By the Committees on Appropriations; Health, Aging, and Long-Term Care; and Senator Peaden

309-2536-03

A bill to be entitled

An act relating to health programs; amending s. 120.80, F.S.; exempting hearings in the Agency for Health Care Administration from the requirement of being conducted by an administrative law judge; amending s. 400.0255, F.S.; providing for certain hearings to be conducted by the agency's Office of Fair Hearings relating to resident transfer or discharge; amending s. 408.15, F.S.; providing authority of the agency to establish and conduct Medicaid fair hearings; amending s. 409.91195, F.S.; revising provisions relating to the establishment of the agency's preferred drug list; providing for appeals of preferred drug list decisions through the Office of Fair Hearings; amending s. 400.0239, F.S.; providing for deposit of certain federal nursing home civil penalties into the Quality of Long-Term Care Facility Improvement Trust Fund; providing for expenditures from the fund; amending s. 400.071, F.S.; requiring additional information from applicants for licensure to operate health care facilities; amending s. 400.414, F.S.; revising grounds for denial, revocation, or suspension of a license; amending s. 400.419, F.S.; providing for imposition of administrative fines; providing grounds for such fines; amending s. 400.417, F.S.; revising methods of notifying a facility of the necessity of renewing a license; amending s.

400.557, F.S.; revising methods of notifying adult day care centers of the necessity of renewing a license; amending s. 400.619, F.S.; providing for notification of an adult family-care home of the necessity of renewing a license and providing the method therefor; amending s. 400.980, F.S.; deleting obsolete provisions; amending s. 408.061, F.S.; revising requirements for data submission by nursing homes and continuing care facilities; amending s. 408.062, F.S.; revising duties of the agency with respect to evaluating and monitoring data and reporting its findings; amending s. 408.831, F.S.; providing conditions on a change of ownership or a change of licensee, registrant, or certificateholder; amending s. 409.811, F.S.; defining the term "managed care plan"; amending s. 409.8132, F.S.; creating a cross-reference to such definition; amending s. 409.91188, F.S.; authorizing the agency to contract with private or public entities for health care services; amending s. 409.912, F.S.; revising provisions relating to cost-effective purchasing of health care; deleting provisions relating to preenrollments by managed care plans; deleting obsolete provisions; amending s. 409.901, F.S.; redefining the terms "third party" and "third-party benefit"; amending s. 409.905, F.S.; revising standards for authorization for hospital inpatient services; amending s.

409.913, F.S.; deleting a requirement that a hearing be conducted within a specified time; amending s. 409.919, F.S.; authorizing the agency to adopt rules relating to interagency agreements; amending s. 766.314, F.S.; redefining the term "infant delivered"; amending s. 400.462, F.S.; redefining the terms "companion" and "sitter"; amending s. 400.464, F.S.; deleting references to regulated entities other than home health agencies; increasing penalties for specified violations and providing penalties for persons operating home health agencies who fail to cease operation when directed to do so; amending s. 400.471, F.S.; requiring additional information from applicants for home health agency licensure; amending s. 400.487, F.S.; revising requirements relating to treatment orders when claims are submitted to managed care organizations; amending s. 400.491, F.S.; deleting a requirement that home health agencies maintain a service provision plan for clients receiving nonskilled services; amending s. 400.512, F.S., relating to screening of home health agency personnel; deleting references to persons employed as companions and homemakers; amending s. 400.515, F.S.; revising provisions relating to injunctive proceedings by the agency; amending s. 415.102, F.S.; redefining the term "vulnerable adult" for purposes of the Adult Protective Services Act; repealing s.

400.509, F.S., relating to registration of service providers exempt from licensure; 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 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. 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 65-2 ~~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 3. 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 4. 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 use, 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 list ~~formulary~~ decisions using the Medicaid fair hearing process administered by the agency's Office of Fair Hearings ~~Department of Children and Family Services~~.

Section 5. Subsections (1) and (2) of section 400.0239, Florida Statutes, are amended to read:

400.0239 Quality of Long-Term Care Facility Improvement Trust Fund.--

(1) There is created within the Agency for Health Care Administration a Quality of Long-Term Care Facility Improvement Trust Fund to support activities and programs directly related to improvement of the care of nursing home and assisted living facility residents. The trust fund shall be funded through proceeds generated pursuant to ss. 400.0238 and 400.4298, through funds specifically appropriated by the Legislature, ~~and~~ through gifts, endowments, and other charitable contributions allowed under federal and state law, and federal nursing home civil monetary penalties collected by the Centers for Medicare and Medicaid Services and returned to the state. These funds must be used in accordance with federal requirements.

(2) Expenditures from the trust fund shall be allowable for direct support of the following:

(a) Development and operation of a mentoring program, in consultation with the Department of Health and the Department of Elderly Affairs, for increasing the competence,

professionalism, and career preparation of long-term care facility direct care staff, including nurses, nursing assistants, and social service and dietary personnel.

(b) Development and implementation of specialized training programs for long-term care facility personnel who provide direct care for residents with Alzheimer's disease and other dementias, residents at risk of developing pressure sores, and residents with special nutrition and hydration needs.

(c) Areas of deficient practice identified through regulation or state monitoring.

(d)~~(c)~~ Provision of economic and other incentives to enhance the stability and career development of the nursing home direct care workforce, including paid sabbaticals for exemplary direct care career staff to visit facilities throughout the state to train and motivate younger workers to commit to careers in long-term care.

(e)~~(d)~~ Promotion and support for the formation and active involvement of resident and family councils in the improvement of nursing home care.

(f) Evaluation of special resident needs in long-term care facilities, including challenges in meeting resident needs; appropriateness of placement and setting; and deficiencies cited related to caring for special needs.

(g) Other initiatives authorized by the Centers for Medicare and Medicaid Services for the use of federal civil monetary penalties, including projects recommended through the Medicaid Up or Out program pursuant to s. 400.148.

Section 6. Subsection (12) is added to section 400.071, Florida Statutes, to read:

400.071 Application for license.--

(12) The applicant must provide the agency with proof of legal right to occupy the property before a license may be issued. Proof may include, but is not limited to, copies of warranty deeds, lease or rental agreements, contracts for deeds, or quitclaim deeds.

Section 7. Section 400.414, Florida Statutes, is amended to read:

400.414 Denial, revocation, or suspension of license; ~~imposition of administrative fine;~~grounds.--

(1) The agency may deny, revoke, or suspend any license issued under this part, or impose an administrative fine in the manner provided in chapter 120, for any of the following actions by an assisted living facility, for the actions of any person subject to level 2 background screening under s. 400.4174, or for the actions of any facility employee:

(a) An intentional or negligent act seriously affecting the health, safety, or welfare of a resident of the facility.

(b) The determination by the agency that the owner lacks the financial ability to provide continuing adequate care to residents.

(c) Misappropriation or conversion of the property of a resident of the facility.

(d) Failure to follow the criteria and procedures provided under part I of chapter 394 relating to the transportation, voluntary admission, and involuntary examination of a facility resident.

(e) A citation of any of the following deficiencies as defined in s. 400.419:

1. One or more cited class I deficiencies;

2. Three or more cited class II deficiencies; or

3. Five or more cited class III deficiencies that have been cited on a single survey and have not been corrected within the time specified.~~One or more class I, three or more class II, or five or more repeated or recurring identical or similar class III violations that are similar or identical to violations which were identified by the agency within the last 2 years.~~

(f) A determination that a person subject to level 2 background screening under s. 400.4174(1) does not meet the screening standards of s. 435.04 or that the facility is retaining an employee subject to level 1 background screening standards under s. 400.4174(2) who does not meet the screening standards of s. 435.03 and for whom exemptions from disqualification have not been provided by the agency.

(g) A determination that an employee, volunteer, administrator, or owner, or person who otherwise has access to the residents of a facility does not meet the criteria specified in s. 435.03(2), and the owner or administrator has not taken action to remove the person. Exemptions from disqualification may be granted as set forth in s. 435.07. No administrative action may be taken against the facility if the person is granted an exemption.

(h) Violation of a moratorium.

(i) Failure of the license applicant, the licensee during relicensure, or a licensee that holds a provisional license to meet the minimum license requirements of this part, or related rules, at the time of license application or renewal.

(j) A fraudulent statement or omission of any material fact on an application for a license or any other document

required by the agency, including the submission of a license application that conceals the fact that any board member, officer, or person owning 5 percent or more of the facility may not meet the background screening requirements of s. 400.4174, or that the applicant has been excluded, permanently suspended, or terminated from the Medicaid or Medicare programs.

(k) An intentional or negligent life-threatening act in violation of the uniform firesafety standards for assisted living facilities or other firesafety standards that threatens the health, safety, or welfare of a resident of a facility, as communicated to the agency by the local authority having jurisdiction or the State Fire Marshal.

(l) Exclusion, permanent suspension, or termination from the Medicare or Medicaid programs.

(m) Knowingly operating any unlicensed facility or providing without a license any service that must be licensed under this chapter.

(n) Any act constituting a ground upon which application for a license may be denied.

Administrative proceedings challenging agency action under this subsection shall be reviewed on the basis of the facts and conditions that resulted in the agency action.

(2) Upon notification by the local authority having jurisdiction or by the State Fire Marshal, the agency may deny or revoke the license of an assisted living facility that fails to correct cited fire code violations that affect or threaten the health, safety, or welfare of a resident of a facility.

(3) The agency may deny a license to any applicant or to any officer or board member of an applicant who is a firm, corporation, partnership, or association or who owns 5 percent or more of the facility, if the applicant, officer, or board member has or had a 25-percent or greater financial or ownership interest in any other facility licensed under this part, or in any entity licensed by this state or another state to provide health or residential care, which facility or entity during the 5 years prior to the application for a license closed due to financial inability to operate; had a receiver appointed or a license denied, suspended, or revoked; was subject to a moratorium on admissions; had an injunctive proceeding initiated against it; or has an outstanding fine assessed under this chapter.

(4) The agency shall deny or revoke the license of an assisted living facility that has two or more class I violations that are similar or identical to violations identified by the agency during a survey, inspection, monitoring visit, or complaint investigation occurring within the previous 2 years.

(5) An action taken by the agency to suspend, deny, or revoke a facility's license under this part, in which the agency claims that the facility owner or an employee of the facility has threatened the health, safety, or welfare of a resident of the facility be heard by the Division of Administrative Hearings of the Department of Management Services within 120 days after receipt of the facility's request for a hearing, unless that time limitation is waived by both parties. The administrative law judge must render a decision within 30 days after receipt of a proposed recommended order.

(6) The agency shall provide to the Division of Hotels and Restaurants of the Department of Business and Professional Regulation, on a monthly basis, a list of those assisted living facilities that have had their licenses denied, suspended, or revoked or that are involved in an appellate proceeding pursuant to s. 120.60 related to the denial, suspension, or revocation of a license.

(7) Agency notification of a license suspension or revocation, or denial of a license renewal, shall be posted and visible to the public at the facility.

(8) The agency may issue a temporary license pending final disposition of a proceeding involving the suspension or revocation of an assisted living facility license.

Section 8. Section 400.419, Florida Statutes, is amended to read:

400.419 Violations; administrative fines; imposition of administrative fines; grounds.--

(1) The agency shall impose an administrative fine in the manner provided in chapter 120 for any of the actions or violations as set forth within this section by an assisted living facility, for the actions of any persons subject to level 2 background screening under s. 400.4174, for the actions of any facility employee, or for an intentional or negligent act seriously affecting the health, safety, or welfare of a resident of the facility.

(2)~~(1)~~ Each violation of this part and adopted rules shall be classified according to the nature of the violation and the gravity of its probable effect on facility residents. The agency shall indicate the classification on the written notice of the violation as follows:

(a) Class "I" violations are those conditions or occurrences related to the operation and maintenance of a facility or to the personal care of residents which the agency determines present an imminent danger to the residents or guests of the facility or a substantial probability that death or serious physical or emotional harm would result therefrom. The condition or practice constituting a class I violation shall be abated or eliminated within 24 hours, unless a fixed period, as determined by the agency, is required for correction. The agency shall impose an administrative fine for a cited class I violation ~~is subject to an administrative fine~~ in an amount not less than $5,000 and not exceeding $10,000 for each violation. A fine may be levied notwithstanding the correction of the violation.

(b) Class "II" violations are those conditions or occurrences related to the operation and maintenance of a facility or to the personal care of residents which the agency determines directly threaten the physical or emotional health, safety, or security of the facility residents, other than class I violations. The agency shall impose an administrative fine for a cited class II violation ~~is subject to an administrative fine~~ in an amount not less than $1,000 and not exceeding $5,000 for each violation. A fine shall be levied notwithstanding the correction of the violation ~~A citation for a class II violation must specify the time within which the violation is required to be corrected~~.

(c) Class "III" violations are those conditions or occurrences related to the operation and maintenance of a facility or to the personal care of residents which the agency determines indirectly or potentially threaten the physical or emotional health, safety, or security of facility residents,

other than class I or class II violations. The agency shall impose an administrative fine for a cited class III violation in an amount ~~is subject to an administrative fine~~ of not less than $500 and not exceeding $1,000 for each violation. A citation for a class III violation must specify the time within which the violation is required to be corrected. If a class III violation is corrected within the time specified, no fine may be imposed, unless it is a repeated offense.

(d) Class "IV" violations are those conditions or occurrences related to the operation and maintenance of a building or to required reports, forms, or documents that do not have the potential of negatively affecting residents. These violations are of a type that the agency determines do not threaten the health, safety, or security of residents of the facility. The agency shall impose an administrative fine for a cited class IV violation in an amount ~~A facility that does not correct a class IV violation within the time specified in the agency-approved corrective action plan is subject to an administrative fine~~ of not less than $100 nor more than $200 for each violation. A citation for a class IV violation must specify the time within which the violation is required to be corrected. If a class IV violation is corrected within the time specified, no fine shall be imposed.Any class IV violation that is corrected during the time an agency survey is being conducted will be identified as an agency finding and not as a violation.

(3)~~(2)~~ In determining if a penalty is to be imposed and in fixing the amount of the fine, the agency shall consider the following factors:

(a) The gravity of the violation, including the probability that death or serious physical or emotional harm

to a resident will result or has resulted, the severity of the action or potential harm, and the extent to which the provisions of the applicable laws or rules were violated.

(b) Actions taken by the owner or administrator to correct violations.

(c) Any previous violations.

(d) The financial benefit to the facility of committing or continuing the violation.

(e) The licensed capacity of the facility.

(4)~~(3)~~ Each day of continuing violation after the date fixed for termination of the violation, as ordered by the agency, constitutes an additional, separate, and distinct violation.

(5)~~(4)~~ Any action taken to correct a violation shall be documented in writing by the owner or administrator of the facility and verified through followup visits by agency personnel. The agency may impose a fine and, in the case of an owner-operated facility, revoke or deny a facility's license when a facility administrator fraudulently misrepresents action taken to correct a violation.

(6)~~(5)~~ For fines that are upheld following administrative or judicial review, the violator shall pay the fine, plus interest at the rate as specified in s. 55.03, for each day beyond the date set by the agency for payment of the fine.

(7)~~(6)~~ Any unlicensed facility that continues to operate after agency notification is subject to a $1,000 fine per day.

(8)~~(7)~~ Any licensed facility whose owner or administrator concurrently operates an unlicensed facility shall be subject to an administrative fine of $5,000 per day.

(9)~~(8)~~ Any facility whose owner fails to apply for a change-of-ownership license in accordance with s. 400.412 and operates the facility under the new ownership is subject to a fine of $5,000.

(10)~~(9)~~ In addition to any administrative fines imposed, the agency may assess a survey fee, equal to the lesser of one half of the facility's biennial license and bed fee or $500, to cover the cost of conducting initial complaint investigations that result in the finding of a violation that was the subject of the complaint or monitoring visits conducted under s. 400.428(3)(c) to verify the correction of the violations.

(11)~~(10)~~ The agency, as an alternative to or in conjunction with an administrative action against a facility for violations of this part and adopted rules, shall make a reasonable attempt to discuss each violation and recommended corrective action with the owner or administrator of the facility, prior to written notification. The agency, instead of fixing a period within which the facility shall enter into compliance with standards, may request a plan of corrective action from the facility which demonstrates a good faith effort to remedy each violation by a specific date, subject to the approval of the agency.

(12)~~(11)~~ Administrative fines paid by any facility under this section shall be deposited into the Health Care Trust Fund and expended as provided in s. 400.418.

(13)~~(12)~~ The agency shall develop and disseminate an annual list of all facilities sanctioned or fined $5,000 or more for violations of state standards, the number and class of violations involved, the penalties imposed, and the current status of cases. The list shall be disseminated, at no charge,

to the Department of Elderly Affairs, the Department of Health, the Department of Children and Family Services, the area agencies on aging, the Florida Statewide Advocacy Council, and the state and local ombudsman councils. The Department of Children and Family Services shall disseminate the list to service providers under contract to the department who are responsible for referring persons to a facility for residency. The agency may charge a fee commensurate with the cost of printing and postage to other interested parties requesting a copy of this list.

Section 9. Subsection (1) of section 400.417, Florida Statutes, is amended to read:

400.417 Expiration of license; renewal; conditional license.--

(1) Biennial licenses, unless sooner suspended or revoked, shall expire 2 years from the date of issuance. Limited nursing, extended congregate care, and limited mental health licenses shall expire at the same time as the facility's standard license, regardless of when issued. The agency shall notify the facility ~~by certified mail~~ at least 120 days prior to expiration that a renewal license is necessary to continue operation. The notification must be provided electronically or by mail delivery.Ninety days prior to the expiration date, an application for renewal shall be submitted to the agency. Fees must be prorated. The failure to file a timely renewal application shall result in a late fee charged to the facility in an amount equal to 50 percent of the current fee.

Section 10. Subsection (1) of section 400.557, Florida Statutes, is amended to read:

400.557 Expiration of license; renewal; conditional license or permit.--

(1) A license issued for the operation of an adult day care center, unless sooner suspended or revoked, expires 2 years after the date of issuance. The agency shall notify a licensee ~~by certified mail, return receipt requested,~~ at least 120 days before the expiration date that license renewal is required to continue operation. The notification must be provided electronically or by mail delivery. At least 90 days prior to the expiration date, an application for renewal must be submitted to the agency. A license shall be renewed, upon the filing of an application on forms furnished by the agency, if the applicant has first met the requirements of this part and of the rules adopted under this part. The applicant must file with the application satisfactory proof of financial ability to operate the center in accordance with the requirements of this part and in accordance with the needs of the participants to be served and an affidavit of compliance with the background screening requirements of s. 400.5572.

Section 11. Subsection (3) of section 400.619, Florida Statutes, is amended to read:

400.619 Licensure application and renewal.--

(3) The agency shall notify a licensee at least 120 days before the expiration date that license renewal is required to continue operation. The notification must be provided electronically or by mail delivery. Application for a license or annual license renewal must be made on a form provided by the agency, signed under oath, and must be accompanied by a licensing fee of $100 per year.

Section 12. Paragraph (h) of subsection (4) of section 400.980, Florida Statutes, is repealed.

Section 13. Subsections (4) and (6) of section 408.061, Florida Statutes, are amended to read:

408.061 Data collection; uniform systems of financial reporting; information relating to physician charges; confidential information; immunity.--

(4)~~(a)~~ Within 120 days after the end of its fiscal year, each health care facility, excluding nursing homes and continuing care facilities as defined in s. 408.07(23) and (36), shall file with the agency, on forms adopted by the agency and based on the uniform system of financial reporting, its actual financial experience for that fiscal year, including expenditures, revenues, and statistical measures. Such data may be based on internal financial reports which are certified to be complete and accurate by the provider. However, hospitals' actual financial experience shall be their audited actual experience. ~~Nursing homes that do not participate in the Medicare or Medicaid programs shall also submit audited actual experience.~~Every nursing home shall submit to the agency, in a format designated by the agency, a statistical profile of the nursing home residents. The agency, in conjunction with the Department of Elderly Affairs and the Department of Health, shall review these statistical profiles and develop recommendations for the types of residents who might more appropriately be placed in their homes or other noninstitutional settings.

~~(b) Each nursing home shall also submit a schedule of the charges in effect at the beginning of the fiscal year and any changes that were made during the fiscal year. A nursing home which is certified under Title XIX of the Social Security Act and files annual Medicaid cost reports may substitute copies of such reports and any Medicaid audits to the agency~~

~~in lieu of a report and audit required under this subsection. For such facilities, the agency may require only information in compliance with this chapter that is not contained in the Medicaid cost report. Facilities that are certified under Title XVIII, but not Title XIX, of the Social Security Act must submit a report as developed by the agency. This report shall be substantially the same as the Medicaid cost report and shall not require any more information than is contained in the Medicare cost report unless that information is required of all nursing homes. The audit under Title XVIII shall satisfy the audit requirement under this subsection.~~

~~(6) Any nursing home which assesses residents a separate charge for personal laundry services shall submit to the agency data on the monthly charge for such services, excluding drycleaning. For facilities that charge based on the amount of laundry, the most recent schedule of charges and the average monthly charge shall be submitted to the agency.~~

Section 14. Subsection (2) of section 408.062, Florida Statutes, is repealed.

Section 15. Present subsection (2) of section 408.831, Florida Statutes, is renumbered as subsection (3), and a new subsection (2) is added to that section, to read:

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

(2) In reviewing any application requesting a change of ownership or change of the licensee, registrant, or certificateholder, the transferor shall, prior to agency approval of the change, repay or make arrangements to repay any amounts owed to the agency. If the transferor fails to repay or make arrangements to repay the amounts owed to the agency, the issuance of a license, registration, or

certificate to the transferee shall be delayed until repayment or until arrangements for repayment are made.

Section 16. Present 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 that 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 17. 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 18. 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) of this section and to 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, 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, 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 that ensures fiscal soundness and that 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. The agency may bear the cost of providing certain services when those costs exceed established risk limits or

arrangements whereby certain 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 the furnishing of health care.

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

Section 19. Section 409.912, Florida Statutes, is amended to read:

409.912 Cost-effective purchasing of health care.--The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. The agency shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services. The agency may establish prior authorization requirements for certain populations of Medicaid beneficiaries, certain drug classes, or particular drugs to prevent fraud, abuse, overuse, and possible dangerous drug interactions. The Pharmaceutical

and Therapeutics Committee shall make recommendations to the agency on drugs for which prior authorization is required. The agency shall inform the Pharmaceutical and Therapeutics Committee of its decisions regarding drugs subject to prior authorization.

(1) The agency may enter into agreements with appropriate agents of other state agencies or of any agency of the Federal Government and accept such duties in respect to social welfare or public aid as may be necessary to implement the provisions of Title XIX of the Social Security Act and ss. 409.901-409.920.

(2) The agency may contract with health maintenance organizations certified pursuant to part I of chapter 641 for the provision of services to recipients.

(3) The agency may contract with:

(a) An entity that provides no prepaid health care services other than Medicaid services under contract with the agency and which is owned and operated by a county, county health department, or county-owned and operated hospital to provide health care services on a prepaid or fixed-sum basis to recipients, which entity may provide such prepaid services either directly or through arrangements with other providers. Such prepaid health care services entities must be licensed under parts I and III by January 1, 1998, and until then are exempt from the provisions of part I of chapter 641. An entity recognized under this paragraph which demonstrates to the satisfaction of the Department of Insurance that it is backed by the full faith and credit of the county in which it is located may be exempted from s. 641.225.

(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 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. 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.

(c) A federally qualified health center or an entity owned by one or more federally qualified health centers or an entity owned by other migrant and community health centers receiving non-Medicaid financial support from the Federal Government to provide health care services on a prepaid or fixed-sum basis to recipients. Such prepaid health care services entity must be licensed under parts I and III of chapter 641, but shall be prohibited from serving Medicaid recipients on a prepaid basis, until such licensure has been obtained. However, such an entity is exempt from s. 641.225 if the entity meets the requirements specified in subsections (14) and (15).

(d) A provider service 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.~~

(e) An entity that provides comprehensive behavioral health care services to certain Medicaid recipients through an administrative services organization agreement. Such an entity must possess the clinical systems and operational competence to provide comprehensive 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. Any contract awarded under this paragraph must be competitively procured. The agency must ensure that Medicaid recipients have available the choice of at least two managed care plans for their behavioral health care services.

(f) An entity that provides in-home physician services to test the cost-effectiveness of enhanced home-based medical care to Medicaid recipients with degenerative neurological diseases and other diseases or disabling conditions associated with high costs to Medicaid. The program shall be designed to serve very disabled persons and to reduce Medicaid reimbursed costs for inpatient, outpatient, and emergency department

services. The agency shall contract with vendors on a risk-sharing basis.

(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 department ~~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.

(h) An entity authorized in s. 430.205 to contract with the agency and the Department of Elderly Affairs to provide health care and social services on a prepaid or fixed-sum basis to elderly recipients. Such prepaid health care services entities are exempt from the provisions of part I of chapter 641 for the first 3 years of operation. An entity recognized under this paragraph that demonstrates to the satisfaction of the Department of Insurance that it is backed by the full faith and credit of one or more counties in which it operates may be exempted from s. 641.225.

(i) A Children's Medical Services network, as defined in s. 391.021.

(4) The agency may contract with any public or private entity otherwise 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, if each entity involved in providing services:

(a) Is organized primarily for the purpose of providing health care or other services of the type regularly offered to Medicaid recipients;

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

(c) Makes provisions satisfactory to the agency for insolvency protection and ensures that neither enrolled Medicaid recipients nor the agency will be liable for the debts of the entity;

(d) Submits to the agency, if a private entity, a financial plan that the agency finds to be fiscally sound and that provides for working capital in the form of cash or equivalent liquid assets excluding revenues from Medicaid premium payments equal to at least the first 3 months of operating expenses or $200,000, whichever is greater;

(e) Furnishes 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 the furnishing of health care;

(f) Provides, through contract or otherwise, for periodic review of its medical facilities and services, as required by the agency; and

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

(5) The agency may contract on a prepaid or fixed-sum basis with any health insurer that:

(a) Pays for health care services provided to enrolled Medicaid recipients in exchange for a premium payment paid by the agency;

(b) Assumes the underwriting risk; and

(c) Is organized and licensed under applicable provisions of the Florida Insurance Code and is currently in good standing with the Department of Insurance.

(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.

(7) The Agency for Health Care Administration may provide cost-effective purchasing of chiropractic services on a fee-for-service basis to Medicaid recipients through arrangements with a statewide chiropractic preferred provider organization incorporated in this state as a not-for-profit corporation. The agency shall ensure that the benefit limits and prior authorization requirements in the current Medicaid program shall apply to the services provided by the chiropractic preferred provider organization.

(8) The agency shall not contract on a prepaid or fixed-sum basis for Medicaid services with an entity which knows or reasonably should know that any officer, director, agent, managing employee, or owner of stock or beneficial interest in excess of 5 percent common or preferred stock, or the entity itself, has been found guilty of, regardless of adjudication, or entered a plea of nolo contendere, or guilty, to:

(a) Fraud;

(b) Violation of federal or state antitrust statutes, including those proscribing price fixing between competitors and the allocation of customers among competitors;

(c) Commission of a felony involving embezzlement, theft, forgery, income tax evasion, bribery, falsification or destruction of records, making false statements, receiving stolen property, making false claims, or obstruction of justice; or

(d) Any crime in any jurisdiction which directly relates to the provision of health services on a prepaid or fixed-sum basis.

(9) The agency, after notifying the Legislature, may apply for waivers of applicable federal laws and regulations as necessary to implement more appropriate systems of health care for Medicaid recipients and reduce the cost of the Medicaid program to the state and federal governments and shall implement such programs, after legislative approval, within a reasonable period of time after federal approval. These programs must be designed primarily to reduce the need for inpatient care, custodial care and other long-term or institutional care, and other high-cost services.

(a) Prior to seeking legislative approval of such a waiver as authorized by this subsection, the agency shall provide notice and an opportunity for public comment. Notice shall be provided to all persons who have made requests of the agency for advance notice and shall be published in the Florida Administrative Weekly not less than 28 days prior to the intended action.

(b) Notwithstanding s. 216.292, funds that are appropriated to the Department of Elderly Affairs for the Assisted Living for the Elderly Medicaid waiver and are not expended shall be transferred to the agency to fund Medicaid-reimbursed nursing home care.

(10) The agency shall establish a postpayment utilization control program designed to identify recipients who may inappropriately overuse or underuse Medicaid services and shall provide methods to correct such misuse.

(11) The agency shall develop and provide coordinated systems of care for Medicaid recipients and may contract with public or private entities to develop and administer such systems of care among public and private health care providers in a given geographic area.

(12) The agency shall operate or contract for the operation of utilization management and incentive systems designed to encourage cost-effective use services.

(13)(a) The agency shall operate the Comprehensive Assessment and Review (CARES) nursing facility preadmission screening program to ensure that Medicaid payment for nursing facility care is made only for individuals whose conditions require such care and to ensure that long-term care services are provided in the setting most appropriate to the needs of the person and in the most economical manner possible. The CARES program shall also ensure that individuals participating in Medicaid home and community-based waiver programs meet criteria for those programs, consistent with approved federal waivers.

(b) The agency shall operate the CARES program through an interagency agreement with the Department of Elderly Affairs.

(c) Prior to making payment for nursing facility services for a Medicaid recipient, the agency must verify that the nursing facility preadmission screening program has determined that the individual requires nursing facility care and that the individual cannot be safely served in

community-based programs. The nursing facility preadmission screening program shall refer a Medicaid recipient to a community-based program if the individual could be safely served at a lower cost and the recipient chooses to participate in such program.

(d) By January 1 of each year, the agency shall submit a report to the Legislature and the Office of Long-Term-Care Policy describing the operations of the CARES program. The report must describe:

1. Rate of diversion to community alternative programs;

2. CARES program staffing needs to achieve additional diversions;

3. Reasons the program is unable to place individuals in less restrictive settings when such individuals desired such services and could have been served in such settings;

4. Barriers to appropriate placement, including barriers due to policies or operations of other agencies or state-funded programs; and

5. Statutory changes necessary to ensure that individuals in need of long-term care services receive care in the least restrictive environment.

(14)(a) The agency shall identify health care utilization and price patterns within the Medicaid program which are not cost-effective or medically appropriate and assess the effectiveness of new or alternate methods of providing and monitoring service, and may implement such methods as it considers appropriate. Such methods may include disease management initiatives, an integrated and systematic approach for managing the health care needs of recipients who are at risk of or diagnosed with a specific disease by using

best practices, prevention strategies, clinical-practice improvement, clinical interventions and protocols, outcomes research, information technology, and other tools and resources to reduce overall costs and improve measurable outcomes.

(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 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. The agency may apply for any federal waivers needed to implement this paragraph.

(15) An entity contracting on a prepaid or fixed-sum basis shall, in addition to meeting any applicable statutory surplus requirements, also maintain at all times in the form of cash, investments that mature in less than 180 days allowable as admitted assets by the Department of Insurance, and restricted funds or deposits controlled by the agency or the Department of Insurance, a surplus amount equal to one-and-one-half times the entity's monthly Medicaid prepaid

revenues. As used in this subsection, the term "surplus" means the entity's total assets minus total liabilities. If an entity's surplus falls below an amount equal to one-and-one-half times the entity's monthly Medicaid prepaid revenues, the agency shall prohibit the entity from engaging in marketing and preenrollment activities, shall cease to process new enrollments, and shall not renew the entity's contract until the required balance is achieved. The requirements of this subsection do not apply:

(a) Where a public entity agrees to fund any deficit incurred by the contracting entity; or

(b) Where the entity's performance and obligations are guaranteed in writing by a guaranteeing organization which:

1. Has been in operation for at least 5 years and has assets in excess of $50 million; or

2. Submits a written guarantee acceptable to the agency which is irrevocable during the term of the contracting entity's contract with the agency and, upon termination of the contract, until the agency receives proof of satisfaction of all outstanding obligations incurred under the contract.

(16)(a) The agency may require an entity contracting on a prepaid or fixed-sum basis to establish a restricted insolvency protection account with a federally guaranteed financial institution licensed to do business in this state. The entity shall deposit into that account 5 percent of the capitation payments made by the agency each month until a maximum total of 2 percent of the total current contract amount is reached. The restricted insolvency protection account may be drawn upon with the authorized signatures of two persons designated by the entity and two representatives of the agency. If the agency finds that the entity is

insolvent, the agency may draw upon the account solely with the two authorized signatures of representatives of the agency, and the funds may be disbursed to meet financial obligations incurred by the entity under the prepaid contract. If the contract is terminated, expired, or not continued, the account balance must be released by the agency to the entity upon receipt of proof of satisfaction of all outstanding obligations incurred under this contract.

(b) The agency may waive the insolvency protection account requirement in writing when evidence is on file with the agency of adequate insolvency insurance and reinsurance that will protect enrollees if the entity becomes unable to meet its obligations.

(17) An entity that contracts with the agency on a prepaid or fixed-sum basis for the provision of Medicaid services shall reimburse any hospital or physician that is outside the entity's authorized geographic service area as specified in its contract with the agency, and that provides services authorized by the entity to its members, at a rate negotiated with the hospital or physician for the provision of services or according to the lesser of the following:

(a) The usual and customary charges made to the general public by the hospital or physician; or

(b) The Florida Medicaid reimbursement rate established for the hospital or physician.

(18) When a merger or acquisition of a Medicaid prepaid contractor has been approved by the Department of Insurance pursuant to s. 628.4615, the agency shall approve the assignment or transfer of the appropriate Medicaid prepaid contract upon request of the surviving entity of the merger or acquisition if the contractor and the other entity have been

in good standing with the agency for the most recent 12-month period, unless the agency determines that the assignment or transfer would be detrimental to the Medicaid recipients or the Medicaid program. To be in good standing, an entity must not have failed accreditation or committed any material violation of the requirements of s. 641.52 and must meet the Medicaid contract requirements. For purposes of this section, a merger or acquisition means a change in controlling interest of an entity, including an asset or stock purchase.

(19) Any entity contracting with the agency pursuant to this section to provide health care services to Medicaid recipients is prohibited from engaging in any of the following practices or activities:

(a) Practices that are discriminatory, including, but not limited to, attempts to discourage participation on the basis of actual or perceived health status.

(b) Activities that could mislead or confuse recipients, or misrepresent the organization, its marketing representatives, or the agency. Violations of this paragraph include, but are not limited to:

1. False or misleading claims that marketing representatives are employees or representatives of the state or county, or of anyone other than the entity or the organization by whom they are reimbursed.

2. False or misleading claims that the entity is recommended or endorsed by any state or county agency, or by any other organization which has not certified its endorsement in writing to the entity.

3. False or misleading claims that the state or county recommends that a Medicaid recipient enroll with an entity.

4. Claims that a Medicaid recipient will lose benefits under the Medicaid program, or any other health or welfare benefits to which the recipient is legally entitled, if the recipient does not enroll with the entity.

(c) Granting or offering of any monetary or other valuable consideration for enrollment, except as authorized by subsection (21).

(d) Door-to-door solicitation of recipients who have not contacted the entity or who have not invited the entity to make a presentation.

(e) Solicitation of Medicaid recipients by marketing representatives stationed in state offices unless approved and supervised by the agency or its agent and approved by the affected state agency when solicitation occurs in an office of the state agency. The agency shall ensure that marketing representatives stationed in state offices shall market their managed care plans to Medicaid recipients only in designated areas and in such a way as to not interfere with the recipients' activities in the state office.

(f) Enrollment of Medicaid recipients.

(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 $2,500 per violation. In no event shall such fine exceed an aggregate amount of $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 $20,000 for each such violation. In no event shall such fine exceed an aggregate amount of $100,000

for all knowing and willful violations arising out of the same action.

(21) A health maintenance organization or a person or entity exempt from chapter 641 that is under contract with the agency for the provision of health care services to Medicaid recipients may not use or distribute marketing materials used to solicit Medicaid recipients, unless such materials have been approved by the agency. The provisions of this subsection do not apply to general advertising and marketing materials used by a health maintenance organization to solicit both non-Medicaid subscribers and Medicaid recipients.

(22) Upon approval by the agency, health maintenance organizations and persons or entities exempt from chapter 641 that are under contract with the agency for the provision of health care services to Medicaid recipients may be permitted within the capitation rate to provide additional health benefits that the agency has found are of high quality, are practicably available, provide reasonable value to the recipient, and are provided at no additional cost to the state.

(23) The agency shall utilize the statewide health maintenance organization complaint hotline for the purpose of investigating and resolving Medicaid and prepaid health plan complaints, maintaining a record of complaints and confirmed problems, and receiving disenrollment requests made by recipients.

(24) The agency shall require the publication of the health maintenance organization's and the prepaid health plan's consumer services telephone numbers and the "800" telephone number of the statewide health maintenance organization complaint hotline on each Medicaid identification

card issued by a health maintenance organization or prepaid health plan contracting with the agency to serve Medicaid recipients and on each subscriber handbook issued to a Medicaid recipient.

(25) The agency shall establish a health care quality improvement system for those entities contracting with the agency pursuant to this section, incorporating all the standards and guidelines developed by the Medicaid Bureau of the Health Care Financing Administration as a part of the quality assurance reform initiative. The system shall include, but need not be limited to, the following:

(a) Guidelines for internal quality assurance programs, including standards for:

1. Written quality assurance program descriptions.

2. Responsibilities of the governing body for monitoring, evaluating, and making improvements to care.

3. An active quality assurance committee.

4. Quality assurance program supervision.

5. Requiring the program to have adequate resources to effectively carry out its specified activities.

6. Provider participation in the quality assurance program.

7. Delegation of quality assurance program activities.

8. Credentialing and recredentialing.

9. Enrollee rights and responsibilities.

10. Availability and accessibility to services and care.

11. Ambulatory care facilities.

12. Accessibility and availability of medical records, as well as proper recordkeeping and process for record review.

13. Utilization review.

14. A continuity of care system.

15. Quality assurance program documentation.

16. Coordination of quality assurance activity with other management activity.

17. Delivering care to pregnant women and infants; to elderly and disabled recipients, especially those who are at risk of institutional placement; to persons with developmental disabilities; and to adults who have chronic, high-cost medical conditions.

(b) Guidelines which require the entities to conduct quality-of-care studies which:

1. Target specific conditions and specific health service delivery issues for focused monitoring and evaluation.

2. Use clinical care standards or practice guidelines to objectively evaluate the care the entity delivers or fails to deliver for the targeted clinical conditions and health services delivery issues.

3. Use quality indicators derived from the clinical care standards or practice guidelines to screen and monitor care and services delivered.

(c) Guidelines for external quality review of each contractor which require: focused studies of patterns of care; individual care review in specific situations; and followup activities on previous pattern-of-care study findings and individual-care-review findings. In designing the external quality review function and determining how it is to operate as part of the state's overall quality improvement system, the agency shall construct its external quality review organization and entity contracts to address each of the following:

1. Delineating the role of the external quality review organization.

2. Length of the external quality review organization contract with the state.

3. Participation of the contracting entities in designing external quality review organization review activities.

4. Potential variation in the type of clinical conditions and health services delivery issues to be studied at each plan.

5. Determining the number of focused pattern-of-care studies to be conducted for each plan.

6. Methods for implementing focused studies.

7. Individual care review.

8. Followup activities.

(26) In order to ensure that children receive health care services for which an entity has already been compensated, an entity contracting with the agency pursuant to this section shall achieve an annual Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Service screening rate of at least 60 percent for those recipients continuously enrolled for at least 8 months. The agency shall develop a method by which the EPSDT screening rate shall be calculated. For any entity which does not achieve the annual 60 percent rate, the entity must submit a corrective action plan for the agency's approval. If the entity does not meet the standard established in the corrective action plan during the specified timeframe, the agency is authorized to impose appropriate contract sanctions. At least annually, the agency shall publicly release the EPSDT Services screening rates of each

entity it has contracted with on a prepaid basis to serve Medicaid recipients.

(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.

(28) Any lists of providers made available to Medicaid recipients, MediPass enrollees, or managed care plan enrollees shall be arranged alphabetically showing the provider's name

and specialty and, separately, by specialty in alphabetical order.

(29) The agency shall establish an enhanced managed care quality assurance oversight function, to include at least the following components:

(a) At least quarterly analysis and followup, including sanctions as appropriate, of managed care participant utilization of services.

(b) At least quarterly analysis and followup, including sanctions as appropriate, of quality findings of the Medicaid peer review organization and other external quality assurance programs.

(c) At least quarterly analysis and followup, including sanctions as appropriate, of the fiscal viability of managed care plans.

(d) At least quarterly analysis and followup, including sanctions as appropriate, of managed care participant satisfaction and disenrollment surveys.

(e) The agency shall conduct regular and ongoing Medicaid recipient satisfaction surveys.

The analyses and followup activities conducted by the agency under its enhanced managed care quality assurance oversight function shall not duplicate the activities of accreditation reviewers for entities regulated under part III of chapter 641, but may include a review of the finding of such reviewers.

(30) Each managed care plan that is under contract with the agency to provide health care services to Medicaid recipients shall annually conduct a background check with the Florida Department of Law Enforcement of all persons with

ownership interest of 5 percent or more or executive management responsibility for the managed care plan and shall submit to the agency information concerning any such person who has been found guilty of, regardless of adjudication, or has entered a plea of nolo contendere or guilty to, any of the offenses listed in s. 435.03.

(31) The agency shall, by rule, develop a process whereby a Medicaid managed care plan enrollee who wishes to enter hospice care may be disenrolled from the managed care plan within 24 hours after contacting the agency regarding such request. The agency rule shall include a methodology for the agency to recoup managed care plan payments on a pro rata basis if payment has been made for the enrollment month when disenrollment occurs.

(32) The agency and entities which contract with the agency to provide health care services to Medicaid recipients under this section or s. 409.9122 must comply with the provisions of s. 641.513 in providing emergency services and care to Medicaid recipients and MediPass recipients.

(33) All entities providing health care services to Medicaid recipients shall make available, and encourage all pregnant women and mothers with infants to receive, and provide documentation in the medical records to reflect, the following:

(a) Healthy Start prenatal or infant screening.

(b) Healthy Start care coordination, when screening or other factors indicate need.

(c) Healthy Start enhanced services in accordance with the prenatal or infant screening results.

(d) Immunizations in accordance with recommendations of the Advisory Committee on Immunization Practices of the

United States Public Health Service and the American Academy of Pediatrics, as appropriate.

(e) Counseling and services for family planning to all women and their partners.

(f) A scheduled postpartum visit for the purpose of voluntary family planning, to include discussion of all methods of contraception, as appropriate.

(g) Referral to the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

(34) Any entity that provides Medicaid prepaid health plan services shall ensure the appropriate coordination of health care services with an assisted living facility in cases where a Medicaid recipient is both a member of the entity's prepaid health plan and a resident of the assisted living facility. If the entity is at risk for Medicaid targeted case management and behavioral health services, the entity shall inform the assisted living facility of the procedures to follow should an emergent condition arise.

(35) The agency may seek and implement federal waivers necessary to provide for cost-effective purchasing of home health services, private duty nursing services, transportation, independent laboratory services, and durable medical equipment and supplies through competitive bidding pursuant to s. 287.057. The agency may request appropriate waivers from the federal Health Care Financing Administration in order to competitively bid such services. The agency may exclude providers not selected through the bidding process from the Medicaid provider network.

~~(36) The Agency for Health Care Administration is directed to issue a request for proposal or intent to negotiate to implement on a demonstration basis an outpatient~~

~~specialty services pilot project in a rural and urban county in the state. As used in this subsection, the term "outpatient specialty services" means clinical laboratory, diagnostic imaging, and specified home medical services to include durable medical equipment, prosthetics and orthotics, and infusion therapy.~~

~~(a) The entity that is awarded the contract to provide Medicaid managed care outpatient specialty services must, at a minimum, meet the following criteria:~~

~~1. The entity must be licensed by the Department of Insurance under part II of chapter 641.~~

~~2. The entity must be experienced in providing outpatient specialty services.~~

~~3. The entity must demonstrate to the satisfaction of the agency that it provides high-quality services to its patients.~~

~~4. The entity must demonstrate that it has in place a complaints and grievance process to assist Medicaid recipients enrolled in the pilot managed care program to resolve complaints and grievances.~~

~~(b) The pilot managed care program shall operate for a period of 3 years. The objective of the pilot program shall be to determine the cost-effectiveness and effects on utilization, access, and quality of providing outpatient specialty services to Medicaid recipients on a prepaid, capitated basis.~~

~~(c) The agency shall conduct a quality assurance review of the prepaid health clinic each year that the demonstration program is in effect. The prepaid health clinic is responsible for all expenses incurred by the agency in conducting a quality assurance review.~~

~~(d) The entity that is awarded the contract to provide outpatient specialty services to Medicaid recipients shall report data required by the agency in a format specified by the agency, for the purpose of conducting the evaluation required in paragraph (e).~~

~~(e) The agency shall conduct an evaluation of the pilot managed care program and report its findings to the Governor and the Legislature by no later than January 1, 2001.~~

(36)~~(37)~~ The agency shall enter into agreements with not-for-profit organizations based in this state for the purpose of providing vision screening.

(37)~~(38)~~(a) The agency shall implement a Medicaid prescribed-drug spending-control program that includes the following components:

1. Medicaid prescribed-drug coverage for brand-name drugs for adult Medicaid recipients is limited to the dispensing of four brand-name drugs per month per recipient. Children are exempt from this restriction. Antiretroviral agents are excluded from this limitation. No requirements for prior authorization or other restrictions on medications used to treat mental illnesses such as schizophrenia, severe depression, or bipolar disorder may be imposed on Medicaid recipients. Medications that will be available without restriction for persons with mental illnesses include atypical antipsychotic medications, conventional antipsychotic medications, selective serotonin reuptake inhibitors, and other medications used for the treatment of serious mental illnesses. The agency shall also limit the amount of a prescribed drug dispensed to no more than a 34-day supply. The agency shall continue to provide unlimited generic drugs, contraceptive drugs and items, and diabetic supplies. Although

a drug may be included on the preferred drug formulary, it would not be exempt from the four-brand limit. The agency may authorize exceptions to the brand-name-drug restriction based upon the treatment needs of the patients, only when such exceptions are based on prior consultation provided by the agency or an agency contractor, but the agency must establish procedures to ensure that:

a. There will be a response to a request for prior consultation by telephone or other telecommunication device within 24 hours after receipt of a request for prior consultation;

b. A 72-hour supply of the drug prescribed will be provided in an emergency or when the agency does not provide a response within 24 hours as required by sub-subparagraph a.; and

c. Except for the exception for nursing home residents and other institutionalized adults and except for drugs on the restricted formulary for which prior authorization may be sought by an institutional or community pharmacy, prior authorization for an exception to the brand-name-drug restriction is sought by the prescriber and not by the pharmacy. When prior authorization is granted for a patient in an institutional setting beyond the brand-name-drug restriction, such approval is authorized for 12 months and monthly prior authorization is not required for that patient.

2. Reimbursement to pharmacies for Medicaid prescribed drugs shall be set at the average wholesale price less 13.25 percent.

3. The agency shall develop and implement a process for managing the drug therapies of Medicaid recipients who are using significant numbers of prescribed drugs each month. The

management process may include, but is not limited to, comprehensive, physician-directed medical-record reviews, claims analyses, and case evaluations to determine the medical necessity and appropriateness of a patient's treatment plan and drug therapies. The agency may contract with a private organization to provide drug-program-management services. The Medicaid drug benefit management program shall include initiatives to manage drug therapies for HIV/AIDS patients, patients using 20 or more unique prescriptions in a 180-day period, and the top 1,000 patients in annual spending.

4. The agency may limit the size of its pharmacy network based on need, competitive bidding, price negotiations, credentialing, or similar criteria. The agency shall give special consideration to rural areas in determining the size and location of pharmacies included in the Medicaid pharmacy network. A pharmacy credentialing process may include criteria such as a pharmacy's full-service status, location, size, patient educational programs, patient consultation, disease-management services, and other characteristics. The agency may impose a moratorium on Medicaid pharmacy enrollment when it is determined that it has a sufficient number of Medicaid-participating providers.

5. The agency shall develop and implement a program that requires Medicaid practitioners who prescribe drugs to use a counterfeit-proof prescription pad for Medicaid prescriptions. The agency shall require the use of standardized counterfeit-proof prescription pads by Medicaid-participating prescribers or prescribers who write prescriptions for Medicaid recipients. The agency may implement the program in targeted geographic areas or statewide.

6. The agency may enter into arrangements that require manufacturers of generic drugs prescribed to Medicaid recipients to provide rebates of at least 15.1 percent of the average manufacturer price for the manufacturer's generic products. These arrangements shall require that if a generic-drug manufacturer pays federal rebates for Medicaid-reimbursed drugs at a level below 15.1 percent, the manufacturer must provide a supplemental rebate to the state in an amount necessary to achieve a 15.1-percent rebate level.

7. The agency may establish a preferred drug formulary in accordance with 42 U.S.C. s. 1396r-8, and, pursuant to the establishment of such formulary, it is authorized to negotiate supplemental rebates from manufacturers that are in addition to those required by Title XIX of the Social Security Act and at no less than 10 percent of the average manufacturer price as defined in 42 U.S.C. s. 1936 on the last day of a quarter unless the federal or supplemental rebate, or both, equals or exceeds 25 percent. There is no upper limit on the supplemental rebates the agency may negotiate. The agency may determine that specific products, brand-name or generic, are competitive at lower rebate percentages. Agreement to pay the minimum supplemental rebate percentage will guarantee a manufacturer that the Medicaid Pharmaceutical and Therapeutics Committee will consider a product for inclusion on the preferred drug formulary. However, a pharmaceutical manufacturer is not guaranteed placement on the formulary by simply paying the minimum supplemental rebate. Agency decisions will be made on the clinical efficacy of a drug and recommendations of the Medicaid Pharmaceutical and Therapeutics Committee, as well as the price of competing products minus federal and state rebates. The agency is

authorized to contract with an outside agency or contractor to conduct negotiations for supplemental rebates. For the purposes of this section, the term "supplemental rebates" may include, at the agency's discretion, cash rebates and other program benefits that offset a Medicaid expenditure. Such other program benefits may include, but are not limited to, disease management programs, drug product donation programs, drug utilization control programs, prescriber and beneficiary counseling and education, fraud and abuse initiatives, and other services or administrative investments with guaranteed savings to the Medicaid program in the same year the rebate reduction is included in the General Appropriations Act. The agency is authorized to seek any federal waivers to implement this initiative.

8. The agency shall establish an advisory committee for the purposes of studying the feasibility of using a restricted drug formulary for nursing home residents and other institutionalized adults. The committee shall be comprised of seven members appointed by the Secretary of Health Care Administration. The committee members shall include two physicians licensed under chapter 458 or chapter 459; three pharmacists licensed under chapter 465 and appointed from a list of recommendations provided by the Florida Long-Term Care Pharmacy Alliance; and two pharmacists licensed under chapter 465.

9. The Agency for Health Care Administration shall expand home delivery of pharmacy products. To assist Medicaid patients in securing their prescriptions and reduce program costs, the agency shall expand its current mail-order-pharmacy diabetes-supply program to include all generic and brand-name drugs used by Medicaid patients with diabetes. Medicaid

recipients in the current program may obtain nondiabetes drugs on a voluntary basis. This initiative is limited to the geographic area covered by the current contract. The agency may seek and implement any federal waivers necessary to implement this subparagraph.

(b) The agency shall implement this subsection to the extent that funds are appropriated to administer the Medicaid prescribed-drug spending-control program. The agency may contract all or any part of this program to private organizations.

(c) The agency shall submit quarterly reports to the Governor, the President of the Senate, and the Speaker of the House of Representatives which must include, but need not be limited to, the progress made in implementing this subsection and its effect on Medicaid prescribed-drug expenditures.

(38)~~(39)~~ Notwithstanding the provisions of chapter 287, the agency may, at its discretion, renew a contract or contracts for fiscal intermediary services one or more times for such periods as the agency may decide; however, all such renewals may not combine to exceed a total period longer than the term of the original contract.

(39)~~(40)~~ The agency shall provide for the development of a demonstration project by establishment in Miami-Dade County of a long-term-care facility licensed pursuant to chapter 395 to improve access to health care for a predominantly minority, medically underserved, and medically complex population and to evaluate alternatives to nursing home care and general acute care for such population. Such project is to be located in a health care condominium and colocated with licensed facilities providing a continuum of care. The establishment of this project is not subject to the

provisions of s. 408.036 or s. 408.039. The agency shall report its findings to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 1, 2003.

Section 20. Subsections (25) and (26) of section 409.901, Florida Statutes, are amended to read:

409.901 Definitions; ss. 409.901-409.920.--As used in ss. 409.901-409.920, except as otherwise specifically provided, the term:

(25) "Third party" means an individual, entity, or program, excluding Medicaid, that is, may be, could be, should be, or has been liable for all or part of the cost of medical services related to any medical assistance covered by Medicaid. <u>The term includes third party administrators and pharmacy benefit managers.</u>

(26) "Third-party benefit" means any benefit that is or may be available at any time through contract, court award, judgment, settlement, agreement, or any arrangement between a third party and any person or entity, including, without limitation, a Medicaid recipient, a provider, another third party, an insurer, or the agency, for any Medicaid-covered injury, illness, goods, or services, including costs of medical services related thereto, for personal injury or for death of the recipient, but specifically excluding policies of life insurance on the recipient, unless available under terms of the policy to pay medical expenses prior to death. The term includes, without limitation, collateral, as defined in this section, health insurance, any benefit under a health maintenance organization, <u>Neurological Injury Compensation Association funds,</u>preferred provider arrangement, a prepaid health clinic, liability insurance, uninsured motorist

insurance or personal injury protection coverage, medical benefits under workers' compensation, and any obligation under law or equity to provide medical support.

Section 21. 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 22. Subsection (30) of section 409.913, Florida Statutes, is amended to read:

409.913 Oversight of the integrity of the Medicaid program.--The agency shall operate a program to oversee the activities of Florida Medicaid recipients, and providers and their representatives, to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent

possible, and to recover overpayments and impose sanctions as appropriate. 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.

(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 23. 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; 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 24. Paragraph (a) of subsection (4) of section 766.314, Florida Statutes, is amended to read:

766.314 Assessments; plan of operation.--

(4) The following persons and entities shall pay into the association an initial assessment in accordance with the plan of operation:

(a) On or before October 1, 1988, each hospital licensed under chapter 395 shall pay an initial assessment of $50 per infant delivered in the hospital during the prior calendar year, as reported to the Agency for Health Care Administration; provided, however, that a hospital owned or operated by the state or a county, special taxing district, or other political subdivision of the state shall not be required to pay the initial assessment or any assessment required by subsection (5). The term "infant delivered" includes live births and not stillbirths, but the term does not include infants delivered by employees or agents of the Board of Regents, ~~or~~ those born in a teaching hospital as defined in s. 408.07, or those born in a teaching hospital as defined in s. 395.806 which had been deemed by the association as being exempt from assessments since fiscal year 1997 to fiscal year 2001. The initial assessment and any assessment imposed pursuant to subsection (5) may not include any infant born to a charity patient (as defined by rule of the Agency for Health Care Administration) or born to a patient for whom the hospital receives Medicaid reimbursement, if the sum of the annual charges for charity patients plus the annual Medicaid contractuals of the hospital exceeds 10 percent of the total annual gross operating revenues of the hospital. The hospital is responsible for documenting, to the satisfaction of the association, the exclusion of any birth from the computation

of the assessment. Upon demonstration of financial need by a hospital, the association may provide for installment payments of assessments.

Section 25. Subsection (5) of section 400.462, Florida Statutes, is amended to read:

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

(5) "Companion" or "sitter" means a person who provides companionship to an elderly, handicapped, or convalescent individual;~~cares for an elderly, handicapped, or convalescent individual and~~ accompanies such individual on trips and outings;and may prepare and serve meals to such individual. A companion may not provide hands-on personal care to a client.

Section 26. Subsections (4) and (5) of section 400.464, Florida Statutes, are amended to read:

400.464 Home health agencies to be licensed; expiration of license; exemptions; unlawful acts; penalties.--

(4)(a) An organization may not provide, offer, or advertise home health services to the public unless the organization has a valid license or is specifically exempted under this part. An organization that offers or advertises to the public any service for which licensure ~~or registration~~ is required under this part must include in the advertisement the license number ~~or regulation number~~ issued to the organization by the agency. The agency shall assess a fine of not less than $100 to any licensee ~~or registrant~~ who fails to include the license ~~or registration~~ number when submitting the advertisement for publication, broadcast, or printing. The holder of a license issued under this part may not advertise or indicate to the public that it holds a home health agency

or nurse registry license other than the one it has been issued.

(b) A person who violates paragraph (a) is subject to an injunctive proceeding under s. 400.515. A violation of paragraph (a) is a deceptive and unfair trade practice and constitutes a violation of the Florida Deceptive and Unfair Trade Practices Act under part II of chapter 501.

(c) A person who violates the provisions of paragraph (a) commits a felony ~~misdemeanor~~ of the third ~~second~~ degree, punishable as provided in s. 775.082, ~~or~~ s. 775.083, or s. 775.084. Any person who commits a second or subsequent violation commits a felony ~~misdemeanor~~ of the second ~~first~~ degree, punishable as provided in s. 775.082, ~~or~~ s. 775.083, or s. 775.084. Each day of continuing violation constitutes a separate offense.

(d) Any person who owns, operates, or maintains an unlicensed home health agency or unlicensed nurse registry and who, within 10 working days after receiving notification from the agency, fails to cease operation and apply for a license under this part commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. Each day of continued operation is a separate offense.

(e) Any home health agency, as defined in this part, or nurse registry that fails to cease operation after agency notification may be fined $500 for each day of noncompliance.

(5) The following are exempt from the licensure requirements of this part:

(a) A home health agency operated by the Federal Government.

(b) Home health services provided by a state agency, either directly or through a contractor with:

1. The Department of Elderly Affairs.

2. The Department of Health, a community health center, or a rural health network that furnishes home visits for the purpose of providing environmental assessments, case management, health education, personal care services, family planning, or followup treatment, or for the purpose of monitoring and tracking disease.

3. Services provided to persons who have developmental disabilities, as defined in s. 393.063(12).

4. Companion and sitter organizations that were ~~registered under s. 400.509(1) on January 1, 1999, and were~~ authorized to provide personal services under s. 393.063(33) under a developmental services provider certificate on January 1, 1999, may continue to provide such services to past, present, and future clients of the organization who need such services, notwithstanding the provisions of this act.

5. The Department of Children and Family Services.

(c) A health care professional, whether or not incorporated, who is licensed under chapter 457; chapter 458; chapter 459; part I of chapter 464; chapter 467; part I, part III, part V, or part X of chapter 468; chapter 480; chapter 486; chapter 490; or chapter 491; and who is acting alone within the scope of his or her professional license to provide care to patients in their homes.

(d) A home health aide or certified nursing assistant who is acting in his or her individual capacity, within the definitions and standards of his or her occupation, and who provides hands-on care to patients in their homes.

(e) An individual who acts alone, in his or her individual capacity, and who is not employed by or affiliated with a licensed home health agency or registered with a licensed nurse registry. This exemption does not entitle an individual to perform home health services without the required professional license.

(f) The delivery of instructional services in home dialysis and home dialysis supplies and equipment.

(g) The delivery of nursing home services for which the nursing home is licensed under part II of this chapter, to serve its residents in its facility.

(h) The delivery of assisted living facility services for which the assisted living facility is licensed under part III of this chapter, to serve its residents in its facility.

(i) The delivery of hospice services for which the hospice is licensed under part VI of this chapter, to serve hospice patients admitted to its service.

(j) A hospital that provides services for which it is licensed under chapter 395.

(k) The delivery of community residential services for which the community residential home is licensed under chapter 419, to serve the residents in its facility.

(l) A not-for-profit, community-based agency that provides early intervention services to infants and toddlers.

(m) Certified rehabilitation agencies and comprehensive outpatient rehabilitation facilities that are certified under Title 18 of the Social Security Act.

(n) The delivery of adult family care home services for which the adult family care home is licensed under part VII of this chapter, to serve the residents in its facility.

Section 27. Subsection (2) of section 400.471, Florida Statutes, is amended to read:

400.471 Application for license; fee; provisional license; temporary permit.--

(2) The applicant must file with the application satisfactory proof that the home health agency is in compliance with this part and applicable rules, including:

(a) A listing of services to be provided, either directly by the applicant or through contractual arrangements with existing providers;

(b) The number and discipline of professional staff to be employed; ~~and~~

(c) Proof of financial ability to operate; and~~.~~

(d) Completion of volume data questions on the renewal application.

Section 28. Subsection (2) of section 400.487, Florida Statutes, is amended to read:

400.487 Home health service agreements; physician's treatment orders; patient assessment; establishment and review of plan of care; provision of services; orders not to resuscitate.--

(2) When required by the provisions of chapter 464; part I, part III, or part V of chapter 468; or chapter 486, the attending physician for a patient who is to receive skilled care must establish treatment orders. The treatment orders must be signed by the physician. If the claim is submitted to a managed care organization, the treatment orders shall be signed in the time allowed under the provider agreement. The treatment orders shall ~~within 30 days after the start of care and must~~ be reviewed, as frequently as the patient's illness requires, by the physician in consultation

with the home health agency ~~personnel that provide services to the patient~~.

Section 29. Section 400.491, Florida Statutes, is amended to read:

400.491 Clinical records.--

~~(1)~~ The home health agency must maintain for each patient who receives skilled care a clinical record that includes pertinent past and current medical, nursing, social and other therapeutic information, the treatment orders, and other such information as is necessary for the safe and adequate care of the patient. When home health services are terminated, the record must show the date and reason for termination. Such records are considered patient records under s. 456.057, and must be maintained by the home health agency for 5 years following termination of services. If a patient transfers to another home health agency, a copy of his or her record must be provided to the other home health agency upon request.

~~(2) The home health agency must maintain for each client who receives nonskilled care a service provision plan. Such records must be maintained by the home health agency for 1 year following termination of services.~~

Section 30. Section 400.512, Florida Statutes, is amended to read:

400.512 Screening of home health agency personnel and~~,~~ nurse registry personnel~~, and companions and homemakers~~.--The agency shall require employment or contractor screening as provided in chapter 435, using the level 1 standards for screening set forth in that chapter, for home health agency personnel and~~,~~persons referred for employment by nurse

registries~~; and persons employed by companion or homemaker services registered under s. 400.509~~.

(1)(a) The Agency for Health Care Administration may, upon request, grant exemptions from disqualification from employment or contracting under this section as provided in s. 435.07, except for health care practitioners licensed by the Department of Health or a regulatory board within that department.

(b) The appropriate regulatory board within the Department of Health, or that department itself when there is no board, may, upon request of the licensed health care practitioner, grant exemptions from disqualification from employment or contracting under this section as provided in s. 435.07.

(2) The administrator of each home health agency and~~,~~ the managing employee of each nurse registry~~, and the managing employee of each companion or homemaker service registered under s. 400.509~~ must sign an affidavit annually, under penalty of perjury, stating that all personnel hired or~~,~~ contracted with~~, or registered~~ on or after October 1, 1994, who enter the home of a patient or client in their service capacity have been screened and that its remaining personnel have worked for the home health agency ~~or registrant~~ continuously since before October 1, 1994.

(3) As a prerequisite to operating as a home health agency or~~,~~ nurse registry, ~~or companion or homemaker service under s. 400.509,~~ the administrator or managing employee, respectively, must submit to the agency his or her name and any other information necessary to conduct a complete screening according to this section. The agency shall submit the information to the Department of Law Enforcement for state

processing. The agency shall review the record of the administrator or manager with respect to the offenses specified in this section and shall notify the owner of its findings. If disposition information is missing on a criminal record, the administrator or manager, upon request of the agency, must obtain and supply within 30 days the missing disposition information to the agency. Failure to supply missing information within 30 days or to show reasonable efforts to obtain such information will result in automatic disqualification.

(4) Proof of compliance with the screening requirements of chapter 435 shall be accepted in lieu of the requirements of this section if the person has been continuously employed or registered without a breach in service that exceeds 180 days, the proof of compliance is not more than 2 years old, and the person has been screened by the Department of Law Enforcement. A home health agency or ~~,~~ nurse registry ~~, or companion or homemaker service registered under s. 400.509~~ shall directly provide proof of compliance to another home health agency or ~~,~~ nurse registry ~~, or companion or homemaker service registered under s. 400.509~~. The recipient home health agency or ~~,~~ nurse registry ~~, or companion or homemaker service registered under s. 400.509~~ may not accept any proof of compliance directly from the person who requires screening. Proof of compliance with the screening requirements of this section shall be provided upon request to the person screened by the home health agencies or ~~,~~ nurse registries ~~; or companion or homemaker services registered under s. 400.509~~.

(5) There is no monetary liability on the part of, and no cause of action for damages arises against, a licensed home health agency or ~~,~~ licensed nurse registry ~~, or companion or~~

~~homemaker service registered under s. 400.509,~~that, upon notice that the employee or contractor has been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense prohibited under s. 435.03 or under any similar statute of another jurisdiction, terminates the employee or contractor, whether or not the employee or contractor has filed for an exemption with the agency in accordance with chapter 435 and whether or not the time for filing has expired.

(6) The costs of processing the statewide correspondence criminal records checks must be borne by the home health agency or~~;~~the nurse registry~~; or the companion or homemaker service registered under s. 400.509,~~or by the person being screened, at the discretion of the home health agency or~~,~~nurse registry~~, or s. 400.509 registrant~~.

(7)(a) It is a misdemeanor of the first degree, punishable under s. 775.082 or s. 775.083, for any person willfully, knowingly, or intentionally to:

1. Fail, by false statement, misrepresentation, impersonation, or other fraudulent means, to disclose in any application for voluntary or paid employment a material fact used in making a determination as to such person's qualifications to be an employee under this section;

2. Operate or attempt to operate an entity licensed ~~or registered~~ under this part with persons who do not meet the minimum standards for good moral character as contained in this section; or

3. Use information from the criminal records obtained under this section for any purpose other than screening that person for employment as specified in this section or release

such information to any other person for any purpose other than screening for employment under this section.

(b) It is a felony of the third degree, punishable under s. 775.082, s. 775.083, or s. 775.084, for any person willfully, knowingly, or intentionally to use information from the juvenile records of a person obtained under this section for any purpose other than screening for employment under this section.

Section 31. Section 400.515, Florida Statutes, is amended to read:

400.515 Injunction proceedings.--Notwithstanding the existence or pursuit of any other remedy, the agency may maintain an action in the name of the state for injunction or other process to enforce the provisions of this part and rules adopted to implement this part.~~The Agency for Health Care Administration may institute injunction proceedings in a court of competent jurisdiction when violation of this part or of applicable rules constitutes an emergency affecting the immediate health and safety of a patient or client.~~

Section 32. Subsection (26) of section 415.102, Florida Statutes, is amended to read:

415.102 Definitions of terms used in ss. 415.101-415.113.--As used in ss. 415.101-415.113, the term:

(26) "Vulnerable adult" means a person 18 years of age or older whose ability to perform the normal activities of daily living or to provide for his or her own care or protection is impaired due to a long-term mental, emotional, physical, or developmental disability or dysfunctioning, or brain damage, or the infirmities of aging.

Section 33. Section 400.509, Florida Statutes, is repealed.

Section 34. This act shall take effect July 1, 2003.

STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN COMMITTEE SUBSTITUTE FOR CS for Senate Bill 400

The Committee Substitute clarifies the definition of "vulnerable adult" include individuals whose disability is long-term.