CHAPTER 2001-377

House Bill No. 29-C

An act relating to the Agency for Health Care Administration; repealing s. 409.904(11), F.S., which provides eligibility of specified persons for certain optional medical assistance; amending s. 409.904, F.S.; revising standards for eligibility for certain optional medical assistance; amending s. 409.906, F.S.; revising guidelines for payment for certain services; revising eligibility for certain Medicaid services; amending s. 409.9065, F.S.; prescribing enrollment levels with respect to pharmaceutical expense assistance; amending s. 409.907, F.S.; authorizing withholding of Medicaid payments in certain circumstances; prescribing additional requirements with respect to providers' submission of information; prescribing additional duties for the agency with respect to provider applications; amending s. 409.908, F.S.; providing temporary authorization for the agency to make special payments to designated Medicaid providers and use intergovernmental transfers for certain payments; revising pharmacy dispensing fees for Medicaid drugs; amending ss. 409.912, 409.9122, F.S.; providing for expanded home delivery of pharmacy products; revising provisions relating to choice counseling for recipients; defining the term "managed care plans"; amending s. 409.913, F.S.; prescribing additional sanctions that may be imposed upon a Medicaid provider; eliminating a limit on costs that may be recovered against a provider; requiring disclosure of certain information before an administrative hearing; providing for withholding payments in cases of Medicaid abuse and in cases subject to administrative proceedings; prescribing agency procedures in cases of overpayment; providing venue for Medicaid overpayment cases; repealing s. 414.41(4), F.S., relating to agency procedures in cases of overpayment; repealing s. 400.0225, F.S., relating to consumer-satisfaction surveys; amending s. 400.179, F.S.; declaring liability for overpayment when a nursing facility is sold; amending s. 400.191, F.S.; eliminating a provision relating to consumer-satisfaction and family-satisfaction surveys; amending s. 400.235, F.S.; eliminating a provision relating to participation in the consumer-satisfaction process; amending s. 400.071, F.S.; eliminating a provision relating to participation in a consumer-satisfaction-measurement process; amending s. 409.815, F.S.; conforming a cross-reference; amending s. 624.91, F.S., relating to the Florida Healthy Kids Corporation Act; providing temporary authorization for the agency to revise a local matching requirement; providing effective dates.

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

Section 1. Effective July 1, 2002, subsection (11) of section 409.904, Florida Statutes, is repealed.

Section 2. Effective July 1, 2002, subsections (1) and (2) of section 409.904, Florida Statutes, are amended to read:

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

(1) A person who is age 65 or older or is determined to be disabled, whose income is at or below 88 ~~100~~ percent of federal poverty level, and whose assets do not exceed established limitations.

(2)(a) A pregnant woman who would otherwise qualify for Medicaid under s. 409.903(5) except for her level of income and whose assets fall within the limits established by the Department of Children and Family Services for the medically needy. A pregnant woman who applies for medically needy eligibility may not be made presumptively eligible.

(b) A child under age 21 who would otherwise qualify for Medicaid or the Florida Kidcare program except for the family's level of income and whose assets fall within the limits established by the Department of Children and Family Services for the medically needy. ~~A family, a pregnant woman, a child under age 18, a person age 65 or over, or a blind or disabled person who would be eligible under any group listed in s. 409.903(1), (2), or (3), except that the income or assets of such family or person exceed established limitations.~~

For a ~~family or~~ person in this group, medical expenses are deductible from income in accordance with federal requirements in order to make a determination of eligibility. A ~~family or~~ person in this group, which group is known as the "medically needy," is eligible to receive the same services as other Medicaid recipients, with the exception of services in skilled nursing facilities and intermediate care facilities for the developmentally disabled.

Section 3. Effective July 1, 2002, subsections (1), (12), and (23) of section 409.906, Florida Statutes, are amended to read:

409.906 Optional Medicaid services.—Subject to specific appropriations, the agency may make payments for services which are optional to the state under Title XIX of the Social Security Act and are furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any optional service that is provided shall be provided only when medically necessary and in accordance with state and federal law. Optional services rendered by providers in mobile units to Medicaid recipients may be restricted or prohibited by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. If necessary to safeguard the state's systems of providing services to elderly and disabled persons and subject to the notice and review provisions of s. 216.177, the Governor may

direct the Agency for Health Care Administration to amend the Medicaid state plan to delete the optional Medicaid service known as "Intermediate Care Facilities for the Developmentally Disabled." Optional services may include:

(1) ADULT DENTURE SERVICES.—The agency may pay for dentures, the procedures required to seat dentures, and the repair and reline of dentures, provided by or under the direction of a licensed dentist, for a recipient who is age 21 or older. However, Medicaid will not provide reimbursement for dental services provided in a mobile dental unit, except for a mobile dental unit:

(a) Owned by, operated by, or having a contractual agreement with the Department of Health and complying with Medicaid's county health department clinic services program specifications as a county health department clinic services provider.

(b) Owned by, operated by, or having a contractual arrangement with a federally qualified health center and complying with Medicaid's federally qualified health center specifications as a federally qualified health center provider.

(c) Rendering dental services to Medicaid recipients, 21 years of age and older, at nursing facilities.

(d) Owned by, operated by, or having a contractual agreement with a state-approved dental educational institution.

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

(12) CHILDREN'S HEARING SERVICES.—The agency may pay for hearing and related services, including hearing evaluations, hearing aid devices, dispensing of the hearing aid, and related repairs, if provided to a recipient under age 21 by a licensed hearing aid specialist, otolaryngologist, otologist, audiologist, or physician.

(23) CHILDREN'S VISUAL SERVICES.—The agency may pay for visual examinations, eyeglasses, and eyeglass repairs for a recipient under age 21, if they are prescribed by a licensed physician specializing in diseases of the eye or by a licensed optometrist.

Section 4. Subsection (13) of section 409.906, Florida Statutes, is amended to read:

409.906 Optional Medicaid services.—Subject to specific appropriations, the agency may make payments for services which are optional to the state under Title XIX of the Social Security Act and are furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any optional service that is provided shall be provided only when medically necessary and in accordance with state and federal law. Optional services rendered by providers in mobile units to Medicaid recipients may be restricted or prohibited by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number

of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. If necessary to safeguard the state's systems of providing services to elderly and disabled persons and subject to the notice and review provisions of s. 216.177, the Governor may direct the Agency for Health Care Administration to amend the Medicaid state plan to delete the optional Medicaid service known as "Intermediate Care Facilities for the Developmentally Disabled." Optional services may include:

(13) HOME AND COMMUNITY-BASED SERVICES.—The agency may pay for home-based or community-based services that are rendered to a recipient in accordance with a federally approved waiver program. The agency may limit or eliminate coverage for certain Project AIDS Care Waiver services, preauthorize high-cost or highly utilized services, or make any other adjustments necessary to comply with any limitations or directions provided for in the General Appropriations Act.

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

409.9065 Pharmaceutical expense assistance.—

(3) BENEFITS.—Medications covered under the pharmaceutical expense assistance program are those covered under the Medicaid program in s. 409.906(19) ~~s. 409.906(20)~~. Monthly benefit payments shall be limited to $80 per program participant. Participants are required to make a 10-percent coinsurance payment for each prescription purchased through this program.

(5) NONENTITLEMENT.—The pharmaceutical expense assistance program established by this section is not an entitlement. Enrollment levels are limited to those authorized by the Legislature in the annual General Appropriations Act. If funds are insufficient to serve all individuals eligible under subsection (2) and seeking coverage, the agency may develop a waiting list based on application dates to use in enrolling individuals in unfilled enrollment slots.

Section 6. Effective upon this act becoming a law, subsections (7) and (9) of section 409.907, Florida Statutes, are amended to read:

409.907 Medicaid provider agreements.—The agency may make payments for medical assistance and related services rendered to Medicaid recipients only to an individual or entity who has a provider agreement in effect with the agency, who is performing services or supplying goods in accordance with federal, state, and local law, and who agrees that no person shall, on the grounds of handicap, race, color, or national origin, or for any other reason, be subjected to discrimination under any program or activity for which the provider receives payment from the agency.

(7) The agency may require, as a condition of participating in the Medicaid program and before entering into the provider agreement, that the provider submit information, in an initial and any required renewal applications, concerning the professional, business, and personal background of the

provider and permit an onsite inspection of the provider's service location by agency staff or other personnel designated by the agency to perform this function. As a continuing condition of participation in the Medicaid program, a provider shall immediately notify the agency of any current or pending bankruptcy filing. Before entering into the provider agreement, or as a condition of continuing participation in the Medicaid program, the agency may also require that Medicaid providers reimbursed on a fee-for-services basis or fee schedule basis which is not cost-based, post a surety bond not to exceed $50,000 or the total amount billed by the provider to the program during the current or most recent calendar year, whichever is greater. For new providers, the amount of the surety bond shall be determined by the agency based on the provider's estimate of its first year's billing. If the provider's billing during the first year exceeds the bond amount, the agency may require the provider to acquire an additional bond equal to the actual billing level of the provider. A provider's bond shall not exceed $50,000 if a physician or group of physicians licensed under chapter 458, chapter 459, or chapter 460 has a 50 percent or greater ownership interest in the provider or if the provider is an assisted living facility licensed under part III of chapter 400. The bonds permitted by this section are in addition to the bonds referenced in s. 400.179(4)(d). If the provider is a corporation, partnership, association, or other entity, the agency may require the provider to submit information concerning the background of that entity and of any principal of the entity, including any partner or shareholder having an ownership interest in the entity equal to 5 percent or greater, and any treating provider who participates in or intends to participate in Medicaid through the entity. The information must include:

(a) Proof of holding a valid license or operating certificate, as applicable, if required by the state or local jurisdiction in which the provider is located or if required by the Federal Government.

(b) Information concerning any prior violation, fine, suspension, termination, or other administrative action taken under the Medicaid laws, rules, or regulations of this state or of any other state or the Federal Government; any prior violation of the laws, rules, or regulations relating to the Medicare program; any prior violation of the rules or regulations of any other public or private insurer; and any prior violation of the laws, rules, or regulations of any regulatory body of this or any other state.

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

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

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

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

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

Section 7. Paragraph (d) is added to subsection (12) of section 409.908, Florida Statutes, and subsection (14) of that section is amended, to read:

409.908 Reimbursement of Medicaid providers.—Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(12)

(d) For the 2001-2002 fiscal year only and if necessary to meet the requirements for grants and donations for the special Medicaid payments authorized in the 2001-2002 General Appropriations Act, the agency may make special Medicaid payments to qualified Medicaid providers designated by the agency, notwithstanding any provision of this subsection to the contrary, and may use intergovernmental transfers from state entities to serve as the state share of such payments.

(14) A provider of prescribed drugs shall be reimbursed the least of the amount billed by the provider, the provider's usual and customary charge, or the Medicaid maximum allowable fee established by the agency, plus a dispensing fee. The agency is directed to implement a variable dispensing fee for payments for prescribed medicines while ensuring continued access for Medicaid recipients. The variable dispensing fee may be based upon, but not limited to, either or both the volume of prescriptions dispensed by a specific pharmacy provider, ~~and~~ the volume of prescriptions dispensed to an

individual recipient, and dispensing of preferred-drug-list products. The agency shall increase the pharmacy dispensing fee authorized by statute and in the annual General Appropriations Act by $0.50 for the dispensing of a Medicaid preferred-drug-list product and reduce the pharmacy dispensing fee by $0.50 for the dispensing of a Medicaid product that is not included on the preferred-drug list. The agency is authorized to limit reimbursement for prescribed medicine in order to comply with any limitations or directions provided for in the General Appropriations Act, which may include implementing a prospective or concurrent utilization review program.

Section 8. Paragraph (a) of subsection (37) of section 409.912, Florida Statutes, is amended to read:

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

(37)(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.

Section 9. Effective upon this act becoming a law, subsection (26) of section 409.912, Florida Statutes, is amended to read:

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

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

Section 10. Effective July 1, 2002, paragraph (e) of subsection (2) of section 409.9122, Florida Statutes, is amended to read:

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

(2)

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

Section 11. Effective upon this act becoming a law, paragraph (f) of subsection (2) of section 409.9122, Florida Statutes, is amended to read:

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

(2)

(f) When a Medicaid recipient does not choose a managed care plan or MediPass provider, the agency shall assign the Medicaid recipient to a managed care plan or MediPass provider. Medicaid recipients who are subject to mandatory assignment but who fail to make a choice shall be assigned to managed care plans or provider service networks until an equal enrollment of 50 percent in MediPass ~~and provider service networks~~ and 50 percent in managed care plans is achieved. Once equal enrollment is achieved, the assignments shall be divided in order to maintain an equal enrollment in MediPass and managed care plans. Thereafter, assignment of Medicaid recipients who fail to make a choice shall be based proportionally on the preferences of recipients who have made a choice in the previous period. Such proportions shall be revised at least quarterly to reflect an update of the preferences of Medicaid recipients. The agency shall also disproportionately assign Medicaid-eligible children in families who are required to but have failed to make a choice of managed care plan or MediPass for their child and who are to be assigned to the MediPass program to children's networks as described in s. 409.912(3)(g) and where available. The disproportionate assignment of children to children's networks shall be made until the agency has determined that the children's networks have sufficient numbers to be economically operated. For purposes of this paragraph, when referring to assignment, the term "managed care plans" includes exclusive provider organizations, provider service networks, minority physician networks, and pediatric emergency department diversion programs authorized by this

chapter or the General Appropriations Act. When making assignments, the agency shall take into account the following criteria:

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

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

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

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

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

409.913 Oversight of the integrity of the Medicaid program.—The agency shall operate a program to oversee the activities of Florida Medicaid recipients, and providers and their representatives, to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible, and to recover overpayments and impose sanctions as appropriate.

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

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

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

(c) Imposition of a fine of up to $5,000 for each violation. Each day that an ongoing violation continues, such as refusing to furnish Medicaid-related records or refusing access to records, is considered, for the purposes of this section, to be a separate violation. Each instance of improper billing of a Medicaid recipient; each instance of including an unallowable cost on a hospital or nursing home Medicaid cost report after the provider or authorized representative has been advised in an audit exit conference or previous audit report of the cost unallowability; each instance of furnishing a Medicaid recipient goods or professional services that are inappropriate or of inferior quality as determined by competent peer judgment; each instance of knowingly submitting a materially false or erroneous Medicaid provider enrollment application, request for prior authorization for Medicaid services, drug exception request, or cost report; each instance of inappropriate prescribing of drugs for a Medicaid recipient as determined by competent peer judgment; and each false or erroneous Medicaid claim leading to an overpayment to a provider is considered, for the purposes of this section, to be a separate violation.

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

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

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

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

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

(22)(a) In an audit or investigation of a violation committed by a provider which is conducted pursuant to this section, the agency is entitled to recover all ~~up to $15,000 in~~ investigative, legal, and expert witness costs if the agency's findings were not contested by the provider or, if contested, the agency ultimately prevailed.

(24)(a) The agency may withhold Medicaid payments, in whole or in part, to a provider upon receipt of reliable evidence that the circumstances giving rise to the need for a withholding of payments involve fraud, ~~or~~ willful misrepresentation, or abuse under the Medicaid program, or a crime committed while rendering goods or services to Medicaid recipients, pending completion of legal proceedings. If it is determined that fraud, willful misrepresentation, abuse, or a crime did not occur, the payments withheld must be paid to the provider within 14 days after such determination with interest at the rate of 10 percent a year. Any money withheld in accordance with this paragraph shall be placed in a suspended account, readily accessible to the agency, so that any payment ultimately due the provider shall be made within 14 days. ~~Furthermore, the authority to withhold payments under this paragraph shall not apply to physicians whose alleged overpayments are being determined by administrative proceedings pursuant to chapter 120.~~

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

(a) Withhold, and continue to withhold during the pendency of an administrative hearing pursuant to chapter 120, any medical assistance reimbursement payments until such time as the overpayment is recovered, unless within 30 days after receiving notice thereof the provider:

1. Makes repayment in full; or

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

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

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

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

Section 13. Subsection (4) of section 414.41, Florida Statutes, is repealed.

Section 14. Section 400.0225, Florida Statutes, is repealed.

Section 15. Paragraph (c) of subsection (5) of section 400.179, Florida Statutes, is amended to read:

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

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

(c) Where the facility transfer takes any form of a sale of assets, in addition to the transferor's continuing liability for any such overpayments, if the transferor fails to meet these obligations, the transferee shall be liable for all liabilities that can be readily identifiable 90 days in advance of the transfer. Such liability shall continue in succession until the debt is ultimately paid or otherwise resolved. It shall be the burden of the transferee to determine the amount of all such readily identifiable overpayments from the Agency for Health Care Administration, and the agency shall cooperate in every way with the identification of such amounts. Readily identifiable

overpayments shall include overpayments that will result from, but not be limited to:

1. Medicaid rate changes or adjustments;

2. Any depreciation recapture;

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

4. Audits completed by the agency.

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

Section 16. Paragraph (a) of subsection (2) of section 400.191, Florida Statutes, is amended to read:

400.191 Availability, distribution, and posting of reports and records.—

(2) The agency shall provide additional information in consumer-friendly printed and electronic formats to assist consumers and their families in comparing and evaluating nursing home facilities.

(a) The agency shall provide an Internet site which shall include at least the following information either directly or indirectly through a link to another established site or sites of the agency's choosing:

1. A list by name and address of all nursing home facilities in this state.

2. Whether such nursing home facilities are proprietary or nonproprietary.

3. The current owner of the facility's license and the year that that entity became the owner of the license.

4. The name of the owner or owners of each facility and whether the facility is affiliated with a company or other organization owning or managing more than one nursing facility in this state.

5. The total number of beds in each facility.

6. The number of private and semiprivate rooms in each facility.

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

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

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

10. Recreational and other programs available at each facility.

11. Special care units or programs offered at each facility.

12. Whether the facility is a part of a retirement community that offers other services pursuant to part III, part IV, or part V.

~~13. The results of consumer and family satisfaction surveys for each facility, as described in s. 400.0225. The results may be converted to a score or scores, which may be presented in either numeric or symbolic form for the intended consumer audience.~~

13.~~14.~~ Survey and deficiency information contained on the Online Survey Certification and Reporting (OSCAR) system of the federal Health Care Financing Administration, including annual survey, revisit, and complaint survey information, for each facility for the past 45 months. For noncertified nursing homes, state survey and deficiency information, including annual survey, revisit, and complaint survey information for the past 45 months shall be provided.

14.~~15.~~ A summary of the Online Survey Certification and Reporting (OSCAR) data for each facility over the past 45 months. Such summary may include a score, rating, or comparison ranking with respect to other facilities based on the number of citations received by the facility of annual, revisit, and complaint surveys; the severity and scope of the citations; and the number of annual recertification surveys the facility has had during the past 45 months. The score, rating, or comparison ranking may be presented in either numeric or symbolic form for the intended consumer audience.

Section 17. Paragraph (c) of subsection (5) of section 400.235, Florida Statutes, is amended to read:

400.235 Nursing home quality and licensure status; Gold Seal Program.—

(5) Facilities must meet the following additional criteria for recognition as a Gold Seal Program facility:

(c) Participate ~~consistently~~ in a ~~the required~~ consumer satisfaction process ~~as prescribed by the agency~~, and demonstrate that information is elicited from residents, family members, and guardians about satisfaction with the nursing facility, its environment, the services and care provided, the staff's skills and interactions with residents, attention to resident's needs, and the facility's efforts to act on information gathered from the consumer satisfaction measures.

A facility assigned a conditional licensure status may not qualify for consideration for the Gold Seal Program until after it has operated for 30 months with no class I or class II deficiencies and has completed a regularly scheduled relicensure survey.

Section 18. Section 400.071, Florida Statutes, is amended to read:

400.071 Application for license.—

(1) An application for a license as required by s. 400.062 shall be made to the agency on forms furnished by it and shall be accompanied by the appropriate license fee.

(2) The application shall be under oath and shall contain the following:

(a) The name, address, and social security number of the applicant if an individual; if the applicant is a firm, partnership, or association, its name, address, and employer identification number (EIN), and the name and address of any controlling interest; and the name by which the facility is to be known.

(b) The name of any person whose name is required on the application under the provisions of paragraph (a) and who owns at least a 10-percent interest in any professional service, firm, association, partnership, or corporation providing goods, leases, or services to the facility for which the application is made, and the name and address of the professional service, firm, association, partnership, or corporation in which such interest is held.

(c) The location of the facility for which a license is sought and an indication, as in the original application, that such location conforms to the local zoning ordinances.

(d) The name of the person or persons under whose management or supervision the facility will be conducted and the name of the administrator.

(e) A signed affidavit disclosing any financial or ownership interest that a person or entity described in paragraph (a) or paragraph (d) has held in the last 5 years in any entity licensed by this state or any other state to provide health or residential care which has closed voluntarily or involuntarily; has filed for bankruptcy; has had a receiver appointed; has had a license denied, suspended, or revoked; or has had an injunction issued against it which was initiated by a regulatory agency. The affidavit must disclose the reason any such entity was closed, whether voluntarily or involuntarily.

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

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

(h) Copies of any civil verdict or judgment involving the applicant rendered within the 10 years preceding the application, relating to medical

negligence, violation of residents' rights, or wrongful death. As a condition of licensure, the licensee agrees to provide to the agency copies of any new verdict or judgment involving the applicant, relating to such matters, within 30 days after filing with the clerk of the court. The information required in this paragraph shall be maintained in the facility's licensure file and in an agency database which is available as a public record.

(3) The applicant shall submit evidence which establishes the good moral character of the applicant, manager, supervisor, and administrator. No applicant, if the applicant is an individual; no member of a board of directors or officer of an applicant, if the applicant is a firm, partnership, association, or corporation; and no licensed nursing home administrator shall have been convicted, or found guilty, regardless of adjudication, of a crime in any jurisdiction which affects or may potentially affect residents in the facility.

(4) Each applicant for licensure must comply with the following requirements:

(a) Upon receipt of a completed, signed, and dated application, the agency shall require background screening of the applicant, in accordance with the level 2 standards for screening set forth in chapter 435. As used in this subsection, the term "applicant" means the facility administrator, or similarly titled individual who is responsible for the day-to-day operation of the licensed facility, and the facility financial officer, or similarly titled individual who is responsible for the financial operation of the licensed facility.

(b) The agency may require background screening for a member of the board of directors of the licensee or an officer or an individual owning 5 percent or more of the licensee if the agency has probable cause to believe that such individual has been convicted of an offense prohibited under the level 2 standards for screening set forth in chapter 435.

(c) Proof of compliance with the level 2 background screening requirements of chapter 435 which has been submitted within the previous 5 years in compliance with any other health care or assisted living licensure requirements of this state is acceptable in fulfillment of paragraph (a). Proof of compliance with background screening which has been submitted within the previous 5 years to fulfill the requirements of the Department of Insurance pursuant to chapter 651 as part of an application for a certificate of authority to operate a continuing care retirement community is acceptable in fulfillment of the Department of Law Enforcement and Federal Bureau of Investigation background check.

(d) A provisional license may be granted to an applicant when each individual required by this section to undergo background screening has met the standards for the Department of Law Enforcement background check, but the agency has not yet received background screening results from the Federal Bureau of Investigation, or a request for a disqualification exemption has been submitted to the agency as set forth in chapter 435, but a response has not yet been issued. A license may be granted to the applicant upon the agency's receipt of a report of the results of the Federal Bureau of Investigation background screening for each individual required by this

section to undergo background screening which confirms that all standards have been met, or upon the granting of a disqualification exemption by the agency as set forth in chapter 435. Any other person who is required to undergo level 2 background screening may serve in his or her capacity pending the agency's receipt of the report from the Federal Bureau of Investigation; however, the person may not continue to serve if the report indicates any violation of background screening standards and a disqualification exemption has not been requested of and granted by the agency as set forth in chapter 435.

(e) Each applicant must submit to the agency, with its application, a description and explanation of any exclusions, permanent suspensions, or terminations of the applicant from the Medicare or Medicaid programs. Proof of compliance with disclosure of ownership and control interest requirements of the Medicaid or Medicare programs shall be accepted in lieu of this submission.

(f) Each applicant must submit to the agency a description and explanation of any conviction of an offense prohibited under the level 2 standards of chapter 435 by a member of the board of directors of the applicant, its officers, or any individual owning 5 percent or more of the applicant. This requirement shall not apply to a director of a not-for-profit corporation or organization if the director serves solely in a voluntary capacity for the corporation or organization, does not regularly take part in the day-to-day operational decisions of the corporation or organization, receives no remuneration for his or her services on the corporation or organization's board of directors, and has no financial interest and has no family members with a financial interest in the corporation or organization, provided that the director and the not-for-profit corporation or organization include in the application a statement affirming that the director's relationship to the corporation satisfies the requirements of this paragraph.

(g) An application for license renewal must contain the information required under paragraphs (e) and (f).

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

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

(7) As a condition of licensure, each licensee, except one offering continuing care agreements as defined in chapter 651, must agree to accept recipients of Title XIX of the Social Security Act on a temporary, emergency basis. The persons whom the agency may require such licensees to accept are those

recipients of Title XIX of the Social Security Act who are residing in a facility in which existing conditions constitute an immediate danger to the health, safety, or security of the residents of the facility.

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

(8)~~(9)~~ The agency may not issue a license to a nursing home that fails to receive a certificate of need under the provisions of ss. 408.031-408.045. It is the intent of the Legislature that, in reviewing a certificate-of-need application to add beds to an existing nursing home facility, preference be given to the application of a licensee who has been awarded a Gold Seal as provided for in s. 400.235, if the applicant otherwise meets the review criteria specified in s. 408.035.

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

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

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

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

409.815 Health benefits coverage; limitations.—

(2) BENCHMARK BENEFITS.—In order for health benefits coverage to qualify for premium assistance payments for an eligible child under ss. 409.810-409.820, the health benefits coverage, except for coverage under Medicaid and Medikids, must include the following minimum benefits, as medically necessary.

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

Section 20. Paragraph (b) of subsection (4) of section 624.91, Florida Statutes, is amended to read:

624.91 The Florida Healthy Kids Corporation Act.—

(4) CORPORATION AUTHORIZATION, DUTIES, POWERS.—

(b) The Florida Healthy Kids Corporation shall phase in a program to:

1. Organize school children groups to facilitate the provision of comprehensive health insurance coverage to children;

2. Arrange for the collection of any family, local contributions, or employer payment or premium, in an amount to be determined by the board of directors, to provide for payment of premiums for comprehensive insurance coverage and for the actual or estimated administrative expenses;

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

4. Establish, with consultation from appropriate professional organizations, standards for preventive health services and providers and comprehensive insurance benefits appropriate to children; provided that such standards for rural areas shall not limit primary care providers to board-certified pediatricians;

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

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

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

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

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

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

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

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

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

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

15. Each fiscal year, establish a maximum number of participants by county, on a statewide basis, who may enroll in the program without the benefit of local matching funds. Thereafter, the corporation may establish local matching requirements for supplemental participation in the program. The corporation may vary local matching requirements and enrollment by county depending on factors which may influence the generation of local match, including, but not limited to, population density, per capita income, existing local tax effort, and other factors. The corporation also may accept in-kind match in lieu of cash for the local match requirement to the extent allowed by Title XXI of the Social Security Act; ~~and~~

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

17. Notwithstanding the requirements of subparagraph 15. to the contrary, establish a local matching requirement of $0.00 for the Title XXI program in each county of the state for the 2001-2002 fiscal year. This subparagraph shall take effect upon becoming a law and shall operate retroactively to July 1, 2001. This subparagraph expires July 1, 2002.

Section 21. Except as otherwise specifically provided in this act, this act shall take effect January 1, 2002.

Approved by the Governor December 17, 2001.

Filed in Office Secretary of State December 17, 2001.