A bill to be entitled

An act relating to health care; amending s. 120.80, F.S.; excluding hearings conducted by the Agency for Health Care Administration from certain administrative law judge assignment requirements; amending s. 154.503, F.S.; requiring the Department of Health to include the Florida Healthy Kids program within certain coordination activity requirements; amending s. 381.90, F.S.; deleting the Florida Healthy Kids Corporation representative from membership in the Health Information Systems Council; amending s. 400.0255, F.S.; designating the agency's Office of Fair Hearings as the entity initiating and conducting certain hearings; providing rulemaking authority for hearing proceedings; amending s. 400.179, F.S.; revising a provision relating to accountability for certain outstanding liabilities to the state under certain circumstances; amending s. 408.15, F.S.; authorizing the agency to establish and conduct Medicaid fair hearings unrelated to eligibility determination; amending s. 409.811, F.S.; defining "managed care plan"; amending s. 409.813, F.S.; specifying health benefit coverage for the Florida Kidcare program under the Florida Healthy Kids program; amending s. 409.8132, F.S.; providing specifications for managed care plans relating to preenrollment in the Medikids program; amending ss. 409.814, 409.816, 409.818, and 409.820, F.S.; revising and clarifying responsibilities of the Department of Health, the Department of Children and Family Services, and the Agency for Health Care Administration in administering the Florida Healthy Kids program; providing certain minimum

premiums for the program; providing for provider standards for primary and specialty care providers; authorizing the agency to contract with certain entities; providing duties of the agency; amending s. 409.904, F.S.; clarifying provisions relating to optional payment for eligible persons; amending s. 409.905, F.S.; increasing a time limit for automatic authorization for inpatient service; amending s. 409.906, F.S.; revising agency authorization to pay for adult dental services; limiting the agency's authority to provide hearing and visual services to children; amending s. 409.9081, F.S.; establishing copayments for nonemergency emergency room visits and for prescription drugs; amending s. 409.9117, F.S.; deleting reference to the Florida Healthy Kids Corporation; amending s. 409.91188, F.S.; providing for a prepaid health plan for Medicaid HIV/AIDS recipients; requiring the agency to issue a request for proposal or intent to implement such plan; providing entity requirements; directing the agency to modify existing waiver applications; specifying reporting requirements; requiring risk sharing; amending s. 409.91195, F.S.; providing that the class review by the Medicaid Pharmaceutical and Therapeutics Committee shall be the top 75 percent of therapeutic classes based on number of prescriptions and biennial review for all other classes; providing for Medicaid recipients to appeal certain agency decisions to the Office of Fair Hearings; amending s. 409.912, F.S.; requiring the agency to ensure certain provider choice for Medicaid recipients; revising provisions authorizing the agency to contract for prepaid behavioral health services

under certain circumstances; clarifying certain provider network provisions; specifying that certain provisions prevail in the event of conflict with other sections of law; authorizing the agency to contract for certain dental services; increasing fines for certain violations; deleting authority for managed care plans to perform preenrollments of Medicaid recipients; amending s. 409.9122, F.S.; revising provisions relating to agency assignments of certain Medicaid recipients to managed care plans under certain circumstances; amending s. 409.913, F.S.; permitting rather than requiring the agency to impose certain sanctions; increasing certain fines; deleting a 90-day time period requirement for conducting an administrative hearing in cases of fraud and abuse within Medicaid; amending s. 409.919, F.S.; providing rulemaking authority for the agency to create interagency agreements; amending s. 411.01, F.S.; requiring the Florida Partnership for School Readiness to submit a report to the agency; deleting a reporting requirement to the Florida Healthy Kids Corporation; amending s. 465.0255, F.S.; requiring the display of the expiration date of prescribed drugs; providing an effective date.

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

Section 1. Subsection (7) of section 120.80, Florida Statutes, is amended to read:

120.80 Exceptions and special requirements; agencies.--

(7) DEPARTMENT OF CHILDREN AND FAMILY SERVICES AND THE AGENCY FOR HEALTH CARE ADMINISTRATION.--Notwithstanding s.

120.57(1)(a), hearings conducted within the Department of Children and Family Services and the Agency for Health Care Administration in the execution of those social and economic programs administered by the former Division of Family Services of the former Department of Health and Rehabilitative Services prior to the reorganization effected by chapter 75-48, Laws of Florida, need not be conducted by an administrative law judge assigned by the division.

Section 2. Paragraph (e) of subsection (2) of section 154.503, Florida Statutes, is amended to read:

154.503 Primary Care for Children and Families Challenge Grant Program; creation; administration.--

(2) The department shall:

(e) Coordinate with the primary care program developed pursuant to s. 154.011, the Florida Healthy Kids ~~Corporation~~ program administered by the Agency for Health Care Administration ~~created in s. 624.91~~, the school health services program created in ss. 381.0056 and 381.0057, the Healthy Communities, Healthy People Program created in s. 381.734, and the volunteer health care provider program developed pursuant to s. 766.1115.

Section 3. Subsection (3) of section 381.90, Florida Statutes, is amended to read:

381.90 Health Information Systems Council; legislative intent; creation, appointment, duties.--

(3) The council shall be composed of the following members or their senior executive-level designees:

(a) The secretary of the Department of Health;

(b) The secretary of the Department of Business and Professional Regulation;

(c) The secretary of the Department of Children and Family Services;

(d) The Secretary of Health Care Administration;

(e) The secretary of the Department of Corrections;

(f) The Attorney General;

(g) The executive director of the Correctional Medical Authority;

(h) Two members representing county health departments, one from a small county and one from a large county, appointed by the Governor;

(i) A representative from the Florida Association of Counties;

(j) The State Treasurer and Insurance Commissioner;

~~(k) A representative from the Florida Healthy Kids Corporation;~~

(k)~~(l)~~ A representative from a school of public health chosen by the Board of Regents;

(l)~~(m)~~ The Commissioner of Education;

(m)~~(n)~~ The secretary of the Department of Elderly Affairs; and

(n)~~(o)~~ The secretary of the Department of Juvenile Justice.

Representatives of the Federal Government may serve without voting rights.

Section 4. Subsections (8), (15), and (16) of section 400.0255, Florida Statutes, are amended to read:

400.0255 Resident transfer or discharge; requirements and procedures; hearings.--

(8) The notice required by subsection (7) must be in writing and must contain all information required by state and federal law, rules, or regulations applicable to Medicaid or Medicare cases. The agency shall develop a standard document to be used by all facilities licensed under this part for purposes of notifying residents of a discharge or transfer. Such document must include a means for a resident to request the local long-term care ombudsman council to review the notice and request information about or assistance with initiating a fair hearing with the agency's ~~department's~~ Office of Fair ~~Appeals~~ Hearings. In addition to any other pertinent information included, the form shall specify the reason allowed under federal or state law that the resident is being discharged or transferred, with an explanation to support this action. Further, the form shall state the effective date of the discharge or transfer and the location to which the resident is being discharged or transferred. The form shall clearly describe the resident's appeal rights and the procedures for filing an appeal, including the right to request the local ombudsman council to review the notice of discharge or transfer. A copy of the notice must be placed in the resident's clinical record, and a copy must be transmitted to the resident's legal guardian or representative and to the local ombudsman council within 5 business days after signature by the resident or resident designee.

(15)(a) The agency's ~~department's~~ Office of Fair ~~Appeals~~ Hearings shall conduct hearings under this section. The office shall notify the facility of a resident's request for a hearing.

(b) The agency ~~department~~ shall, by rule, establish procedures to be used for fair hearings requested by residents. These procedures shall be equivalent to the procedures used for

fair hearings for other Medicaid cases, chapter 10-2, part VI, Florida Administrative Code. The burden of proof must be clear and convincing evidence. A hearing decision must be rendered within 90 days after receipt of the request for hearing.

(c) If the hearing decision is favorable to the resident who has been transferred or discharged, the resident must be readmitted to the facility's first available bed.

(d) The decision of the hearing officer shall be final. Any aggrieved party may appeal the decision to the district court of appeal in the appellate district where the facility is located. Review procedures shall be conducted in accordance with the Florida Rules of Appellate Procedure.

(16) The agency ~~department~~ may adopt rules necessary to administer this section.

Section 5. Paragraph (c) 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:

(c) If a Medicaid overpayment determination is deemed by the agency to be unrecoverable from a transfer or other source, where a ~~the~~ facility transfer takes any form of a sale or transfer of assets, ~~in addition to the transferor's continuing liability for any such overpayments, if the transferor fails to~~

~~meet these obligations,~~ the transferee shall be held accountable for any outstanding liability to the state, regardless of when identified, resulting from changes to allowable costs affecting provider reimbursement for Medicaid participation; Medicaid program integrity overpayment determinations; compliance violations, administrative sanctions, and fines. The transferee shall pay or make arrangements to pay to the agency any amount owed to the agency. Payment assurances may be in the form of an irrevocable credit instrument or payment bond acceptable to the agency or the department provided by or on behalf of the transferor. The issuance of a license to the transferee shall be delayed pending payment or until arrangement for payment acceptable to the agency or the department is made ~~liable for all liabilities that can be readily identifiable 90 days in advance of the transfer~~. ~~Such liability shall continue in succession until the debt is ultimately paid or otherwise resolved. It shall be the burden of the transferee to determine the amount of all such readily identifiable overpayments from the Agency for Health Care Administration, and the agency shall cooperate in every way with the identification of such amounts. Readily identifiable overpayments shall include overpayments that will result from, but not be limited to:~~

~~1. Medicaid rate changes or adjustments;~~

~~2. Any depreciation recapture;~~

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

~~4. Audits completed by the agency.~~

~~The transferor shall remain liable for any such Medicaid overpayments that were not readily identifiable 90 days in advance of the nursing facility transfer.~~

Section 6. Subsection (13) is added to section 408.15, Florida Statutes, to read:

408.15 Powers of the agency.--In addition to the powers granted to the agency elsewhere in this chapter, the agency is authorized to:

(13) Establish and conduct those Medicaid fair hearings that are unrelated to eligibility determinations, in accordance with 42 C.F.R. s. 431.200 and other applicable federal and state laws.

Section 7. Subsections (17) through (27) of section 409.811, Florida Statutes, are renumbered as subsections (18) through (28), respectively, and a new subsection (17) is added to said section, to read:

409.811 Definitions relating to Florida Kidcare Act.--As used in ss. 409.810-409.820, the term:

(17) "Managed care plan" means a health maintenance organization authorized pursuant to chapter 641 or a prepaid health plan authorized pursuant to s. 409.912.

Section 8. Subsection (3) of section 409.813, Florida Statutes, is amended to read:

409.813 Program components; entitlement and nonentitlement.--The Florida Kidcare program includes health benefits coverage provided to children through:

(3) The Florida Healthy Kids program ~~Corporation~~ as created in s. 624.91;

Except for coverage under the Medicaid program, coverage under the Florida Kidcare program is not an entitlement. No cause of action shall arise against the state, the department, the Department of Children and Family Services, or the agency for

failure to make health services available to any person under ss. 409.810-409.820.

Section 9. Subsection (7) of section 409.8132, Florida Statutes, is amended to read:

409.8132 Medikids program component.--

(7) ENROLLMENT.--Enrollment in the Medikids program component may only occur during periodic open enrollment periods as specified by the agency. An applicant may apply for enrollment in the Medikids program component and proceed through the eligibility determination process at any time throughout the year. However, enrollment in Medikids shall not begin until the next open enrollment period; and a child may not receive services under the Medikids program until the child is enrolled in a managed care plan as defined in s. 409.811 or in MediPass. In addition, once determined eligible, an applicant may receive choice counseling and select a managed care plan or MediPass. The agency may initiate mandatory assignment for a Medikids applicant who has not chosen a managed care plan or MediPass provider after the applicant's voluntary choice period ends. An applicant may select MediPass under the Medikids program component only in counties that have fewer than two managed care plans available to serve Medicaid recipients and only if the federal Health Care Financing Administration determines that MediPass constitutes "health insurance coverage" as defined in Title XXI of the Social Security Act.

Section 10. Section 409.814, Florida Statutes, is amended to read:

409.814 Eligibility.--A child whose family income is equal to or below 200 percent of the federal poverty level is eligible for the Florida Kidcare program as provided in this section. In

determining the eligibility of such a child, an assets test is not required. An applicant under 19 years of age who, based on a complete application, appears to be eligible for the Medicaid component of the Florida Kidcare program is presumed eligible for coverage under Medicaid, subject to federal rules. A child who has been deemed presumptively eligible for Medicaid shall not be enrolled in a managed care plan until the child's full eligibility determination for Medicaid has been completed. The Florida Healthy Kids Corporation is ~~may~~, subject to compliance with applicable requirements of the Agency for Health Care Administration and the Department of Children and Family Services, ~~be~~ designated as an entity to conduct presumptive eligibility determinations. An applicant under 19 years of age who, based on a complete application, appears to be eligible for the Medikids, Florida Healthy Kids, or Children's Medical Services network program component, who is screened as ineligible for Medicaid and prior to the monthly verification of the applicant's enrollment in Medicaid or of eligibility for coverage under the state employee health benefit plan, may be enrolled in and begin receiving coverage from the appropriate program component on the first day of the month following the receipt of a completed application. For enrollment in the Children's Medical Services network, a complete application includes the medical or behavioral health screening. If, after verification, an individual is determined to be ineligible for coverage, he or she must be disenrolled from the respective Title XXI-funded Kidcare program component.

(1) A child who is eligible for Medicaid coverage under s. 409.903 or s. 409.904 must be enrolled in Medicaid and is not

eligible to receive health benefits under any other health benefits coverage authorized under ss. 409.810-409.820.

(2) A child who is not eligible for Medicaid, but who is eligible for the Florida Kidcare program, may obtain coverage under any of the other types of health benefits coverage authorized in ss. 409.810-409.820 if such coverage is approved and available in the county in which the child resides. However, a child who is eligible for Medikids may participate in the Florida Healthy Kids program only if the child has a sibling participating in the Florida Healthy Kids program and the child's county of residence permits such enrollment.

(3) A child who is eligible for the Florida Kidcare program who is a child with special health care needs, as determined through a medical or behavioral screening instrument, is eligible for health benefits coverage from and shall be referred to the Children's Medical Services network.

(4) The following children are not eligible to receive premium assistance for health benefits coverage under ss. 409.810-409.820, except under Medicaid if the child would have been eligible for Medicaid under s. 409.903 or s. 409.904 as of June 1, 1997:

(a) A child who is eligible for coverage under a state health benefit plan on the basis of a family member's employment with a public agency in the state.

(b) A child who is covered under a group health benefit plan or under other health insurance coverage, excluding coverage provided under the Florida Healthy Kids Corporation as established under s. 624.91.

(c) A child who is seeking premium assistance for employer-sponsored group coverage, if the child has been covered

by the same employer's group coverage during the 6 months prior to the family's submitting an application for determination of eligibility under the Florida Kidcare program.

(d) A child who is an alien, but who does not meet the definition of qualified alien, in the United States.

(e) A child who is an inmate of a public institution or a patient in an institution for mental diseases.

(5) A child whose family income is above 200 percent of the federal poverty level or a child who is excluded under the provisions of subsection (4) may participate in the Florida Kidcare program, excluding the Medicaid program, but is subject to the following provisions:

(a) The family is not eligible for premium assistance payments and must pay the full cost of the premium, including any administrative costs.

(b) The agency is authorized to place limits on enrollment in Medikids by these children in order to avoid adverse selection. The number of children participating in Medikids whose family income exceeds 200 percent of the federal poverty level must not exceed 10 percent of total enrollees in the Medikids program.

(c) The agency ~~board of directors of the Florida Healthy Kids Corporation~~ is authorized to place limits on enrollment of ~~these~~ children in the Florida Healthy Kids program in order to avoid adverse selection. In addition, the board is authorized to offer a reduced benefit package to these children in order to limit program costs for such families. The number of children participating in the Florida Healthy Kids program whose family income exceeds 200 percent of the federal poverty level must not

exceed 10 percent of total enrollees in the Florida Healthy Kids program.

(d) Children described in this subsection are not counted in the annual enrollment ceiling for the Florida Kidcare program.

(6) Once a child is enrolled in the Florida Kidcare program, the child is eligible for coverage under the program for 6 months without a redetermination or reverification of eligibility, if the family continues to pay the applicable premium. Effective January 1, 1999, a child who has not attained the age of 5 and who has been determined eligible for the Medicaid program is eligible for coverage for 12 months without a redetermination or reverification of eligibility.

(7) When determining or reviewing a child's eligibility under the program, the applicant shall be provided with reasonable notice of changes in eligibility which may affect enrollment in one or more of the program components. When a transition from one program component to another is appropriate, there shall be cooperation between the program components and the affected family which promotes continuity of health care coverage.

Section 11. Subsection (3) of section 409.816, Florida Statutes, is amended to read:

409.816 Limitations on premiums and cost-sharing.--The following limitations on premiums and cost-sharing are established for the program.

(3) Enrollees in families with a family income above 150 percent of the federal poverty level, who are not receiving coverage under the Medicaid program or who are not eligible under s. 409.814(5), may be required to pay enrollment fees; ~~,~~

premiums that shall include $15 for one child, $30 for two children, and $45 for three or more children;~~,~~ copayments;~~,~~ deductibles;~~,~~ coinsurance;~~,~~ or similar charges on a sliding scale related to income, except that the total annual aggregate cost-sharing with respect to all children in a family may not exceed 5 percent of the family's income. However, copayments, deductibles, coinsurance, or similar charges may not be imposed for preventive services, including well-baby and well-child care, age-appropriate immunizations, and routine hearing and vision screenings.

Section 12. Paragraph (b) of subsection (1), paragraphs (a) and (d) of subsection (2), paragraph (a) of subsection (3), and subsections (4) and (6) of section 409.818, Florida Statutes, are amended to read:

409.818 Administration.--In order to implement ss. 409.810-409.820, the following agencies shall have the following duties:

(1) The Department of Children and Family Services shall:

(b) Establish and maintain the eligibility determination process under the program except as specified in subsection (5). The department shall directly, or through the services of a contracted third-party administrator, establish and maintain a process for determining eligibility of children for coverage under the program. The eligibility determination process must be used solely for determining eligibility of applicants for health benefits coverage under the program. The eligibility determination process must include an initial determination of eligibility for any coverage offered under the program, as well as a redetermination or reverification of eligibility each subsequent 6 months. Effective January 1, 1999, a child who has

not attained the age of 5 and who has been determined eligible for the Medicaid program is eligible for coverage for 12 months without a redetermination or reverification of eligibility. In conducting an eligibility determination, the department shall determine if the child has special health care needs. The department, in consultation with the Agency for Health Care Administration ~~and the Florida Healthy Kids Corporation~~, shall develop procedures for redetermining eligibility which enable a family to easily update any change in circumstances which could affect eligibility. The department may accept changes in a family's status as reported to the department by the Florida Healthy Kids Corporation without requiring a new application from the family. Redetermination of a child's eligibility for Medicaid may not be linked to a child's eligibility determination for other programs.

(2) The Department of Health shall:

(a) Design an eligibility intake process for the program, in coordination with the Department of Children and Family Services and~~,~~ the agency~~, and the Florida Healthy Kids Corporation~~. The eligibility intake process may include local intake points that are determined by the Department of Health in coordination with the Department of Children and Family Services.

(d) In consultation with the agency ~~Florida Healthy Kids Corporation~~ and the Department of Children and Family Services, establishing a toll-free telephone line to assist families with questions about the program.

(3) The Agency for Health Care Administration, under the authority granted in s. 409.914(1), shall:

(a) Calculate the premium assistance payment necessary to comply with the premium and cost-sharing limitations specified in s. 409.816. The premium assistance payment for each enrollee in a health insurance plan participating in the Florida Healthy Kids program ~~Corporation~~ shall equal the premium approved by the agency ~~Florida Healthy Kids Corporation~~ and the Department of Insurance pursuant to ss. 627.410 and 641.31, less any enrollee's share of the premium established within the limitations specified in s. 409.816. The premium assistance payment for each enrollee in an employer-sponsored health insurance plan approved under ss. 409.810-409.820 shall equal the premium for the plan adjusted for any benchmark benefit plan actuarial equivalent benefit rider approved by the Department of Insurance pursuant to ss. 627.410 and 641.31, less any enrollee's share of the premium established within the limitations specified in s. 409.816. In calculating the premium assistance payment levels for children with family coverage, the agency shall set the premium assistance payment levels for each child proportionately to the total cost of family coverage.

The agency is designated the lead state agency for Title XXI of the Social Security Act for purposes of receipt of federal funds, for reporting purposes, and for ensuring compliance with federal and state regulations and rules.

(4) The Department of Insurance shall certify that health benefits coverage plans that seek to provide services under the Florida Kidcare program, except those offered through the Florida Healthy Kids program ~~Corporation~~ or the Children's Medical Services network, meet, exceed, or are actuarially equivalent to the benchmark benefit plan and that health

insurance plans will be offered at an approved rate. In determining actuarial equivalence of benefits coverage, the Department of Insurance and health insurance plans must comply with the requirements of s. 2103 of Title XXI of the Social Security Act. The department shall adopt rules necessary for certifying health benefits coverage plans.

(6) The agency, the Department of Health, the Department of Children and Family Services, ~~the Florida Healthy Kids Corporation,~~ and the Department of Insurance, after consultation with and approval of the Speaker of the House of Representatives and the President of the Senate, are authorized to make program modifications that are necessary to overcome any objections of the United States Department of Health and Human Services to obtain approval of the state's child health insurance plan under Title XXI of the Social Security Act.

Section 13. Section 409.820, Florida Statutes, is amended to read:

409.820 Provider quality assurance and access standards.--

(1) The Deputy Secretary for Children's Medical Services of ~~Except for Medicaid,~~ the Department of Health, in coordination ~~consultation~~ with the agency ~~and the Florida Healthy Kids Corporation~~, shall develop a minimum set of provider quality assurance and access standards for all program components. Provider standards shall apply to primary and specialty care providers as well as facilities. The standards must include a process for granting exceptions, to be approved by the Deputy Secretary for Children's Medical Services, to specific requirements for quality assurance and access. Compliance with the standards shall be a condition of program participation by health benefits coverage providers. These

standards shall comply with the provisions of this chapter and chapter 641 and Title XXI of the Social Security Act.

(2) The agency shall contract only with those managed care plans and providers meeting the standards developed pursuant to this section. The agency shall work with the Department of Health to develop and implement quality assurance monitoring of plans and providers with regard to such standards, including peer review, review of capacity, and credentialing of providers.

Section 14. Subsection (2) 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.

(2) A caretaker relative or parent, a pregnant woman, a child under age 19 who would otherwise qualify for Florida Kidcare Medicaid or~~,~~ 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. For a family or person in one of these coverage groups, 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 July ~~May~~ 1, 2003, when determining the eligibility of an ~~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 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 15. Paragraph (a) of subsection (5) of section 409.905, Florida Statutes, is amended to read:

409.905 Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law. Mandatory services rendered by providers in mobile units to Medicaid recipients may be restricted 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, number of services, or 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.

(5) HOSPITAL INPATIENT SERVICES.--The agency shall pay for all covered services provided for the medical care and treatment of a recipient who is admitted as an inpatient by a licensed

physician or dentist to a hospital licensed under part I of chapter 395. However, the agency shall limit the payment for inpatient hospital services for a Medicaid recipient 21 years of age or older to 45 days or the number of days necessary to comply with the General Appropriations Act.

(a) The agency is authorized to implement reimbursement and utilization management reforms in order to comply with any limitations or directions in the General Appropriations Act, which may include, but are not limited to: prior authorization for inpatient psychiatric days; prior authorization for nonemergency hospital inpatient admissions for individuals 21 years of age and older; authorization of emergency and urgent-care admissions within 24 hours after admission; enhanced utilization and concurrent review programs for highly utilized services; reduction or elimination of covered days of service; adjusting reimbursement ceilings for variable costs; adjusting reimbursement ceilings for fixed and property costs; and implementing target rates of increase. The agency may limit prior authorization for hospital inpatient services to selected diagnosis-related groups, based on an analysis of the cost and potential for unnecessary hospitalizations represented by certain diagnoses. Admissions for normal delivery and newborns are exempt from requirements for prior authorization. In implementing the provisions of this section related to prior authorization, the agency shall ensure that the process for authorization is accessible 24 hours per day, 7 days per week and authorization is automatically granted when not denied within 24 ~~4~~ hours after the request. Authorization procedures must include steps for review of denials. Upon implementing the prior authorization program for hospital inpatient services, the

agency shall discontinue its hospital retrospective review program.

Section 16. Subsections (1), (12), and (23) of section 409.906, Florida Statutes, are amended to read:

409.906 Optional Medicaid services.--Subject to specific appropriations, the agency may make payments for 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 SERVICES.--The agency may pay for dentures ~~medically necessary~~, the ~~emergency dental~~ procedures required to seat dentures, and the repair and relining of dentures, provided by or under the direction of a licensed

dentist ~~alleviate pain or infection. Emergency dental care shall be limited to emergency oral examinations, necessary radiographs, extractions, and incision and drainage of abscess~~, for a recipient who is age 65 ~~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.

(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 younger than 21 years of age 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 younger than 21 years of age, if they are prescribed by a licensed physician specializing in diseases of the eye or by a licensed optometrist.

Section 17. Paragraphs (c) and (d) are added to subsection (1) of section 409.9081, Florida Statutes, to read:

409.9081 Copayments.--

(1) The agency shall require, subject to federal regulations and limitations, each Medicaid recipient to pay at the time of service a nominal copayment for the following Medicaid services:

(c) Prescribed drug services: a $2 copayment for each generic drug, $5 for each Medicaid preferred drug list product, and $15 for each non-Medicaid preferred drug list brand name drug.

(d) Hospital outpatient services, emergency department: up to $15 for each hospital outpatient emergency department encounter that is for nonemergency purposes.

Section 18. Paragraph (h) of subsection (2) of section 409.9117, Florida Statutes, is amended to read:

409.9117 Primary care disproportionate share program.--

(2) In the establishment and funding of this program, the agency shall use the following criteria in addition to those specified in s. 409.911, payments may not be made to a hospital unless the hospital agrees to:

(h) Work with ~~the Florida Healthy Kids Corporation,~~ the Florida Health Care Purchasing Cooperative~~,~~ and business health coalitions, as appropriate, to develop a feasibility study and plan to provide a low-cost comprehensive health insurance plan to persons who reside within the area and who do not have access to such a plan.

Any hospital that fails to comply with any of the provisions of this subsection, or any other contractual condition, may not

receive payments under this section until full compliance is achieved.

Section 19. Section 409.91188, Florida Statutes, is amended to read:

409.91188 Specialty prepaid health plans for Medicaid recipients with HIV or AIDS.—

(1) The Agency for Health Care Administration shall issue a request for proposal or intent to implement a ~~is authorized to~~ contract with specialty prepaid health plans authorized pursuant to subsection (2) and pay them on a prepaid capitated basis to provide Medicaid benefits to Medicaid-eligible recipients who have human immunodeficiency syndrome (HIV) or acquired immunodeficiency syndrome (AIDS). The agency shall apply for or amend existing applications for and ~~is authorized to~~ implement federal waivers or other necessary federal authorization to implement the prepaid health plans authorized by this section. The agency shall procure the specialty prepaid health plans through a competitive procurement. In awarding a contract to a managed care plan, the agency shall take into account price, quality, accessibility, linkages to community-based organizations, experience in operating and administering specialty prepaid capitated health plans for AIDS and HIV populations, and the comprehensiveness of the benefit package offered by the plan. The agency may bid the HIV/AIDS specialty plans on a ~~county, regional, or~~ statewide basis. ~~Qualified plans must be licensed under chapter 641.~~ The agency shall monitor and evaluate the implementation of this waiver program if it is approved by the Federal Government and shall report on its status to the President of the Senate and the Speaker of the House of Representatives by February 1, 2004 ~~2001~~. To improve

coordination of medical care delivery and to increase cost efficiency for the Medicaid program in treating HIV disease, the Agency for Health Care Administration shall seek all necessary federal waivers to allow participation in the Medipass HIV disease management program for Medicare beneficiaries who test positive for HIV infection and who also qualify for Medicaid benefits such as prescription medications not covered by Medicare.

(2) The agency may contract with any public or private entity authorized by this section, on a prepaid or fixed-sum basis, for the provision of health care services to recipients. An entity may provide prepaid services to recipients, either directly or through arrangements with other entities. Each entity shall:

(a) Be organized primarily for the purpose of providing health care or other services of the type regularly offered to Medicaid recipients in compliance with federal laws.

(b) Ensure that services meet the standards set by the agency for quality, appropriateness, and timeliness.

(c) Make provisions satisfactory to the agency for insolvency protection and ensure that neither enrolled Medicaid recipients nor the agency is liable for the debts of the entity.

(d) Provide to the agency a financial plan which ensures fiscal soundness and which may include provisions pursuant to which the entity and the agency share in the risk of providing health care services. The contractual arrangement between an entity and the agency shall provide for risk sharing, in which the entity assumes 75 percent or more of risk and the agency assumes the smaller percentage of risk. The agency may bear the cost of providing services when those costs exceed established

risk limits or arrangements whereby services are specifically excluded under the terms of the contract between an entity and the agency.

(e) Provide, through contract or otherwise, for periodic review of its medical facilities and services, as required by the agency.

(f) Furnish evidence satisfactory to the agency of adequate liability insurance coverage or an adequate plan of self-insurance to respond to claims for injuries arising out of furnishing health care.

(g) Provide organizational, operational, financial, and other information required by the agency.

Section 20. Subsections (4) and (11) of section 409.91195, Florida Statutes, are 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.

(4) Upon recommendation of the Medicaid Pharmaceutical and Therapeutics Committee, the agency shall adopt a preferred drug list. To the extent feasible, the committee shall review the top 75 percent of all drug classes, based on utilization, included in the formulary at least every 12 months~~,~~ and all other therapeutic classes biennially. The committee may recommend additions to and deletions from the formulary, such that the formulary provides for medically appropriate drug therapies for Medicaid patients which achieve cost savings contained in the General Appropriations Act.

(11) Medicaid recipients may appeal agency preferred drug formulary decisions using the Medicaid fair hearing process administered by the agency's Office of Fair Hearings ~~Department of Children and Family Services~~.

Section 21. Paragraphs (b), (d), and (g) of subsection (3) and subsections (6), (20), and (27) of section 409.912, Florida Statutes, are amended, and subsection (41) is added to said section, 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:

(b) An entity that is providing comprehensive behavioral health care services to certain Medicaid recipients through a capitated, prepaid arrangement pursuant to the federal waiver provided for by s. 409.905(5). Such an entity must be licensed under chapter 624, chapter 636, or chapter 641 and must possess the clinical systems and operational competence to manage risk and provide comprehensive behavioral health care to Medicaid recipients. As used in this paragraph, the term "comprehensive behavioral health care services" means covered mental health and substance abuse treatment services that are available to Medicaid recipients. The secretary of the Department of Children and Family Services shall approve provisions of procurements related to children in the department's care or custody prior to enrolling such children in a prepaid behavioral health plan. Any contract awarded under this paragraph must be competitively procured. In developing the behavioral health care prepaid plan procurement document, the agency shall ensure that the procurement document requires the contractor to develop and implement a plan to ensure compliance with s. 394.4574 related to services provided to residents of licensed assisted living facilities that hold a limited mental health license. The agency must ensure that Medicaid recipients are offered a choice of behavioral health care providers within the managed care plan. The agency may seek and implement federal waivers to allow the state to require certain Medicaid recipients to be assigned to a single prepaid mental health plan for comprehensive behavioral health care services with the provision that individuals will have a choice of providers and the provider network meets the agency’s specifications ~~have available the choice of 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. The agency may contract for prepaid behavioral health services anywhere in the state if the agency has determined, in consultation with the Department of Children and Family Services, that a geographic area is prepared for a prepaid, capitated behavioral health system of care. ~~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.~~

2.~~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.

3.~~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.

4.~~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.

(d) A provider network ~~No more than four provider service networks for demonstration projects to test Medicaid direct~~

~~contracting. The demonstration projects~~ may be reimbursed on a fee-for-service or prepaid basis. A provider service network which is reimbursed by the agency on a prepaid basis shall be exempt from parts I and III of chapter 641, but must meet appropriate financial reserve, quality assurance, and patient rights requirements as established by the agency. The agency shall award contracts on a competitive bid basis and shall select bidders based upon price and quality of care. ~~Medicaid recipients assigned to a demonstration project shall be chosen equally from those who would otherwise have been assigned to prepaid plans and MediPass.~~ The agency is authorized to seek federal Medicaid waivers as necessary to implement the provisions of this section. A demonstration project awarded pursuant to this paragraph shall be for 4 years from the date of implementation.

(g) Children's or adult'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 and pediatric~~ emergency departments' diversion programs. The networks shall provide after-hour operations, including evening and weekend hours, to promote, when appropriate, the use of the children's and adult's networks rather than hospital emergency departments.

(6) The agency may contract on a prepaid or fixed-sum basis with an exclusive provider organization to provide health care services to Medicaid recipients provided that the exclusive provider organization meets applicable managed care plan requirements in this section, ss. 409.9122, 409.9123, 409.9128,

and 627.6472, and other applicable provisions of law. The provisions of this section and ss. 409.9122, 409.9123, 409.9128, and 641.31 shall prevail to the extent of any conflict with any provision of s. 627.6472.

(20) The agency may impose a fine for a violation of this section or the contract with the agency by a person or entity that is under contract with the agency. With respect to any nonwillful violation, such fine shall not exceed $5,000 ~~$2,500~~ per violation. In no event shall such fine exceed an aggregate amount of $20,000 ~~$10,000~~ for all nonwillful violations arising out of the same action. With respect to any knowing and willful violation of this section or the contract with the agency, the agency may impose a fine upon the entity in an amount not to exceed $40,000 ~~$20,000~~ for each such violation. In no event shall such fine exceed an aggregate amount of $200,000 ~~$100,000~~ for all knowing and willful violations arising out of the same action.

(27) The agency shall perform enrollments and disenrollments for Medicaid recipients who are eligible for MediPass or managed care plans. ~~Notwithstanding the prohibition contained in paragraph (18)(f), managed care plans may perform preenrollments of Medicaid recipients under the supervision of the agency or its agents. For the purposes of this section, "preenrollment" means the provision of marketing and educational materials to a Medicaid recipient and assistance in completing the application forms, but shall not include actual enrollment into a managed care plan.~~ An application for enrollment shall not be deemed complete until the agency or its agent verifies that the recipient made an informed, voluntary choice. The agency, in cooperation with the Department of Children and

Family Services, may test new marketing initiatives to inform Medicaid recipients about their managed care options at selected sites. The agency shall report to the Legislature on the effectiveness of such initiatives. The agency may contract with a third party to perform managed care plan and MediPass enrollment and disenrollment services for Medicaid recipients and is authorized to adopt rules to implement such services. The agency may adjust the capitation rate only to cover the costs of a third-party enrollment and disenrollment contract, and for agency supervision and management of the managed care plan enrollment and disenrollment contract.

(41) The agency may contract, on a prepaid or fixed-sum basis, with an appropriately licensed prepaid dental health plan to provide Medicaid covered dental services to child or adult Medicaid recipients.

Section 22. Paragraphs (f) and (k) of subsection (2) of section 409.9122, Florida Statutes, 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 until an enrollment of 45 percent in MediPass and 55 percent in managed care plans is achieved. Once this enrollment is achieved, the assignments shall be divided in order to maintain an 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 disproportionately assign Medicaid-eligible recipients who are required to but have failed to make a choice of managed care plan or MediPass, including children, 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 programs authorized by this chapter or the General Appropriations Act, in such manner as the agency deems appropriate, until the agency has determined that the 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 enrollment of 45 percent in MediPass~~

~~and 55 percent in managed care plans is achieved. Once that enrollment is achieved, the assignments shall be divided in order to maintain an 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 organizations, provider service networks, Children's Medical Services network, minority physician networks, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act. When making assignments, the agency shall take into account the following criteria:

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

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

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

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

5. The agency has authority to make mandatory assignments based on quality of service and performance of managed care plans.

Section 23. Subsections (15) and (30) of section 409.913, Florida Statutes, are amended to read:

409.913 Oversight of the integrity of the Medicaid program.--The agency shall operate a program to oversee the activities of Florida Medicaid recipients, and providers and their representatives, to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible, and to recover overpayments and impose sanctions as appropriate. Beginning January 1, 2003, and each year thereafter, the agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs shall submit a joint report to the Legislature documenting the effectiveness of the state's efforts to control Medicaid fraud and abuse and to recover Medicaid overpayments during the previous fiscal year. The report must describe the number of cases opened and investigated each year; the sources of the cases opened; the disposition of the cases closed each year; the amount of overpayments alleged in preliminary and final audit letters; the number and amount of fines or penalties imposed; any reductions in overpayment amounts negotiated in settlement agreements or by other means; the amount of final agency determinations of overpayments; the amount deducted from federal claiming as a result of overpayments; the amount of overpayments recovered each year; the amount of cost of investigation recovered each year; the average length of time to collect from the time the case was opened until the overpayment is paid in full; the amount determined as 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.

(15) The agency may ~~shall~~ 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 $10,000 ~~$5,000~~ for each violation. Each day that an ongoing violation continues, such as refusing to furnish Medicaid-related records or refusing access to records, is considered, for the purposes of this section, to be a separate violation. Each instance of improper billing of a Medicaid recipient; each instance of including an unallowable cost on a hospital or nursing home Medicaid cost report after the provider or authorized representative has been advised in an audit exit conference or previous audit report of the cost unallowability; each instance of furnishing a Medicaid recipient goods or professional services that are inappropriate or of

inferior quality as determined by competent peer judgment; each instance of knowingly submitting a materially false or erroneous Medicaid provider enrollment application, request for prior authorization for Medicaid services, drug exception request, or cost report; each instance of inappropriate prescribing of drugs for a Medicaid recipient as determined by competent peer judgment; and each false or erroneous Medicaid claim leading to an overpayment to a provider is considered, for the purposes of this section, to be a separate violation.

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

(e) A fine, not to exceed $20,000 ~~$10,000~~, for a violation of paragraph (14)(i).

(f) Imposition of liens against provider assets, including, but not limited to, financial assets and real property, not to exceed the amount of fines or recoveries sought, upon entry of an order determining that such moneys are due or recoverable.

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

(h) Comprehensive followup 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) 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.~~

(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 a Medicaid ~~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.

Section 24. Section 409.919, Florida Statutes, is amended to read:

409.919 Rules.--The agency shall adopt any rules necessary to comply with or administer ss. 409.901-409.920, and those rules necessary to effect and implement interagency agreements between the agency and other departments, and all rules necessary to comply with federal requirements. In addition, the Department of Children and Family Services shall adopt and accept transfer of any rules necessary to carry out its responsibilities for receiving and processing Medicaid applications and determining Medicaid eligibility, and for assuring compliance with and administering ss. 409.901-409.906, as they relate to these responsibilities, and any other

provisions related to responsibility for the determination of Medicaid eligibility.

Section 25. Paragraph (s) of subsection (4) of section 411.01, Florida Statutes, is amended to read:

411.01 Florida Partnership for School Readiness; school readiness coalitions.--

(4) FLORIDA PARTNERSHIP FOR SCHOOL READINESS.--

(s) The partnership shall submit an annual report of its activities to the Governor, the Agency for Health Care Administration ~~the executive director of the Florida Healthy Kids Corporation~~, the President of the Senate, the Speaker of the House of Representatives, and the minority leaders of both houses of the Legislature. In addition, the partnership's reports and recommendations shall be made available to the Florida Board of Education, other appropriate state agencies and entities, district school boards, central agencies for child care, and county health departments. The annual report must provide an analysis of school readiness activities across the state, including the number of children who were served in the programs and the number of children who were ready for school.

To ensure that the system for measuring school readiness is comprehensive and appropriate statewide, as the system is developed and implemented, the partnership must consult with representatives of district school systems, providers of public and private child care, health care providers, large and small employers, experts in education for children with disabilities, and experts in child development.

Section 26. Subsection (2) of section 465.0255, Florida Statutes, is amended to read:

465.0255 Expiration date of medicinal drugs; display; related use and storage instructions.--

(2) Each pharmacist for a community pharmacy dispensing medicinal drugs and each practitioner dispensing medicinal drugs on an outpatient basis shall display on the outside of the container of each medicinal drug dispensed, or in other written form delivered to the purchaser, the expiration date when provided by the manufacturer, repackager, or other distributor of the drug, which shall be consistent with the manufacturer's expiration date, and appropriate instructions regarding the proper use and storage of the drug. Nothing in this section shall impose liability on the dispensing pharmacist or practitioner for damages related to, or caused by, a medicinal drug that loses its effectiveness prior to the expiration date displayed by the dispensing pharmacist or practitioner.

Section 27. This act shall take effect July 1, 2003.