaid Pharmaceutical and Therapeutics Committee at the next regularly scheduled meeting. To the extent possible, upon notice by a manufacturer the agency shall also schedule a product review for any new product at the next regularly scheduled Medicaid Pharmaceutical and Therapeutics Committee.

Section 26. Paragraph (b) of subsection (3) and paragraph (b) of subsection (13) of section 409.912, Florida Statutes, are 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

1 classes, or particular drugs to prevent fraud, abuse, overuse,
2 and possible dangerous drug interactions. The Pharmaceutical
3 and Therapeutics Committee shall make recommendations to the
4 agency on drugs for which prior authorization is required. The
5 agency shall inform the Pharmaceutical and Therapeutics
6 Committee of its decisions regarding drugs subject to prior
7 authorization.
8 (3) The agency may contract with:
9 (b) An entity that is providing comprehensive
10 behavioral health care services to certain Medicaid recipients
11 through a capitated, prepaid arrangement pursuant to the
12 federal waiver provided for by s. 409.905(5). Such an entity
13 must be licensed under chapter 624, chapter 636, or chapter
14 641 and must possess the clinical systems and operational
15 competence to manage risk and provide comprehensive behavioral
16 health care to Medicaid recipients. As used in this paragraph,
17 the term "comprehensive behavioral health care services" means
18 covered mental health and substance abuse treatment services
19 that are available to Medicaid recipients. The secretary of
20 the Department of Children and Family Services shall approve
21 provisions of procurements related to children in the
22 department's care or custody prior to enrolling such children
23 in a prepaid behavioral health plan. Any contract awarded
24 under this paragraph must be competitively procured. In
25 developing the behavioral health care prepaid plan procurement
26 document, the agency shall ensure that the procurement
27 document requires the contractor to develop and implement a
28 plan to ensure compliance with s. 394.4574 related to services
29 provided to residents of licensed assisted living facilities
30 that hold a limited mental health license. The agency must
31 ensure that Medicaid recipients have available the choice of

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at least two managed care plans for their behavioral health care services. To ensure unimpaired access to behavioral health care services by Medicaid recipients, all contracts issued pursuant to this paragraph shall require 80 percent of the capitation paid to the managed care plan, including health maintenance organizations, to be expended for the provision of behavioral health care services. In the event the managed care plan expends less than 80 percent of the capitation paid pursuant to this paragraph for the provision of behavioral health care services, the difference shall be returned to the agency. The agency shall provide the managed care plan with a certification letter indicating the amount of capitation paid during each calendar year for the provision of behavioral health care services pursuant to this section.The agency may reimburse for substance-abuse-treatment services on a fee-for-service basis until the agency finds that adequate funds are available for capitated, prepaid arrangements.

1. By January 1, 2001, the agency shall modify the contracts with the entities providing comprehensive inpatient and outpatient mental health care services to Medicaid recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk Counties, to include substance-abuse-treatment services.

2. By December 31, 2001, the agency shall contract with entities providing comprehensive behavioral health care services to Medicaid recipients through capitated, prepaid arrangements in Charlotte, Collier, DeSoto, Escambia, Glades, Hendry, Lee, Okaloosa, Pasco, Pinellas, Santa Rosa, Sarasota, and Walton Counties. The agency may contract with entities providing comprehensive behavioral health care services to Medicaid recipients through capitated, prepaid arrangements in Alachua County. The agency may determine if Sarasota County

shall be included as a separate catchment area or included in any other agency geographic area.

3. Children residing in a Department of Juvenile Justice residential program approved as a Medicaid behavioral health overlay services provider shall not be included in a behavioral health care prepaid health plan pursuant to this paragraph.

4. In converting to a prepaid system of delivery, the agency shall in its procurement document require an entity providing comprehensive behavioral health care services to prevent the displacement of indigent care patients by enrollees in the Medicaid prepaid health plan providing behavioral health care services from facilities receiving state funding to provide indigent behavioral health care, to facilities licensed under chapter 395 which do not receive state funding for indigent behavioral health care, or reimburse the unsubsidized facility for the cost of behavioral health care provided to the displaced indigent care patient.

5. Traditional community mental health providers under contract with the Department of Children and Family Services pursuant to part IV of chapter 394 and inpatient mental health providers licensed pursuant to chapter 395 must be offered an opportunity to accept or decline a contract to participate in any provider network for prepaid behavioral health services.

(13)

(b) The responsibility of the agency under this subsection shall include the development of capabilities to identify actual and optimal practice patterns; patient and provider educational initiatives; methods for determining patient compliance with prescribed treatments; fraud, waste,

and abuse prevention and detection programs; and beneficiary case management programs.

1. The practice pattern identification program shall evaluate practitioner prescribing patterns based on national and regional practice guidelines, comparing practitioners to their peer groups. The agency and its Drug Utilization Review Board shall consult with a panel of practicing health care professionals consisting of the following: the Speaker of the House of Representatives and the President of the Senate shall each appoint three physicians licensed under chapter 458 or chapter 459; and the Governor shall appoint two pharmacists licensed under chapter 465 and one dentist licensed under chapter 466 who is an oral surgeon. Terms of the panel members shall expire at the discretion of the appointing official. The panel shall begin its work by August 1, 1999, regardless of the number of appointments made by that date. The advisory panel shall be responsible for evaluating treatment guidelines and recommending ways to incorporate their use in the practice pattern identification program. Practitioners who are prescribing inappropriately or inefficiently, as determined by the agency, may have their prescribing of certain drugs subject to prior authorization.

2. The agency shall also develop educational interventions designed to promote the proper use of medications by providers and beneficiaries.

3. The agency shall implement a pharmacy fraud, waste, and abuse initiative that may include a surety bond or letter of credit requirement for participating pharmacies, enhanced provider auditing practices, the use of additional fraud and abuse software, recipient management programs for beneficiaries inappropriately using their benefits, and other

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steps that will eliminate provider and recipient fraud, waste, and abuse. The initiative shall address enforcement efforts to reduce the number and use of counterfeit prescriptions.

4. By September 30, 2002, the agency shall contract with an entity in the state to implement a wireless handheld clinical pharmacology drug information database for practitioners. The initiative shall be designed to enhance the agency's efforts to reduce fraud, abuse, and errors in the prescription drug benefit program and to otherwise further the intent of this paragraph.

5.~~4.~~ The agency may apply for any federal waivers needed to implement this paragraph.

Section 27. Paragraph (g) of subsection (3) and paragraph (c) of subsection (37) of section 409.912, Florida Statutes, as amended by sections 8 and 9 of chapter 2001-377, Laws of Florida, are amended, and paragraph (h) is added to said subsection (3), 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.

(3) The agency may contract with:

(g) Children's provider networks that provide care coordination and care management for Medicaid-eligible pediatric patients, primary care, authorization of specialty care, and other urgent and emergency care through organized providers designed to service Medicaid eligibles under age 18 <u>and pediatric emergency departments' diversion programs</u>. The networks shall provide after-hour operations, including evening and weekend hours, to promote, when appropriate, the use of the children's networks rather than hospital emergency departments.

<u>(h) A Children's Medical Services network, as defined in s. 391.021.</u>

(37)

(c) The agency shall submit <u>quarterly reports</u> ~~a report~~ to the Governor, the President of the Senate, and the Speaker of the House of Representatives <u>which</u> ~~by January 15 of each year. The report~~ must include, but need not be limited to, the progress made in implementing <u>this subsection and its</u> ~~Medicaid cost-containment measures and their~~ effect on Medicaid prescribed-drug expenditures.

Section 28. Paragraphs (f) and (k) of subsection (2) of section 409.9122, Florida Statutes, as amended by section 11 of chapter 2001-377, Laws of Florida, are amended to read:

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

(2)

(f) When a Medicaid recipient does not choose a managed care plan or MediPass provider, the agency shall assign the Medicaid recipient to a managed care plan or MediPass provider. Medicaid recipients who are subject to mandatory assignment but who fail to make a choice shall be assigned to managed care plans ~~or provider service networks~~ until an ~~equal~~ enrollment of 45 ~~50~~ percent in MediPass and 55 ~~50~~ percent in managed care plans is achieved. Once this ~~equal~~ enrollment is achieved, the assignments shall be divided in order to maintain an ~~equal~~ enrollment in MediPass and managed care plans which is in a 45 percent and 55 percent proportion, respectively. Thereafter, assignment of Medicaid recipients who fail to make a choice shall be based proportionally on the preferences of recipients who have made a choice in the previous period. Such proportions shall be revised at least quarterly to reflect an update of the preferences of Medicaid recipients. The agency shall ~~also~~ disproportionately assign Medicaid-eligible recipients ~~children in families~~ who are required to but have failed to make a choice of managed care plan or MediPass, including children,~~for their child~~ and who are to be assigned to the MediPass program to children's networks as described in s. 409.912(3)(g), Children's Medical Services network as defined in s. 391.021, exclusive provider organizations, provider service networks, minority physician networks, and pediatric emergency department diversion

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programs authorized by this chapter or the General Appropriations Act, in such manner as the agency deems appropriate,~~and where available. The disproportionate assignment of children to children's networks shall be made~~ until the agency has determined that the ~~children's~~ networks and programs have sufficient numbers to be economically operated. For purposes of this paragraph, when referring to assignment, the term "managed care plans" includes health maintenance organizations,exclusive provider organizations, provider service networks, minority physician networks, Children's Medical Services network,and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act. Beginning July 1, 2002, the agency shall assign all children in families who have not made a choice of a managed care plan or MediPass in the required timeframe to a pediatric emergency room diversion program described in s. 409.912(3)(g) that, as of July 1, 2002, has executed a contract with the agency, until such network or program has reached an enrollment of 15,000 children. Once that minimum enrollment level has been reached, the agency shall assign children who have not chosen a managed care plan or MediPass to the network or program in a manner that maintains the minimum enrollment in the network or program at not less than 15,000 children. To the extent practicable, the agency shall also assign all eligible children in the same family to such network or program.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.

(k) When a Medicaid recipient does not choose a managed care plan or MediPass provider, the agency shall assign the Medicaid recipient to a managed care plan, except in those counties in which there are fewer than two managed care plans accepting Medicaid enrollees, in which case assignment shall be to a managed care plan or a MediPass provider. Medicaid recipients in counties with fewer than two managed care plans accepting Medicaid enrollees who are subject to mandatory assignment but who fail to make a choice shall be assigned to managed care plans until an ~~equal~~ enrollment of 45 ~~50~~ percent in MediPass ~~and provider service networks~~ and 55 ~~50~~ percent in managed care plans is achieved. Once that ~~equal~~ enrollment is achieved, the assignments shall be divided in order to maintain an ~~equal~~ enrollment in MediPass and managed care plans which is in a 45 percent and 55 percent proportion, respectively. In geographic areas where the agency is contracting for the provision of comprehensive behavioral health services through a capitated prepaid arrangement, recipients who fail to make a choice shall be assigned equally to MediPass or a managed care plan. For purposes of this paragraph, when referring to assignment, the term "managed care plans" includes exclusive provider

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1 organizations, provider service networks, Children's Medical
2 Services network, minority physician networks, and pediatric
3 emergency department diversion programs authorized by this
4 chapter or the General Appropriations Act.When making
5 assignments, the agency shall take into account the following
6 criteria:
7 1. A managed care plan has sufficient network capacity
8 to meet the need of members.
9 2. The managed care plan or MediPass has previously
10 enrolled the recipient as a member, or one of the managed care
11 plan's primary care providers or MediPass providers has
12 previously provided health care to the recipient.
13 3. The agency has knowledge that the member has
14 previously expressed a preference for a particular managed
15 care plan or MediPass provider as indicated by Medicaid
16 fee-for-service claims data, but has failed to make a choice.
17 4. The managed care plan's or MediPass primary care
18 providers are geographically accessible to the recipient's
19 residence.
20 5. The agency has authority to make mandatory
21 assignments based on quality of service and performance of
22 managed care plans.
23 Section 29. Paragraph (l) is added to subsection (2)
24 of section 409.9122, Florida Statutes, to read:
25 409.9122 Mandatory Medicaid managed care enrollment;
26 programs and procedures.--
27 (2)
28 (l) Notwithstanding the provisions of chapter 287, the
29 agency may, at its discretion, renew cost-effective contracts
30 for choice counseling services once or more for such periods
31 as the agency may decide. However, all such renewals may not

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1 combine to exceed a total period longer than the term of the
2 original contract.
3 Section 30. Section 409.913, Florida Statutes, as
4 amended by section 12 of chapter 2001-377, Laws of Florida, is
5 amended to read:
6 409.913 Oversight of the integrity of the Medicaid
7 program.--The agency shall operate a program to oversee the
8 activities of Florida Medicaid recipients, and providers and
9 their representatives, to ensure that fraudulent and abusive
10 behavior and neglect of recipients occur to the minimum extent
11 possible, and to recover overpayments and impose sanctions as
12 appropriate. Beginning January 1, 2003, and each year
13 thereafter, the agency and the Medicaid Fraud Control Unit of
14 the Department of Legal Affairs shall submit a joint report to
15 the Legislature documenting the effectiveness of the state's
16 efforts to control Medicaid fraud and abuse and to recover
17 Medicaid overpayments during the previous fiscal year. The
18 report must describe the number of cases opened and
19 investigated each year; the sources of the cases opened; the
20 disposition of the cases closed each year; the amount of
21 overpayments alleged in preliminary and final audit letters;
22 the number and amount of fines or penalties imposed; any
23 reductions in overpayment amounts negotiated in settlement
24 agreements or by other means; the amount of final agency
25 determinations of overpayments; the amount deducted from
26 federal claiming as a result of overpayments; the amount of
27 overpayments recovered each year; the amount of cost of
28 investigation recovered each year; the average length of time
29 to collect from the time the case was opened until the
30 overpayment is paid in full; the amount determined as
31 uncollectible and the portion of the uncollectible amount

subsequently reclaimed from the Federal Government; the number of providers, by type, that are terminated from participation in the Medicaid program as a result of fraud and abuse; and all costs associated with discovering and prosecuting cases of Medicaid overpayments and making recoveries in such cases. The report must also document actions taken to prevent overpayments and the number of providers prevented from enrolling in or reenrolling in the Medicaid program as a result of documented Medicaid fraud and abuse and must recommend changes necessary to prevent or recover overpayments. For the 2001-2002 fiscal year, the agency shall prepare a report that contains as much of this information as is available to it.

(1) For the purposes of this section, the term:

(a) "Abuse" means:

1. Provider practices that are inconsistent with generally accepted business or medical practices and that result in an unnecessary cost to the Medicaid program or in reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for health care.

2. Recipient practices that result in unnecessary cost to the Medicaid program.

(b) "Complaint" means an allegation that fraud, abuse, or an overpayment has occurred.

(c)~~(b)~~ "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to herself or himself or another person. The term includes any act that constitutes fraud under applicable federal or state law.

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(d)~~(c)~~ "Medical necessity" or "medically necessary" means any goods or services necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice. For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. Determinations of medical necessity must be made by a licensed physician employed by or under contract with the agency and must be based upon information available at the time the goods or services are provided.

(e)~~(d)~~ "Overpayment" includes any amount that is not authorized to be paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake.

(f)~~(e)~~ "Person" means any natural person, corporation, partnership, association, clinic, group, or other entity, whether or not such person is enrolled in the Medicaid program or is a provider of health care.

(2) The agency shall conduct, or cause to be conducted by contract or otherwise, reviews, investigations, analyses, audits, or any combination thereof, to determine possible fraud, abuse, overpayment, or recipient neglect in the Medicaid program and shall report the findings of any overpayments in audit reports as appropriate.

(3) The agency may conduct, or may contract for, prepayment review of provider claims to ensure cost-effective purchasing, billing, and provision of care to Medicaid recipients. Such prepayment reviews may be conducted as

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determined appropriate by the agency, without any suspicion or allegation of fraud, abuse, or neglect.

(4) Any suspected criminal violation identified by the agency must be referred to the Medicaid Fraud Control Unit of the Office of the Attorney General for investigation. The agency and the Attorney General shall enter into a memorandum of understanding, which must include, but need not be limited to, a protocol for regularly sharing information and coordinating casework. The protocol must establish a procedure for the referral by the agency of cases involving suspected Medicaid fraud to the Medicaid Fraud Control Unit for investigation, and the return to the agency of those cases where investigation determines that administrative action by the agency is appropriate. Offices of the Medicaid program integrity program and the Medicaid Fraud Control Unit of the Department of Legal Affairs, shall, to the extent possible, be collocated. The agency and the Department of Legal Affairs shall periodically conduct joint training and other joint activities designed to increase communication and coordination in recovering overpayments.

(5) A Medicaid provider is subject to having goods and services that are paid for by the Medicaid program reviewed by an appropriate peer-review organization designated by the agency. The written findings of the applicable peer-review organization are admissible in any court or administrative proceeding as evidence of medical necessity or the lack thereof.

(6) Any notice required to be given to a provider under this section is presumed to be sufficient notice if sent to the address last shown on the provider enrollment file. It is the responsibility of the provider to furnish and keep the

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agency informed of the provider's current address. United States Postal Service proof of mailing or certified or registered mailing of such notice to the provider at the address shown on the provider enrollment file constitutes sufficient proof of notice. Any notice required to be given to the agency by this section must be sent to the agency at an address designated by rule.

(7) When presenting a claim for payment under the Medicaid program, a provider has an affirmative duty to supervise the provision of, and be responsible for, goods and services claimed to have been provided, to supervise and be responsible for preparation and submission of the claim, and to present a claim that is true and accurate and that is for goods and services that:

(a) Have actually been furnished to the recipient by the provider prior to submitting the claim.

(b) Are Medicaid-covered goods or services that are medically necessary.

(c) Are of a quality comparable to those furnished to the general public by the provider's peers.

(d) Have not been billed in whole or in part to a recipient or a recipient's responsible party, except for such copayments, coinsurance, or deductibles as are authorized by the agency.

(e) Are provided in accord with applicable provisions of all Medicaid rules, regulations, handbooks, and policies and in accordance with federal, state, and local law.

(f) Are documented by records made at the time the goods or services were provided, demonstrating the medical necessity for the goods or services rendered. Medicaid goods or services are excessive or not medically necessary unless

1 both the medical basis and the specific need for them are
2 fully and properly documented in the recipient's medical
3 record.
4 (8) A Medicaid provider shall retain medical,
5 professional, financial, and business records pertaining to
6 services and goods furnished to a Medicaid recipient and
7 billed to Medicaid for a period of 5 years after the date of
8 furnishing such services or goods. The agency may investigate,
9 review, or analyze such records, which must be made available
10 during normal business hours. However, 24-hour notice must be
11 provided if patient treatment would be disrupted. The provider
12 is responsible for furnishing to the agency, and keeping the
13 agency informed of the location of, the provider's
14 Medicaid-related records. The authority of the agency to
15 obtain Medicaid-related records from a provider is neither
16 curtailed nor limited during a period of litigation between
17 the agency and the provider.
18 (9) Payments for the services of billing agents or
19 persons participating in the preparation of a Medicaid claim
20 shall not be based on amounts for which they bill nor based on
21 the amount a provider receives from the Medicaid program.
22 (10) The agency may require repayment for
23 inappropriate, medically unnecessary, or excessive goods or
24 services from the person furnishing them, the person under
25 whose supervision they were furnished, or the person causing
26 them to be furnished.
27 (11) The complaint and all information obtained
28 pursuant to an investigation of a Medicaid provider, or the
29 authorized representative or agent of a provider, relating to
30 an allegation of fraud, abuse, or neglect are confidential and
31 exempt from the provisions of s. 119.07(1):

1 (a) Until the agency takes final agency action with
2 respect to the provider and requires repayment of any
3 overpayment, or imposes an administrative sanction;
4 (b) Until the Attorney General refers the case for
5 criminal prosecution;
6 (c) Until 10 days after the complaint is determined
7 without merit; or
8 (d) At all times if the complaint or information is
9 otherwise protected by law.
10 (12) The agency may terminate participation of a
11 Medicaid provider in the Medicaid program and may seek civil
12 remedies or impose other administrative sanctions against a
13 Medicaid provider, if the provider has been:
14 (a) Convicted of a criminal offense related to the
15 delivery of any health care goods or services, including the
16 performance of management or administrative functions relating
17 to the delivery of health care goods or services;
18 (b) Convicted of a criminal offense under federal law
19 or the law of any state relating to the practice of the
20 provider's profession; or
21 (c) Found by a court of competent jurisdiction to have
22 neglected or physically abused a patient in connection with
23 the delivery of health care goods or services.
24 (13) If the provider has been suspended or terminated
25 from participation in the Medicaid program or the Medicare
26 program by the Federal Government or any state, the agency
27 must immediately suspend or terminate, as appropriate, the
28 provider's participation in the Florida Medicaid program for a
29 period no less than that imposed by the Federal Government or
30 any other state, and may not enroll such provider in the
31 Florida Medicaid program while such foreign suspension or

1 termination remains in effect. This sanction is in addition
2 to all other remedies provided by law.
3 (14) The agency may seek any remedy provided by law,
4 including, but not limited to, the remedies provided in
5 subsections (12) and (15) and s. 812.035, if:
6 (a) The provider's license has not been renewed, or
7 has been revoked, suspended, or terminated, for cause, by the
8 licensing agency of any state;
9 (b) The provider has failed to make available or has
10 refused access to Medicaid-related records to an auditor,
11 investigator, or other authorized employee or agent of the
12 agency, the Attorney General, a state attorney, or the Federal
13 Government;
14 (c) The provider has not furnished or has failed to
15 make available such Medicaid-related records as the agency has
16 found necessary to determine whether Medicaid payments are or
17 were due and the amounts thereof;
18 (d) The provider has failed to maintain medical
19 records made at the time of service, or prior to service if
20 prior authorization is required, demonstrating the necessity
21 and appropriateness of the goods or services rendered;
22 (e) The provider is not in compliance with provisions
23 of Medicaid provider publications that have been adopted by
24 reference as rules in the Florida Administrative Code; with
25 provisions of state or federal laws, rules, or regulations;
26 with provisions of the provider agreement between the agency
27 and the provider; or with certifications found on claim forms
28 or on transmittal forms for electronically submitted claims
29 that are submitted by the provider or authorized
30 representative, as such provisions apply to the Medicaid
31 program;

1 (f) The provider or person who ordered or prescribed
2 the care, services, or supplies has furnished, or ordered the
3 furnishing of, goods or services to a recipient which are
4 inappropriate, unnecessary, excessive, or harmful to the
5 recipient or are of inferior quality;
6 (g) The provider has demonstrated a pattern of failure
7 to provide goods or services that are medically necessary;
8 (h) The provider or an authorized representative of
9 the provider, or a person who ordered or prescribed the goods
10 or services, has submitted or caused to be submitted false or
11 a pattern of erroneous Medicaid claims that have resulted in
12 overpayments to a provider or that exceed those to which the
13 provider was entitled under the Medicaid program;
14 (i) The provider or an authorized representative of
15 the provider, or a person who has ordered or prescribed the
16 goods or services, has submitted or caused to be submitted a
17 Medicaid provider enrollment application, a request for prior
18 authorization for Medicaid services, a drug exception request,
19 or a Medicaid cost report that contains materially false or
20 incorrect information;
21 (j) The provider or an authorized representative of
22 the provider has collected from or billed a recipient or a
23 recipient's responsible party improperly for amounts that
24 should not have been so collected or billed by reason of the
25 provider's billing the Medicaid program for the same service;
26 (k) The provider or an authorized representative of
27 the provider has included in a cost report costs that are not
28 allowable under a Florida Title XIX reimbursement plan, after
29 the provider or authorized representative had been advised in
30 an audit exit conference or audit report that the costs were
31 not allowable;

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(l) The provider is charged by information or indictment with fraudulent billing practices. The sanction applied for this reason is limited to suspension of the provider's participation in the Medicaid program for the duration of the indictment unless the provider is found guilty pursuant to the information or indictment;

(m) The provider or a person who has ordered, or prescribed the goods or services is found liable for negligent practice resulting in death or injury to the provider's patient;

(n) The provider fails to demonstrate that it had available during a specific audit or review period sufficient quantities of goods, or sufficient time in the case of services, to support the provider's billings to the Medicaid program;

(o) The provider has failed to comply with the notice and reporting requirements of s. 409.907; ~~or~~

(p) The agency has received reliable information of patient abuse or neglect or of any act prohibited by s. 409.920; or~~.~~

(q) The provider has failed to comply with an agreed-upon repayment schedule.

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

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

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

(c) Imposition of a fine of up to $5,000 for each violation. Each day that an ongoing violation continues, such

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1 as refusing to furnish Medicaid-related records or refusing
2 access to records, is considered, for the purposes of this
3 section, to be a separate violation. Each instance of
4 improper billing of a Medicaid recipient; each instance of
5 including an unallowable cost on a hospital or nursing home
6 Medicaid cost report after the provider or authorized
7 representative has been advised in an audit exit conference or
8 previous audit report of the cost unallowability; each
9 instance of furnishing a Medicaid recipient goods or
10 professional services that are inappropriate or of inferior
11 quality as determined by competent peer judgment; each
12 instance of knowingly submitting a materially false or
13 erroneous Medicaid provider enrollment application, request
14 for prior authorization for Medicaid services, drug exception
15 request, or cost report; each instance of inappropriate
16 prescribing of drugs for a Medicaid recipient as determined by
17 competent peer judgment; and each false or erroneous Medicaid
18 claim leading to an overpayment to a provider is considered,
19 for the purposes of this section, to be a separate violation.
20 (d) Immediate suspension, if the agency has received
21 information of patient abuse or neglect or of any act
22 prohibited by s. 409.920. Upon suspension, the agency must
23 issue an immediate final order under s. 120.569(2)(n).
24 (e) A fine, not to exceed $10,000, for a violation of
25 paragraph (14)(i).
26 (f) Imposition of liens against provider assets,
27 including, but not limited to, financial assets and real
28 property, not to exceed the amount of fines or recoveries
29 sought, upon entry of an order determining that such moneys
30 are due or recoverable.
31

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(g) Prepayment reviews of claims for a specified period of time.

(h) Comprehensive follow-up reviews of providers every 6 months to ensure that they are billing Medicaid correctly.

(i) Corrective-action plans that would remain in effect for providers for up to 3 years and that would be monitored by the agency every 6 months while in effect.

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

The Secretary of Health Care Administration may make a determination that imposition of a sanction or disincentive is not in the best interest of the Medicaid program, in which case a sanction or disincentive shall not be imposed.

(16) In determining the appropriate administrative sanction to be applied, or the duration of any suspension or termination, the agency shall consider:

(a) The seriousness and extent of the violation or violations.

(b) Any prior history of violations by the provider relating to the delivery of health care programs which resulted in either a criminal conviction or in administrative sanction or penalty.

(c) Evidence of continued violation within the provider's management control of Medicaid statutes, rules, regulations, or policies after written notification to the provider of improper practice or instance of violation.

(d) The effect, if any, on the quality of medical care provided to Medicaid recipients as a result of the acts of the provider.

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(e) Any action by a licensing agency respecting the provider in any state in which the provider operates or has operated.

(f) The apparent impact on access by recipients to Medicaid services if the provider is suspended or terminated, in the best judgment of the agency.

The agency shall document the basis for all sanctioning actions and recommendations.

(17) The agency may take action to sanction, suspend, or terminate a particular provider working for a group provider, and may suspend or terminate Medicaid participation at a specific location, rather than or in addition to taking action against an entire group.

(18) The agency shall establish a process for conducting followup reviews of a sampling of providers who have a history of overpayment under the Medicaid program. This process must consider the magnitude of previous fraud or abuse and the potential effect of continued fraud or abuse on Medicaid costs.

(19) In making a determination of overpayment to a provider, the agency must use accepted and valid auditing, accounting, analytical, statistical, or peer-review methods, or combinations thereof. Appropriate statistical methods may include, but are not limited to, sampling and extension to the population, parametric and nonparametric statistics, tests of hypotheses, and other generally accepted statistical methods. Appropriate analytical methods may include, but are not limited to, reviews to determine variances between the quantities of products that a provider had on hand and available to be purveyed to Medicaid recipients during the

review period and the quantities of the same products paid for by the Medicaid program for the same period, taking into appropriate consideration sales of the same products to non-Medicaid customers during the same period. In meeting its burden of proof in any administrative or court proceeding, the agency may introduce the results of such statistical methods as evidence of overpayment.

(20) When making a determination that an overpayment has occurred, the agency shall prepare and issue an audit report to the provider showing the calculation of overpayments.

(21) The audit report, supported by agency work papers, showing an overpayment to a provider constitutes evidence of the overpayment. A provider may not present or elicit testimony, either on direct examination or cross-examination in any court or administrative proceeding, regarding the purchase or acquisition by any means of drugs, goods, or supplies; sales or divestment by any means of drugs, goods, or supplies; or inventory of drugs, goods, or supplies, unless such acquisition, sales, divestment, or inventory is documented by written invoices, written inventory records, or other competent written documentary evidence maintained in the normal course of the provider's business. Notwithstanding the applicable rules of discovery, all documentation that will be offered as evidence at an administrative hearing on a Medicaid overpayment must be exchanged by all parties at least 14 days before the administrative hearing or must be excluded from consideration.

(22)(a) In an audit or investigation of a violation committed by a provider which is conducted pursuant to this section, the agency is entitled to recover all investigative,

legal, and expert witness costs if the agency's findings were not contested by the provider or, if contested, the agency ultimately prevailed.

(b) The agency has the burden of documenting the costs, which include salaries and employee benefits and out-of-pocket expenses. The amount of costs that may be recovered must be reasonable in relation to the seriousness of the violation and must be set taking into consideration the financial resources, earning ability, and needs of the provider, who has the burden of demonstrating such factors.

(c) The provider may pay the costs over a period to be determined by the agency if the agency determines that an extreme hardship would result to the provider from immediate full payment. Any default in payment of costs may be collected by any means authorized by law.

(23) If the agency imposes an administrative sanction under this section upon any provider or other person who is regulated by another state entity, the agency shall notify that other entity of the imposition of the sanction. Such notification must include the provider's or person's name and license number and the specific reasons for sanction.

(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, 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.

(b) Overpayments owed to the agency bear interest at the rate of 10 percent per year from the date of determination of the overpayment by the agency, and payment arrangements must be made at the conclusion of legal proceedings. A provider who does not enter into or adhere to an agreed-upon repayment schedule may be terminated by the agency for nonpayment or partial payment.

(c) The agency, upon entry of a final agency order, a judgment or order of a court of competent jurisdiction, or a stipulation or settlement, may collect the moneys owed by all means allowable by law, including, but not limited to, notifying any fiscal intermediary of Medicare benefits that the state has a superior right of payment. Upon receipt of such written notification, the Medicare fiscal intermediary shall remit to the state the sum claimed.

(25) The agency may impose administrative sanctions against a Medicaid recipient, or the agency may seek any other remedy provided by law, including, but not limited to, the remedies provided in s. 812.035, if the agency finds that a recipient has engaged in solicitation in violation of s. 409.920 or that the recipient has otherwise abused the Medicaid program.

(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:

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(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 as the overpayment is recovered, unless within 30 days after receiving notice thereof the provider:

1. Makes repayment in full; or

2. Establishes a repayment plan that is satisfactory to the Agency for Health Care Administration.

(b) Withhold, and continue to withhold during the pendency of an administrative hearing pursuant to chapter 120, medical assistance reimbursement payments if the terms of a repayment plan are not adhered to by the provider.

~~If a provider requests an administrative hearing pursuant to chapter 120, such hearing must be conducted within 90 days following receipt by the provider of the final audit report, absent exceptionally good cause shown as determined by the administrative law judge or hearing officer. Upon issuance of a final order, the balance outstanding of the amount determined to constitute the overpayment shall become due. Any withholding of payments by the Agency for Health Care Administration pursuant to this section shall be limited so that the monthly medical assistance payment is not reduced by more than 10 percent.~~

(27) Venue for all Medicaid program integrity overpayment cases shall lie in Leon County, at the discretion of the agency.

(28) Notwithstanding other provisions of law, the agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs may review a provider's Medicaid-related records in order to determine the total output of a provider's

practice to reconcile quantities of goods or services billed to Medicaid against quantities of goods or services used in the provider's total practice.

(29) The agency may terminate a provider's participation in the Medicaid program if the provider fails to reimburse an overpayment that has been determined by final order, not subject to further appeal, within 35 days after the date of the final order, unless the provider and the agency have entered into a repayment agreement.

(30) If a provider requests an administrative hearing pursuant to chapter 120, such hearing must be conducted within 90 days following assignment of an administrative law judge, absent exceptionally good cause shown as determined by the administrative law judge or hearing officer. Upon issuance of a final order, the outstanding balance of the amount determined to constitute the overpayment shall become due. If a provider fails to make payments in full, fails to enter into a satisfactory repayment plan, or fails to comply with the terms of a repayment plan or settlement agreement, the agency may withhold medical assistance reimbursement payments until the amount due is paid in full.

(31) Duly authorized agents and employees of the agency shall have the power to inspect, during normal business hours, the records of any pharmacy, wholesale establishment, or manufacturer, or any other place in which drugs and medical supplies are manufactured, packed, packaged, made, stored, sold, or kept for sale, for the purpose of verifying the amount of drugs and medical supplies ordered, delivered, or purchased by a provider. The agency shall provide at least 2 business days' prior notice of any such inspection. The notice must identify the provider whose records will be inspected,

1 and the inspection shall include only records specifically
2 related to that provider.
3 Section 31. Subsections (7) and (8) of section
4 409.920, Florida Statutes, are amended to read:
5 409.920 Medicaid provider fraud.--
6 (7) The Attorney General shall conduct a statewide
7 program of Medicaid fraud control. To accomplish this purpose,
8 the Attorney General shall:
9 (a) Investigate the possible criminal violation of any
10 applicable state law pertaining to fraud in the administration
11 of the Medicaid program, in the provision of medical
12 assistance, or in the activities of providers of health care
13 under the Medicaid program.
14 (b) Investigate the alleged abuse or neglect of
15 patients in health care facilities receiving payments under
16 the Medicaid program, in coordination with the agency.
17 (c) Investigate the alleged misappropriation of
18 patients' private funds in health care facilities receiving
19 payments under the Medicaid program.
20 (d) Refer to the Office of Statewide Prosecution or
21 the appropriate state attorney all violations indicating a
22 substantial potential for criminal prosecution.
23 (e) Refer to the agency all suspected abusive
24 activities not of a criminal or fraudulent nature.
25 ~~(f) Refer to the agency for collection each instance~~
26 ~~of overpayment to a provider of health care under the Medicaid~~
27 ~~program which is discovered during the course of an~~
28 ~~investigation.~~
29 (f)~~(g)~~ Safeguard the privacy rights of all individuals
30 and provide safeguards to prevent the use of patient medical
31 records for any reason beyond the scope of a specific

1 investigation for fraud or abuse, or both, without the
2 patient's written consent.
3 (g) Publicize to state employees and the public the
4 ability of persons to bring suit under the provisions of the
5 Florida False Claims Act and the potential for the persons
6 bringing a civil action under the Florida False Claims Act to
7 obtain a monetary award.
8 (8) In carrying out the duties and responsibilities
9 under this section ~~subsection~~, the Attorney General may:
10 (a) Enter upon the premises of any health care
11 provider, excluding a physician, participating in the Medicaid
12 program to examine all accounts and records that may, in any
13 manner, be relevant in determining the existence of fraud in
14 the Medicaid program, to investigate alleged abuse or neglect
15 of patients, or to investigate alleged misappropriation of
16 patients' private funds. A participating physician is required
17 to make available any accounts or records that may, in any
18 manner, be relevant in determining the existence of fraud in
19 the Medicaid program. The accounts or records of a
20 non-Medicaid patient may not be reviewed by, or turned over
21 to, the Attorney General without the patient's written
22 consent.
23 (b) Subpoena witnesses or materials, including medical
24 records relating to Medicaid recipients, within or outside the
25 state and, through any duly designated employee, administer
26 oaths and affirmations and collect evidence for possible use
27 in either civil or criminal judicial proceedings.
28 (c) Request and receive the assistance of any state
29 attorney or law enforcement agency in the investigation and
30 prosecution of any violation of this section.
31

(d) Seek any civil remedy provided by law, including, but not limited to, the remedies provided in ss. 68.081-68.092, s. 812.035, and this chapter.

(e) Refer to the agency for collection each instance of overpayment to a provider of health care under the Medicaid program which is discovered during the course of an investigation.

Section 32. Section 624.91, Florida Statutes, is amended to read:

624.91 The Florida Healthy Kids Corporation Act.--

(1) SHORT TITLE.--This section may be cited as the "William G. 'Doc' Myers Healthy Kids Corporation Act."

(2) LEGISLATIVE INTENT.--

(a) The Legislature finds that increased access to health care services could improve children's health and reduce the incidence and costs of childhood illness and disabilities among children in this state. Many children do not have comprehensive, affordable health care services available. It is the intent of the Legislature that the Florida Healthy Kids Corporation provide comprehensive health insurance coverage to such children. The corporation is encouraged to cooperate with any existing health service programs funded by the public or the private sector and to work cooperatively with the Florida Partnership for School Readiness.

(b) It is the intent of the Legislature that the Florida Healthy Kids Corporation serve as one of several providers of services to children eligible for medical assistance under Title XXI of the Social Security Act. Although the corporation may serve other children, the Legislature intends the primary recipients of services

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provided through the corporation be school-age children with a family income below 200 percent of the federal poverty level, who do not qualify for Medicaid. It is also the intent of the Legislature that state and local government Florida Healthy Kids funds, ~~to the extent permissible under federal law,~~be used to continue and expand coverage, within available appropriations, to children not eligible for federal matching funds under Title XXI ~~obtain matching federal dollars~~.

(3) NONENTITLEMENT.--Nothing in this section shall be construed as providing an individual with an entitlement to health care services. No cause of action shall arise against the state, the Florida Healthy Kids Corporation, or a unit of local government for failure to make health services available under this section.

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

(a) There is created the Florida Healthy Kids Corporation, a not-for-profit corporation ~~which operates on sites designated by the corporation~~.

(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. Arrange for the collection of any voluntary contributions to provide for payment of premiums for children who are not eligible for medical assistance under Title XXI of

the Social Security Act. Each fiscal year, the corporation shall establish a local match policy for the enrollment of non-Title-XXI-eligible children in the Healthy Kids program. By May 1 of each year, the corporation shall provide written notification of the amount to be remitted to the corporation for the following fiscal year under that policy. Local match sources may include, but are not limited to, funds provided by municipalities, counties, school boards, hospitals, health care providers, charitable organizations, special taxing districts, and private organizations. The minimum local match cash contributions required each fiscal year and local match credits shall be determined by the General Appropriations Act. The corporation shall calculate a county's local match rate based upon that county's percentage of the state's total non-Title-XXI expenditures as reported in the corporation's most recently audited financial statement. In awarding the local match credits, the corporation may consider factors including, but not limited to, population density, per-capita income, and existing child-health-related expenditures and services;

4. Accept voluntary supplemental local match contributions that comply with the requirements of Title XXI of the Social Security Act for the purpose of providing additional coverage in contributing counties under Title XXI;

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

6.~~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;

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

8.~~6.~~ Establish procedures under which providers of local match to, applicants to and participants in the program may have grievances reviewed by an impartial body and reported to the board of directors of the corporation;

9.~~7.~~ Establish participation criteria and, if appropriate, contract with an authorized insurer, health maintenance organization, or insurance administrator to provide administrative services to the corporation;

10.~~8.~~ Establish enrollment criteria which shall include penalties or waiting periods of not fewer than 60 days for reinstatement of coverage upon voluntary cancellation for nonpayment of family premiums;

11.~~9.~~ If a space is available, establish a special open enrollment period of 30 days' duration for any child who is enrolled in Medicaid or Medikids if such child loses Medicaid or Medikids eligibility and becomes eligible for the Florida Healthy Kids program;

12.~~10.~~ Contract with authorized insurers or any provider of health care services, meeting standards established by the corporation, for the provision of comprehensive insurance coverage to participants. Such standards shall include criteria under which the corporation may contract with more than one provider of health care services in program sites. Health plans shall be selected through a competitive bid process. The selection of health plans shall be based primarily on quality criteria established by the board. The health plan selection criteria and scoring

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system, and the scoring results, shall be available upon request for inspection after the bids have been awarded;

13. Establish disenrollment criteria in the event local matching funds are insufficient to cover enrollments;

14.~~11.~~ Develop and implement a plan to publicize the Florida Healthy Kids Corporation, the eligibility requirements of the program, and the procedures for enrollment in the program and to maintain public awareness of the corporation and the program;

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

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

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

18.~~15.~~ Each fiscal year, establish a maximum number of participants ~~by county~~, on a statewide basis, who may enroll in the program ~~without the benefit of local matching funds. Thereafter, the corporation may establish local matching requirements for supplemental participation in the program. The corporation may vary local matching requirements and enrollment by county depending on factors which may influence~~

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~~the generation of local match, including, but not limited to, population density, per capita income, existing local tax effort, and other factors. The corporation also may accept in-kind match in lieu of cash for the local match requirement to the extent allowed by Title XXI of the Social Security Act~~; and

19.~~16.~~ Establish eligibility criteria, premium and cost-sharing requirements, and benefit packages which conform to the provisions of the Florida Kidcare program, as created in ss. 409.810-409.820.

(c) Coverage under the corporation's program is secondary to any other available private coverage held by the participant child or family member. The corporation may establish procedures for coordinating benefits under this program with benefits under other public and private coverage.

(d) The Florida Healthy Kids Corporation shall be a private corporation not for profit, organized pursuant to chapter 617, and shall have all powers necessary to carry out the purposes of this act, including, but not limited to, the power to receive and accept grants, loans, or advances of funds from any public or private agency and to receive and accept from any source contributions of money, property, labor, or any other thing of value, to be held, used, and applied for the purposes of this act.

(5) BOARD OF DIRECTORS.--

(a) The Florida Healthy Kids Corporation shall operate subject to the supervision and approval of a board of directors chaired by the Insurance Commissioner or her or his designee, and composed of 14 ~~12~~ other members selected for 3-year terms of office as follows:

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1. One member appointed by the Commissioner of Education from among three persons nominated by the Florida Association of School Administrators;

2. One member appointed by the Commissioner of Education from among three persons nominated by the Florida Association of School Boards;

3. One member appointed by the Commissioner of Education from the Office of School Health Programs of the Florida Department of Education;

4. One member appointed by the Governor from among three members nominated by the Florida Pediatric Society;

5. One member, appointed by the Governor, who represents the Children's Medical Services Program;

6. One member appointed by the Insurance Commissioner from among three members nominated by the Florida Hospital Association;

7. Two members, appointed by the Insurance Commissioner, who are representatives of authorized health care insurers or health maintenance organizations;

8. One member, appointed by the Insurance Commissioner, who represents the Institute for Child Health Policy;

9. One member, appointed by the Governor, from among three members nominated by the Florida Academy of Family Physicians;

10. One member, appointed by the Governor, who represents the Agency for Health Care Administration; ~~and~~

11. The State Health Officer or her or his designee;~~.~~

12. One member, appointed by the Insurance Commissioner from among three members nominated by the Florida Association of Counties, representing rural counties; and

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1 13. One member, appointed by the Governor from among
2 three members nominated by the Florida Association of
3 Counties, representing urban counties.
4 (b) A member of the board of directors may be removed
5 by the official who appointed that member. The board shall
6 appoint an executive director, who is responsible for other
7 staff authorized by the board.
8 (c) Board members are entitled to receive, from funds
9 of the corporation, reimbursement for per diem and travel
10 expenses as provided by s. 112.061.
11 (d) There shall be no liability on the part of, and no
12 cause of action shall arise against, any member of the board
13 of directors, or its employees or agents, for any action they
14 take in the performance of their powers and duties under this
15 act.
16 (6) LICENSING NOT REQUIRED; FISCAL OPERATION.--
17 (a) The corporation shall not be deemed an insurer.
18 The officers, directors, and employees of the corporation
19 shall not be deemed to be agents of an insurer. Neither the
20 corporation nor any officer, director, or employee of the
21 corporation is subject to the licensing requirements of the
22 insurance code or the rules of the Department of Insurance.
23 However, any marketing representative utilized and compensated
24 by the corporation must be appointed as a representative of
25 the insurers or health services providers with which the
26 corporation contracts.
27 (b) The board has complete fiscal control over the
28 corporation and is responsible for all corporate operations.
29 (c) The Department of Insurance shall supervise any
30 liquidation or dissolution of the corporation and shall have,
31

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1 with respect to such liquidation or dissolution, all power
2 granted to it pursuant to the insurance code.
3 (7) ACCESS TO RECORDS; CONFIDENTIALITY;
4 PENALTIES.--Notwithstanding any other laws to the contrary,
5 the Florida Healthy Kids Corporation shall have access to the
6 medical records of a student upon receipt of permission from a
7 parent or guardian of the student. Such medical records may
8 be maintained by state and local agencies. Any identifying
9 information, including medical records and family financial
10 information, obtained by the corporation pursuant to this
11 subsection is confidential and is exempt from the provisions
12 of s. 119.07(1). Neither the corporation nor the staff or
13 agents of the corporation may release, without the written
14 consent of the participant or the parent or guardian of the
15 participant, to any state or federal agency, to any private
16 business or person, or to any other entity, any confidential
17 information received pursuant to this subsection. A violation
18 of this subsection is a misdemeanor of the second degree,
19 punishable as provided in s. 775.082 or s. 775.083.
20 Section 33. Paragraph (a) of subsection (2) of section
21 627.6425, Florida Statutes, is amended to read:
22 627.6425 Renewability of individual coverage.--
23 (2) An insurer may nonrenew or discontinue health
24 insurance coverage of an individual in the individual market
25 based only on one or more of the following:
26 (a) The individual has failed to pay premiums, ~~or~~
27 contributions, or a required copayment payable to the insurer
28 in accordance with the terms of the health insurance coverage
29 or the insurer has not received timely premium payments. When
30 the copayment is payable to the insurer and exceeds $300, the
31 insurer shall allow the insured up to 90 days after the date

1 of the procedure to pay the required copayment. The insurer
2 shall print in 10-point type on the Declaration of Benefits
3 page notification that the insured could be terminated for
4 failure to make any required copayment to the insurer.
5 Section 34. Subsection (2) of section 766.110, Florida
6 Statutes, is amended to read:
7 766.110 Liability of health care facilities.--
8 (2) Every hospital licensed under chapter 395 may
9 carry liability insurance or adequately insure itself in an
10 amount of not less than $1.5 million per claim, $5 million
11 annual aggregate to cover all medical injuries to patients
12 resulting from negligent acts or omissions on the part of
13 those members of its medical staff who are covered thereby in
14 furtherance of the requirements of ss. 458.320 and 459.0085.
15 Self-insurance coverage extended hereunder to a member of a
16 hospital's medical staff meets the financial responsibility
17 requirements of ss. 458.320 and 459.0085 if the physician's
18 coverage limits are not less than the minimum limits
19 established in ss. 458.320 and 459.0085 and the hospital is a
20 verified trauma center as of July 1, 1990, that has extended
21 self-insurance coverage continuously to members of its medical
22 staff for activities both inside and outside of the hospital
23 since January 1, 1987. Any insurer authorized to write
24 casualty insurance may make available, but shall not be
25 required to write, such coverage. The hospital may assess on
26 an equitable and pro rata basis the following professional
27 health care providers for a portion of the total hospital
28 insurance cost for this coverage: physicians licensed under
29 chapter 458, osteopathic physicians licensed under chapter
30 459, podiatric physicians licensed under chapter 461, dentists
31 licensed under chapter 466, and nurses licensed under part I

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1 of chapter 464. The hospital may provide for a deductible
2 amount to be applied against any individual health care
3 provider found liable in a law suit in tort or for breach of
4 contract. The legislative intent in providing for the
5 deductible to be applied to individual health care providers
6 found negligent or in breach of contract is to instill in each
7 individual health care provider the incentive to avoid the
8 risk of injury to the fullest extent and ensure that the
9 citizens of this state receive the highest quality health care
10 obtainable.
11 Section 35. Paragraph (e) of subsection (8) and
12 subsection (28) of section 393.063, Florida Statutes, are
13 amended to read:
14 393.063 Definitions.--For the purposes of this
15 chapter:
16 (8) "Comprehensive transitional education program"
17 means a group of jointly operating centers or units, the
18 collective purpose of which is to provide a sequential series
19 of educational care, training, treatment, habilitation, and
20 rehabilitation services to persons who have developmental
21 disabilities, as defined in subsection (12), and who have
22 severe or moderate maladaptive behaviors. However, nothing in
23 this subsection shall require comprehensive transitional
24 education programs to provide services only to persons with
25 developmental disabilities, as defined in subsection (12).
26 All such services shall be temporary in nature and delivered
27 in a structured residential setting with the primary goal of
28 incorporating the normalization principle to establish
29 permanent residence for persons with maladaptive behaviors in
30 facilities not associated with the comprehensive transitional
31 education program. The staff shall include psychologists and

teachers, and such staff personnel shall be available to provide services in each component center or unit of the program. The psychologists shall be individuals who are licensed in this state and certified as behavior analysts in this state, or individuals who meet the professional requirements established by the department for district behavior analysts and are certified as behavior analysts in this state.

(e) This subsection shall authorize licensure for comprehensive transitional education programs which by July 1, 1989:

1. Are in actual operation; or

2. Own a fee simple interest in real property for which a county or city government has approved zoning allowing for the placement of the facilities described in this subsection, and have registered an intent with the department to operate a comprehensive transitional education program. However, nothing shall prohibit the assignment by such a registrant to another entity at a different site within the state, so long as there is compliance with all criteria of the comprehensive transitional education program and local zoning requirements and provided that each residential facility within the component centers or units of the program authorized under this subparagraph shall not exceed a capacity of 15 persons.

(28) "Intermediate care facility for the developmentally disabled" or "ICF/DD" means a ~~state-owned-and-operated~~ residential facility licensed and certified in accordance with state law, and certified by the Federal Government pursuant to the Social Security Act, as a provider of Medicaid services to persons who are

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<u>developmentally disabled</u> ~~mentally retarded or who have related conditions~~. The capacity of such a facility shall not be more than 120 clients.

Section 36. Section 400.965, Florida Statutes, is amended to read:

400.965 Action by agency against licensee; grounds.--

(1) Any of the following conditions constitute grounds for action by the agency against a licensee:

(a) A misrepresentation of a material fact in the application;

(b) The commission of an intentional or negligent act materially affecting the health or safety of residents of the facility;

(c) A violation of any provision of this part or rules adopted under this part; or

(d) The commission of any act constituting a ground upon which application for a license may be denied.

(2) If the agency has a reasonable belief that any of such conditions exists, it shall:

(a) In the case of an applicant for original licensure, deny the application.

(b) In the case of an applicant for relicensure or a current licensee, take administrative action as provided in s. 400.968 <u>or s. 400.969</u> or injunctive action as authorized by s. 400.963.

(c) In the case of a facility operating without a license, take injunctive action as authorized in s. 400.963.

Section 37. Subsection (4) of section 400.968, Florida Statutes, is renumbered as section 400.969, Florida Statutes, and amended to read:

<u>400.969 Violation of part; penalties.--</u>

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(1)~~(4)(a)~~ Except as provided in s. 400.967(3), a violation of any provision of this part ~~section~~ or rules adopted by the agency under this part ~~section~~ is punishable by payment of an administrative or civil penalty not to exceed $5,000.

(2)~~(b)~~ A violation of this part ~~section~~ or of rules adopted under this part ~~section~~ is a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083. Each day of a continuing violation is a separate offense.

Section 38. Paragraph (a) of subsection (1) of section 499.012, Florida Statutes, is amended to read:

499.012 Wholesale distribution; definitions; permits; general requirements.--

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

(a) "Wholesale distribution" means distribution of prescription drugs to persons other than a consumer or patient, but does not include:

1. Any of the following activities, which is not a violation of s. 499.005(21) if such activity is conducted in accordance with s. 499.014:

a. The purchase or other acquisition by a hospital or other health care entity that is a member of a group purchasing organization of a prescription drug for its own use from the group purchasing organization or from other hospitals or health care entities that are members of that organization.

b. The sale, purchase, or trade of a prescription drug or an offer to sell, purchase, or trade a prescription drug by a charitable organization described in s. 501(c)(3) of the Internal Revenue Code of 1986, as amended and revised, to a nonprofit affiliate of the organization to the extent otherwise permitted by law.

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1 c. The sale, purchase, or trade of a prescription drug
2 or an offer to sell, purchase, or trade a prescription drug
3 among hospitals or other health care entities that are under
4 common control. For purposes of this section, "common control"
5 means the power to direct or cause the direction of the
6 management and policies of a person or an organization,
7 whether by ownership of stock, by voting rights, by contract,
8 or otherwise.
9 d. The sale, purchase, trade, or other transfer of a
10 prescription drug from or for any federal, state, or local
11 government agency or any entity eligible to purchase
12 prescription drugs at public health services prices pursuant
13 to Pub. L. No. 102-585, s. 602 to a contract provider or its
14 subcontractor for eligible patients of the agency or entity
15 under the following conditions:
16 (I) The agency or entity must obtain written
17 authorization for the sale, purchase, trade, or other transfer
18 of a prescription drug under this sub-subparagraph from the
19 Secretary of Health or his or her designee.
20 (II) The contract provider or subcontractor must be
21 authorized by law to administer or dispense prescription
22 drugs.
23 (III) In the case of a subcontractor, the agency or
24 entity must be a party to and execute the subcontract.
25 (IV) A contract provider or subcontractor must
26 maintain separate and apart from other prescription drug
27 inventory any prescription drugs of the agency or entity in
28 its possession.
29 (V) The contract provider and subcontractor must
30 maintain and produce immediately for inspection all records of
31 movement or transfer of all the prescription drugs belonging

to the agency or entity, including, but not limited to, the records of receipt and disposition of prescription drugs. Each contractor and subcontractor dispensing or administering these drugs must maintain and produce records documenting the dispensing or administration. Records that are required to be maintained include, but are not limited to, a perpetual inventory itemizing drugs received and drugs dispensed by prescription number or administered by patient identifier, which must be submitted to the agency or entity quarterly.

(VI) The contract provider or subcontractor may administer or dispense the prescription drugs only to the eligible patients of the agency or entity or must return the prescription drugs for or to the agency or entity. The contract provider or subcontractor must require proof from each person seeking to fill a prescription or obtain treatment that the person is an eligible patient of the agency or entity and must, at a minimum, maintain a copy of this proof as part of the records of the contractor or subcontractor required under sub-sub-subparagraph (V).

~~(VII) The prescription drugs transferred pursuant to this sub-subparagraph may not be billed to Medicaid.~~

<u>(VII)</u>~~(VIII)~~ In addition to the departmental inspection authority set forth in s. 499.051, the establishment of the contract provider and subcontractor and all records pertaining to prescription drugs subject to this sub-subparagraph shall be subject to inspection by the agency or entity. All records relating to prescription drugs of a manufacturer under this sub-subparagraph shall be subject to audit by the manufacturer of those drugs, without identifying individual patient information.

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2. Any of the following activities, which is not a violation of s. 499.005(21) if such activity is conducted in accordance with rules established by the department:

a. The sale, purchase, or trade of a prescription drug among federal, state, or local government health care entities that are under common control and are authorized to purchase such prescription drug.

b. The sale, purchase, or trade of a prescription drug or an offer to sell, purchase, or trade a prescription drug for emergency medical reasons. For purposes of this sub-subparagraph, the term "emergency medical reasons" includes transfers of prescription drugs by a retail pharmacy to another retail pharmacy to alleviate a temporary shortage.

c. The transfer of a prescription drug acquired by a medical director on behalf of a licensed emergency medical services provider to that emergency medical services provider and its transport vehicles for use in accordance with the provider's license under chapter 401.

d. The revocation of a sale or the return of a prescription drug to the person's prescription drug wholesale supplier.

e. The donation of a prescription drug by a health care entity to a charitable organization that has been granted an exemption under s. 501(c)(3) of the Internal Revenue Code of 1986, as amended, and that is authorized to possess prescription drugs.

f. The transfer of a prescription drug by a person authorized to purchase or receive prescription drugs to a person licensed or permitted to handle reverse distributions or destruction under the laws of the jurisdiction in which the

1 person handling the reverse distribution or destruction
2 receives the drug.
3 3. The distribution of prescription drug samples by
4 manufacturers' representatives or distributors'
5 representatives conducted in accordance with s. 499.028.
6 4. The sale, purchase, or trade of blood and blood
7 components intended for transfusion. As used in this
8 subparagraph, the term "blood" means whole blood collected
9 from a single donor and processed either for transfusion or
10 further manufacturing, and the term "blood components" means
11 that part of the blood separated by physical or mechanical
12 means.
13 5. The lawful dispensing of a prescription drug in
14 accordance with chapter 465.
15 Section 39. The Legislature finds that the home and
16 community-based services delivery system for persons with
17 developmental disabilities and the availability of
18 appropriated funds are two of the critical elements in making
19 services available. Therefore, it is the intent of the
20 Legislature that the Department of Children and Family
21 Services shall develop and implement a comprehensive redesign
22 of the system. The redesign shall include, at a minimum, all
23 actions necessary to achieve an appropriate rate structure,
24 client choice within a specified service package, appropriate
25 assessment strategies, an efficient billing process that
26 contains reconciliation and monitoring components, a redefined
27 role for support coordinators that avoids potential conflicts
28 of interest, and family/client budgets linked to levels of
29 need. Prior to the release of funds in the lump-sum
30 appropriation, the department shall present a plan to the
31 Executive Office of the Governor, the House Fiscal

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Responsibility Council, and the Senate Appropriations Committee. The plan must result in a full implementation of the redesigned system no later than July 1, 2003. At a minimum, the plan must provide that the portions related to direct provider enrollment and billing will be operational no later than March 31, 2003. The plan must further provide that a more effective needs assessment instrument will be deployed by January 1, 2003, and that all clients will be assessed with this device by June 30, 2003. In no event may the department select an assessment instrument without appropriate evidence that it will be reliable and valid. Once such evidence has been obtained, however, the department shall determine the feasibility of contracting with an external vendor to apply the new assessment device to all clients receiving services through the Medicaid waiver. In lieu of using an external vendor, the department may use support coordinators for the assessments if it develops sufficient safeguards and training to significantly improve the inter-rater reliability of the support coordinators administering the assessment.

Section 40. (1) The Agency for Health Care Administration shall conduct a study of health care services provided to children in the state who are medically fragile or dependent on medical technology and conduct a pilot program in Miami-Dade County to provide subacute pediatric transitional care to a maximum of 30 children at any one time. The purposes of the study and the pilot program are to determine ways to permit children who are medically fragile or dependent on medical technology to successfully make a transition from acute care in a health care institution to live with their families when possible, and to provide cost-effective, subacute transitional care services.

1 (2) The agency, in cooperation with the Children's
2 Medical Services Program in the Department of Health, shall
3 conduct a study to identify the total number of children who
4 are medically fragile or dependent on medical technology, from
5 birth through age 21, in the state. By January 1, 2003, the
6 agency must report to the Legislature regarding the children's
7 ages, the locations where the children are served, the types
8 of services received, itemized costs of the services, and the
9 sources of funding that pay for the services, including the
10 proportional share when more than one funding source pays for
11 a service. The study must include information regarding
12 children who are medically fragile or dependent on medical
13 technology residing in hospitals, nursing homes, and medical
14 foster care, and those who live with their parents. The study
15 must describe children served in prescribed pediatric
16 extended-care centers, including their ages and the services
17 they receive. The report must identify the total services
18 provided for each child and the method for paying for those
19 services. The report must also identify the number of such
20 children who could, if appropriate transitional services were
21 available, return home or move to a less institutional
22 setting.
23 (3) Within 30 days after the effective date of this
24 act, the agency shall establish minimum staffing standards and
25 quality requirements for a subacute pediatric transitional
26 care center to be operated as a 2-year pilot program in
27 Miami-Dade County. The pilot program must operate under the
28 license of a hospital licensed under chapter 395, Florida
29 Statutes, or a nursing home licensed under chapter 400,
30 Florida Statutes, and shall use existing beds in the hospital
31 or nursing home. A child's placement in the subacute pediatric

1 transitional care center may not exceed 90 days. The center
2 shall arrange for an alternative placement at the end of a
3 child's stay and a transitional plan for children expected to
4 remain in the facility for the maximum allowed stay.
5 (4) Within 60 days after the effective date of this
6 act, the agency must amend the state Medicaid plan and request
7 any federal waivers necessary to implement and fund the pilot
8 program.
9 (5) The subacute pediatric transitional care center
10 must require level 1 background screening as provided in
11 chapter 435, Florida Statutes, for all employees or
12 prospective employees of the center who are expected to, or
13 whose responsibilities may require them to, provide personal
14 care or services to children, have access to children's living
15 areas, or have access to children's funds or personal
16 property.
17 (6) The subacute pediatric transitional care center
18 must have an advisory board. Membership on the advisory board
19 must include, but need not be limited to:
20 (a) A physician and an advanced registered nurse
21 practitioner who is familiar with services for children who
22 are medically fragile or dependent on medical technology.
23 (b) A registered nurse who has experience in the care
24 of children who are medically fragile or dependent on medical
25 technology.
26 (c) A child development specialist who has experience
27 in the care of children who are medically fragile or dependent
28 on medical technology, and their families.
29 (d) A social worker who has experience in the care of
30 children who are medically fragile or dependent on medical
31 technology, and their families.

1 (e) A consumer representative who is a parent or
2 guardian of a child placed in the center.
3 (7) The advisory board shall:
4 (a) Review the policy and procedure components of the
5 center to assure conformance with applicable standards
6 developed by the agency.
7 (b) Provide consultation with respect to the
8 operational and programmatic components of the center.
9 (8) The subacute pediatric transitional care center
10 must have written policies and procedures governing the
11 admission, transfer, and discharge of children.
12 (9) The admission of each child to the center must be
13 under the supervision of the center nursing administrator or
14 his or her designee and must be in accordance with the
15 center's policies and procedures. Each Medicaid admission must
16 be approved as appropriate for placement in the facility by
17 the Children's Medical Services Multidisciplinary Assessment
18 Team of the Department of Health, in conjunction with the
19 agency.
20 (10) Each child admitted to the center shall be
21 admitted upon prescription of the medical director of the
22 center, licensed pursuant to chapter 458 or chapter 459,
23 Florida Statutes, and the child shall remain under the care of
24 the medical director and the advanced registered nurse
25 practitioner for the duration of his or her stay in the
26 center.
27 (11) Each child admitted to the center must meet at
28 least the following criteria:
29 (a) The child must be medically fragile or dependent
30 on medical technology.
31

1 (b) The child may not, prior to admission, present
2 significant risk of infection to other children or personnel.
3 The medical and nursing directors shall review, on a
4 case-by-case basis, the condition of any child who is
5 suspected of having an infectious disease to determine whether
6 admission is appropriate.
7 (c) The child must be medically stabilized and require
8 skilled nursing care or other interventions.
9 (12) If the child meets the criteria specified in
10 paragraphs (11)(a), (b), and (c), the medical director or
11 nursing director of the center shall implement a preadmission
12 plan that delineates services to be provided and appropriate
13 sources for such services.
14 (a) If the child is hospitalized at the time of
15 referral, preadmission planning must include the participation
16 of the child's parent or guardian and relevant medical,
17 nursing, social services, and developmental staff to assure
18 that the hospital's discharge plans will be implemented
19 following the child's placement in the center.
20 (b) A consent form outlining the purpose of the
21 center, family responsibilities, authorized treatment,
22 appropriate release of liability, and emergency disposition
23 plans must be signed by the parent or guardian and witnessed
24 before the child is admitted to the center. The parent or
25 guardian shall be provided a copy of the consent form.
26 (13) By January 1, 2003, the agency shall report to
27 the Legislature concerning the progress of the pilot program.
28 By January 1, 2004, the agency shall submit to the Legislature
29 a report on the success of the pilot program.
30 Section 41. (1) Notwithstanding s. 409.911(3),
31 Florida Statutes, for the state fiscal year 2002-2003 only,

1 the agency shall distribute moneys under the regular
2 disproportionate share program only to hospitals that meet the
3 federal minimum requirements and to public hospitals. Public
4 hospitals are defined as those hospitals identified as
5 government owned or operated in the Financial Hospital Uniform
6 Reporting System (FHURS) data available to the agency as of
7 January 1, 2002. The following methodology shall be used to
8 distribute disproportionate share dollars to hospitals that
9 meet the federal minimum requirements and to the public
10 hospitals:
11 (a) For hospitals that meet the federal minimum
12 requirements and do not qualify as a public hospital, the
13 following formula shall be used:
14
15 DSHP = (HMD/TMSD)*$1 million
16
17 DSHP = disproportionate share hospital payment.
18 HMD = hospital Medicaid days.
19 TSD = total state Medicaid days.
20
21 (b) The following formulas shall be used to pay
22 disproportionate share dollars to public hospitals:
23 1. For state mental health hospitals:
24
25 DSHP = (HMD/TMDMH) * TAAMH
26
27 The total amount available for the state mental
28 health hospitals shall be the difference
29 between the federal cap for Institutions for
30 Mental Diseases and the amounts paid under the
31 mental health disproportionate share program.

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1 2. For non-state government owned or operated
2 hospitals with 3,200 or more Medicaid days:
3
4 DSHP = [(.82*HCCD/TCCD) + (.18*HMD/TMD)] *
5 TAAPH
6 TAAPH = TAA - TAAMH
7
8 3. For non-state government owned or operated
9 hospitals with less than 3,200 Medicaid days, a total of
10 $400,000 shall be distributed equally among these hospitals.
11
12 Where:
13
14 TAA = total available appropriation.
15 TAAPH = total amount available for public
16 hospitals.
17 TAAMH = total amount available for mental
18 health hospitals.
19 DSHP = disproportionate share hospital
20 payments.
21 HMD = hospital Medicaid days.
22 TMDMH = total state Medicaid days for mental
23 health days.
24 TMD = total state Medicaid days for public
25 hospitals.
26 HCCD = hospital charity care dollars.
27 TCCD = total state charity care dollars for
28 public non-state hospitals.
29
30 In computing the above amounts for public hospitals and
31 hospitals that qualify under the federal minimum requirements,

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1 the agency shall use the 1997 audited data. In the event there
2 is no complete 1997 audited data for a hospital, the agency
3 shall use the 1994 audited data.
4 (2) Notwithstanding s. 409.9112, Florida Statutes, for
5 state fiscal year 2002-2003, only disproportionate share
6 payments to regional perinatal intensive care centers shall be
7 distributed in the same proportion as the disproportionate
8 share payments made to the regional perinatal intensive care
9 centers in the state fiscal year 2001-2002.
10 (3) Notwithstanding s. 409.9117, Florida Statutes, for
11 state fiscal year 2002-2003 only, disproportionate share
12 payments to hospitals that qualify for primary care
13 disproportionate share payments shall be distributed in the
14 same proportion as the primary care disproportionate share
15 payments made to those hospitals in the state fiscal year
16 2001-2002.
17 (4) For state fiscal year 2002-2003 only, no
18 disproportionate share payments shall be made to hospitals
19 under the provisions of s. 409.9119, Florida Statutes. If the
20 Centers for Medicare and Medicaid Services does not approve
21 Florida's inpatient hospital plan amendment for the public
22 disproportionate share program by November 1, 2002, the agency
23 may make payments to the two children's hospitals in the
24 amount of $3,682,293, distributed in the same proportion as
25 the children's disproportionate share payments in state fiscal
26 year 2001-2002.
27 (5) In the event the Centers for Medicare and Medicaid
28 Services does not approve Florida's inpatient hospital state
29 plan amendment for the public disproportionate share program
30 by November 1, 2002, the agency may make payments to hospitals
31 under the regular disproportionate share program, regional

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1 perinatal intensive care centers disproportionate share
2 program, the children's hospital disproportionate share
3 program, and the primary care disproportionate share program
4 using the same methodologies used in state fiscal year
5 2001-2002.
6 (6) This section is repealed on July 1, 2003.
7 Section 42. The Agency for Health Care Administration
8 may conduct a 2-year pilot project to authorize overnight
9 stays in one ambulatory surgical center located in Acute Care
10 Subdistrict 9-1. An overnight stay shall be permitted only to
11 perform plastic and reconstructive surgeries defined by
12 current procedural terminology code numbers 13000-19999. The
13 total time a patient is at the ambulatory surgical center
14 shall not exceed 23 hours and 59 minutes, including the
15 surgery time, and the maximum planned duration of all surgical
16 procedures combined shall not exceed 8 hours. Prior to
17 implementation of the pilot project, the agency shall
18 establish minimum requirements for protecting the health,
19 safety, and welfare of patients receiving overnight care.
20 These shall include, at a minimum, compliance with all
21 statutes and rules applicable to ambulatory surgical centers
22 and the requirements set forth in Rule 64B8-9.009, Florida
23 Administrative Code, relating to Level II and Level III
24 procedures. If the agency implements the pilot project, it
25 shall, within 6 months after its completion, submit a report
26 to the Legislature on whether to expand the pilot project to
27 include all ambulatory surgical centers. The recommendation
28 shall be based on consideration of the efficacy and impact to
29 patient safety and quality of patient care of providing
30 plastic and reconstructive surgeries in the ambulatory
31

1 surgical center setting. The agency is authorized to obtain
2 such data as necessary to implement this section.
3 Section 43. The Office of Program Policy Analysis and
4 Government Accountability, assisted by the Agency for Health
5 Care Administration, and the Florida Association of Counties,
6 shall perform a study to determine the fair share of the
7 counties' contribution to Medicaid nursing home costs. The
8 Office of Program Policy Analysis and Government
9 Accountability shall submit a report on the study to the
10 President of the Senate and the Speaker of the House of
11 Representatives by January 1, 2003. The report shall set out
12 no less than two options and shall make a recommendation as to
13 what would be a fair share of the costs for the counties'
14 contribution for fiscal year 2003-2004. The report shall also
15 set out options and make a recommendation to be considered to
16 ensure that the counties pay their fair share in subsequent
17 years. No recommendation shall be less than the counties'
18 current share of 1.5 percent. Each option shall include a
19 detailed explanation of the analysis that led to the
20 conclusion.
21 Section 44. (1) Effective July 1, 2002, all powers,
22 duties, functions, records, personnel, property, and
23 unexpended balances of appropriations, allocations, and other
24 funds of the Agency for Health Care Administration that relate
25 to consumer complaint services, investigations, and
26 prosecutorial services currently provided by the Agency for
27 Health Care Administration under a contract with the
28 Department of Health are transferred to the Department of
29 Health by a type two transfer, as defined in s. 20.06, Florida
30 Statutes. This transfer of funds shall include all advance
31

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1 payments made from the Medical Quality Assurance Trust Fund to
2 the Agency for Health Care Administration.
3 (2) Effective July 1, 2002, 259 full-time equivalent
4 positions are eliminated from the Agency for Health Care
5 Administration's total number of authorized positions and
6 added to the Department of Health's total number of authorized
7 positions. However, should the General Appropriations Act for
8 fiscal year 2002-2003 reduce the number of positions from the
9 agency's practitioner regulation component, that provision
10 shall be construed to reduce the same number of full-time
11 equivalent positions from the practitioner regulation
12 component which are hereby transferred to the department.
13 (3) The interagency agreement between the Department
14 of Health and the Agency for Health Care Administration shall
15 terminate on June 30, 2002.
16 (4) The Department of Health may contract with the
17 Department of Legal Affairs for the investigative and
18 prosecutorial services transferred to the department.
19 Section 45. Paragraph (g) of subsection (3) of section
20 20.43, Florida Statutes, is amended to read:
21 20.43 Department of Health.--There is created a
22 Department of Health.
23 (3) The following divisions of the Department of
24 Health are established:
25 (g) Division of Medical Quality Assurance, which is
26 responsible for the following boards and professions
27 established within the division:
28 1. The Board of Acupuncture, created under chapter
29 457.
30 2. The Board of Medicine, created under chapter 458.
31

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1 3. The Board of Osteopathic Medicine, created under
2 chapter 459.
3 4. The Board of Chiropractic Medicine, created under
4 chapter 460.
5 5. The Board of Podiatric Medicine, created under
6 chapter 461.
7 6. Naturopathy, as provided under chapter 462.
8 7. The Board of Optometry, created under chapter 463.
9 8. The Board of Nursing, created under part I of
10 chapter 464.
11 9. Nursing assistants, as provided under part II of
12 chapter 464.
13 10. The Board of Pharmacy, created under chapter 465.
14 11. The Board of Dentistry, created under chapter 466.
15 12. Midwifery, as provided under chapter 467.
16 13. The Board of Speech-Language Pathology and
17 Audiology, created under part I of chapter 468.
18 14. The Board of Nursing Home Administrators, created
19 under part II of chapter 468.
20 15. The Board of Occupational Therapy, created under
21 part III of chapter 468.
22 16. Respiratory therapy, as provided under part V of
23 chapter 468.
24 17. Dietetics and nutrition practice, as provided
25 under part X of chapter 468.
26 18. The Board of Athletic Training, created under part
27 XIII of chapter 468.
28 19. The Board of Orthotists and Prosthetists, created
29 under part XIV of chapter 468.
30 20. Electrolysis, as provided under chapter 478.
31

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1 21. The Board of Massage Therapy, created under
2 chapter 480.
3 22. The Board of Clinical Laboratory Personnel,
4 created under part III of chapter 483.
5 23. Medical physicists, as provided under part IV of
6 chapter 483.
7 24. The Board of Opticianry, created under part I of
8 chapter 484.
9 25. The Board of Hearing Aid Specialists, created
10 under part II of chapter 484.
11 26. The Board of Physical Therapy Practice, created
12 under chapter 486.
13 27. The Board of Psychology, created under chapter
14 490.
15 28. School psychologists, as provided under chapter
16 490.
17 29. The Board of Clinical Social Work, Marriage and
18 Family Therapy, and Mental Health Counseling, created under
19 chapter 491.
20
21 ~~The department may contract with the Agency for Health Care~~
22 ~~Administration who shall provide consumer complaint,~~
23 ~~investigative, and prosecutorial services required by the~~
24 ~~Division of Medical Quality Assurance, councils, or boards, as~~
25 ~~appropriate.~~
26 Section 46. Effective July 1, 2002, section 456.047,
27 Florida Statutes, is repealed.
28 Section 47. Subsection (5) of section 414.41, Florida
29 Statutes, is repealed.
30 Section 48. If any provision of this act or its
31 application to any person or circumstance is held invalid, the

1 invalidity shall not affect other provisions or applications
2 of the act which can be given effect without the invalid
3 provision or application, and to this end the provisions of
4 this act are declared severable.
5 Section 49. If any law amended by this act was also
6 amended by a law enacted during the 2002 Regular Session of
7 the Legislature, such laws shall be construed to have been
8 enacted during the same session of the Legislature and full
9 effect shall be given to each if possible.
10 Section 50. Except as otherwise provided herein, this
11 act shall take effect upon becoming a law.
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