CHAPTER 2002-223

Committee Substitute for Senate Bill No. 1276

An act relating to access to health and human services; creating s. 408.911, F.S.; providing a short title; creating s. 408.913, F.S.; requiring the Agency for Health Care Administration to establish as a pilot project a comprehensive health and human services eligibility access system; establishing requirements for each component of the system; creating s. 408.914, F.S.; requiring the Agency for Health Care Administration to phase in implementation of the comprehensive health and human services eligibility access system; specifying timeframes for each implementation phase; requiring that the agency submit a plan for statewide implementation to the Governor and Legislature; creating s. 408.915, F.S.; requiring the Agency for Health Care Administration to develop and implement a pilot project to integrate eligibility determination and information and referral services; establishing requirements for the pilot project; establishing requirements for information and referral; specifying the scope of the project; authorizing the agency to request federal waivers; creating s. 408.916, F.S.; establishing the Health Care Access Steering Committee; providing for membership of the steering committee; providing duties; establishing an expiration date for the steering committee; creating s. 408.917, F.S.; requiring an evaluation of the pilot project; requiring a report to the Governor and Legislature; specifying issues to be addressed in the report; creating s. 408.918, F.S.; authorizing the planning, development, and implementation of the Florida 211 Network; providing objectives for the Florida 211 Network; requiring the Agency for Health Care Administration to establish criteria for certification of information and referral entities to participate in the Florida 211 Network; providing for revocation of 211 numbers from uncertified information and referral entities; providing for assistance in resolving disputes from the Public Service Commission and the Federal Communications Commission; amending s. 409.912, F.S.; authorizing the Agency for Health Care Administration to contract with an entity providing prepaid or fixed-sum health care and social services to elderly recipients; amending s. 430.205, F.S.; requiring the Department of Elderly Affairs and the Agency for Health Care Administration to develop a managed, integrated long-term-care delivery system under a single entity; providing for a pilot project; specifying requirements of the pilot project; specifying requirements for payment rates and risk-sharing agreements; authorizing the Department of Elderly Affairs and the Agency for Health Care Administration to seek federal waivers to implement the pilot; specifying requirements for the Department of Children and Family Services and the Department of Elderly Affairs concerning eligibility determination and nursing home preadmission screening; requiring an evaluation of the pilot project; requiring a report to the Governor and Legislature; specifying issues to be addressed in this report; creating s. 430.041, F.S.; establishing the Office of Long-Term-Care Policy within the Department of Elderly Affairs; requiring the office to make recommenda-

tions for coordinating the services provided by state agencies; providing for the appointment of an advisory board to the Office of Long-Term-Care Policy; specifying membership in the advisory board; providing for reimbursement of per diem and travel expenses for members of the advisory board; requiring that the office submit an annual report to the Governor and Legislature; requiring assistance to the office by state agencies and universities; creating s. 409.221, F.S.; creating the "Florida Consumer-Directed Care Act"; providing legislative findings; providing legislative intent; establishing the consumer-directed care program; providing for consumer selection of certain long-term care services and providers; providing for interagency agreements among the Agency for Health Care Administration and the Department of Elderly Affairs, the Department of Health, and the Department of Children and Family Services; providing for program eligibility and enrollment; providing definitions; providing for consumer budget allowances and purchasing guidelines; specifying authorized services; providing roles and responsibilities of consumers, the agency and departments, and fiduciary intermediaries; providing background screening requirements for persons who render care under the program; providing rulemaking authority of the agency and departments; requiring the agency to apply for federal waivers as necessary; requiring ongoing program reviews and annual reports; requiring the Agency for Health Care Administration and the Department of Elderly Affairs to submit a plan to the Governor and Legislature for reducing nursing home bed days funded under the Medicaid program; amending s. 408.034, F.S.; providing additional requirements for the Agency for Health Care Administration in determining the need for additional nursing facility beds; amending s. 409.912, F.S.; authorizing the Agency for Health Care Administration to contract with vendors on a risk-sharing basis for in-home physician services; requiring the Agency for Health Care Administration to establish a nursing facility preadmission screening program through an interagency agreement with the Department of Elderly Affairs; requiring an annual report to the Legislature and the Office of Long-Term-Care Policy; creating s. 430.7031, F.S.; requiring the Department of Elderly Affairs and the Agency for Health Care Administration to implement a nursing home transition program; providing requirements for the program; amending ss. 409.908, 430.708, and 641.386, F.S., relating to reimbursement of Medicaid providers, certificates of need, and agent licensing and appointment; conforming cross-references to changes made by the act; amending s. 20.41, F.S.; providing for administration of the State Long-Term Care Ombudsman Council by the Department of Elderly Affairs; amending s. 400.0063, F.S.; locating the Office of the State Long-Term Care Ombudsman in the department; providing for appointment of the ombudsman by the Secretary of Elderly Affairs; amending s. 400.0065, F.S.; requiring the secretary's approval of staff for the local ombudsman councils; deleting requirement that the ombudsman prepare an annual legislative budget request; revising rulemaking authority; amending s. 400.0067, F.S.; revising duties of the State Long-Term Care Ombudsman Council; providing duties of the department and secretary;

amending s. 400.0069, F.S.; increasing the maximum membership of the local long-term care ombudsman councils; amending s. 400.0071, F.S.; revising procedures relating to complaints; amending s. 400.0087, F.S.; revising provisions relating to agency oversight; amending s. 400.0089, F.S.; revising reporting responsibilities; requiring the State Long-Term Care Ombudsman Council to publish complaint information quarterly; amending s. 400.0091, F.S.; specifying training requirements for employees of the Office of the State Long-Term Care Ombudsman and its volunteers; amending s. 400.179, F.S.; providing an exemption from certain requirements that the transferor of a nursing facility maintain a bond; amending s. 400.141, F.S.; requiring nursing home facilities to maintain general and professional liability insurance coverage; authorizing state-designated teaching nursing homes to demonstrate certain proof of financial responsibility; amending s. 430.80, F.S.; specifying the minimum proof of financial responsibility required for state-designated teaching nursing homes; amending s. 477.025, F.S.; exempting certain facilities from a provision of law requiring licensing as a cosmetology salon; amending s. 627.9408, F.S.; authorizing the department to adopt by rule certain provisions of the Long-Term Care Insurance Model Regulation, as adopted by the National Association of Insurance Commissioners; repealing s. 400.0066(2) and (3), F.S., relating to the Office of State Long-Term Care Ombudsman; deleting a prohibition on interference with the official duty of any ombudsman staff or volunteers; deleting reference to administrative support by the Department of Elderly Affairs; providing an effective date.

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

Section 1. Section 408.911, Florida Statutes, is created to read:

408.911 Short title.—Sections 408.911-408.918 may be cited as the "Florida Health and Human Services Access Act."

Section 2. Section 408.913, Florida Statutes, is created to read:

408.913 Comprehensive Health and Human Services Eligibility Access System.—

(1) The Agency for Health Care Administration shall develop a comprehensive, automated system for access to health care services. This system shall, to the greatest extent possible, use the capacity of existing automated systems so as to maximize the benefit of investments already made in information technology and minimize additional costs.

(2) The benefit-eligibility component of the system shall include simplified access through coordination with information and referral telephone systems. This does not preclude use of other methods of application, including mail-in applications, office visits, or on-line applications via the Internet. The eligibility component of the system shall include:

(a) Improved access to eligibility-status information.

(b) Development and sharing of information with eligible individuals and families regarding choices available to them for using health care services.

(3) The state agencies providing the medical, clinical, and related health care support services for special populations, including frail elders, adults with disabilities, and children with special needs shall develop systems for these populations which integrate and coordinate care and improved communication. These systems must include development of standard protocols for care planning and assessment, a focus on family involvement, and methods to communicate across systems, including automated methods, in order to improve integration and coordination of services.

Section 3. Section 408.914, Florida Statutes, is created to read:

408.914 Phased implementation plan.—The Agency for Health Care Administration, in consultation with the Health Care Access Steering Committee created in s. 408.916, shall phase in the implementation of the Comprehensive Health and Human Services Eligibility Access System.

(1) The first phase of implementation shall be a pilot project in one or more counties to demonstrate the feasibility of integrating eligibility determination for health care services with information and referral services. The department shall, when selecting an area to be designated as a model area, give consideration to an entity that is a community care for the elderly lead agency and has developed, through a joint effort, an integrated service delivery information network.

(2) Upon demonstration of the feasibility of the first phase of implementation, and subject to appropriation of any necessary resources, the steering committee shall develop a detailed implementation plan for the care-management component of the system. The implementation plan must include the steering committee's recommendation of one or more state agencies that should be designated to implement the care-management component of the system.

(3) Options for further implementation of the system may include a phased implementation of the eligibility component in additional sites before implementing the remaining components of the system or may include implementation of the care management and service system components along with the eligibility components.

(4) The Agency for Health Care Administration, in consultation with the steering committee, shall complete analysis of the initial pilot project by November 1, 2003, and by January 1, 2004, shall submit a plan to the Governor, the President of the Senate, and the Speaker of the House of Representatives for statewide implementation of all components of the system, if warranted. This plan must also include recommendations for incorporating additional public assistance and human services programs into the Comprehensive Health and Human Services Eligibility Access System.

Section 4. Section 408.915, Florida Statutes, is created to read:

408.915 Eligibility pilot project.—The Agency for Health Care Administration, in consultation with the steering committee established in s. 408.916, shall develop and implement a pilot project to integrate the determination of eligibility for health care services with information and referral services.

(1) The pilot project shall operate in one or more contiguous counties, as selected by the agency in consultation with the steering committee.

(2) The pilot project shall focus on developing, to the maximum extent possible, a process for eligibility application which:

(a) Uses a single uniform electronic application process, but permits applying for health services through various entry points, including information and referral providers, state agency program personnel or contracted providers, the mail, or the Internet;

(b) Is linked to a shared database that will have the capability to sort or store information by families as well as individuals;

(c) Permits electronic input and storage of data and electronic verification and exchange of information;

(d) Is compliant with the federal Health Insurance Portability and Accountability Act, as well as all other applicable state and federal confidentiality, financial, and insurance requirements;

(e) Includes an initial screening component for referring applicants to other health and human services programs provided through state agencies and the Florida Healthy Kids Corporation, including programs addressing developmental delays, developmental disabilities, chronic physical illness, mental health needs, substance-abuse treatment needs, elder and aging needs, and other health care needs; and

(f) Includes the level of customer service available to applicants and participants in the pilot project.

(3) The information and referral provider in the site selected as the pilot project shall, at a minimum:

(a) Execute a memorandum of understanding with the local community volunteer placement centers;

(b) Implement, or be in the process of implementing, a shared, web-based, information and eligibility database with community health providers and funders;

(c) Provide comprehensive information and referral services 24 hours per day, 7 days per week;

(d) Agree, in writing, to become accredited within 3 years by a nationally recognized information and referral accrediting agency;

(e) Execute a memorandum of understanding with 911 and other emergency response agencies in the pilot area;

(f) Implement policies and structured training to effectively respond to crisis calls or obtain accreditation by a nationally recognized mental health or crisis accrediting agency;

(g) Obtain teletypewriter and multi-language accessibility, either on-site or through a translation service;

(h) Develop resources to support and publicize information and referral services and provide ongoing education to the public on the availability of such services; and

(i) Provide periodic reports to the Governor, the President of the Senate, and the Speaker of the House of Representatives on the use of the information and referral system and on measures that demonstrate the effectiveness and efficiency of the information and referral services provided.

(4) The pilot project shall include eligibility determinations for the following programs:

(a) Medicaid under Title XIX of the Social Security Act.

(b) Medikids as created in s. 409.8132.

(c) Florida Healthy Kids as described in s. 624.91 and within eligibility guidelines provided in s. 409.814.

(d) Eligibility for Florida Kidcare services outside of the scope of Title XIX or Title XXI of the Social Security Act as provided in s. 409.814.

(e) State and local publicly funded health and social services programs as determined appropriate by the steering committee.

(5) If the Secretary of Health Care Administration, in consultation with the steering committee established in s. 408.916, determines that it would facilitate operation of the pilot project to obtain federal waiver authority, the appropriate state agency shall request such waiver authority from the appropriate federal agency.

Section 5. Section 408.916, Florida Statutes, is created to read:

408.916 Steering committee.—In order to guide the implementation of the pilot project, there is created a Health Care Access Steering Committee.

(1) The steering committee shall be composed of the following members:

(a) The Secretary of Health Care Administration.

(b) The Secretary of Children and Family Services.

(c) The Secretary of Elderly Affairs.

(d) The Secretary of Health.

(e) A representative of the Florida Alliance of Information and Referral Services.

(f) A representative of the Florida Healthy Kids Corporation.

(2) The steering committee may designate additional ad hoc members or technical advisors as the committee finds is appropriate.

(3) The Secretary of Health Care Administration shall be the chairperson of the steering committee.

(4) The steering committee shall provide oversight to the ongoing implementation of the pilot project, provide consultation and guidance on matters of policy, and provide oversight to the evaluation of the pilot project.

(5) The steering committee shall complete its activities by June 30, 2004, and the authorization for the steering committee ends on that date.

Section 6. Section 408.917, Florida Statutes, is created to read:

408.917 Evaluation of the pilot project.—The Agency for Health Care Administration, in consultation with the steering committee, shall conduct or contract for an evaluation of the pilot project under the guidance and oversight of the steering committee. The agency shall ensure that the evaluation is submitted to the Governor and Legislature by January 1, 2004. The evaluation report must address at least the following questions:

(1) What has been the impact of the pilot project on improving access to the process of determining eligibility?

(2) Based on the experience of the pilot project, what is the projected cost of statewide implementation?

(3) What has been the impact of the pilot project on the caseload trends in publicly funded programs and what is the projected impact of statewide implementation?

(4) How has the implementation of the pilot project affected customer satisfaction with access to eligibility determination for state-funded health services?

(5) Does the experience of the pilot project support continued expansion of the concept?

(6) What changes or modifications to the concepts of the pilot project are recommended for future sites?

Section 7. Section 408.918, Florida Statutes, is created to read:

408.918 Florida 211 Network; uniform certification requirements.—

(1) The Legislature authorizes the planning, development, and, subject to appropriations, the implementation of a statewide Florida 211 Network, which shall serve as the single point of coordination for information and referral for health and human services. The objectives for establishing the Florida 211 Network shall be to:

(a) Provide comprehensive and cost-effective access to health and human services information.

(b) Improve access to accurate information by simplifying and enhancing state and local health and human services information and referral systems and by fostering collaboration among information and referral systems.

(c) Electronically connect local information and referral systems to each other, to service providers, and to consumers of information and referral services.

(d) Establish and promote standards for data collection and for distributing information among state and local organizations.

(e) Promote the use of a common dialing access code and the visibility and public awareness of the availability of information and referral services.

(f) Provide a management and administrative structure to support the Florida 211 Network and establish technical assistance, training, and support programs for information and referral-service programs.

(g) Test methods for integrating information and referral services with local and state health and human services programs and for consolidating and streamlining eligibility and case-management processes.

(h) Provide access to standardized, comprehensive data to assist in identifying gaps and needs in health and human services programs.

(i) Provide a unified systems plan with a developed platform, taxonomy, and standards for data management and access.

(2) In order to participate in the Florida 211 Network, a 211 provider must be certified by the Agency for Health Care Administration. The agency shall develop criteria for certification, as recommended by the Florida Alliance of Information and Referral Services, and shall adopt the criteria as administrative rules.

(a) If any provider of information and referral services or other entity leases a 211 number from a local exchange company and is not certified by the agency, the agency shall, after consultation with the local exchange company and the Public Service Commission, request that the Federal Communications Commission direct the local exchange company to revoke the use of the 211 number.

(b) The agency shall seek the assistance and guidance of the Public Service Commission and the Federal Communications Commission in resolving any disputes arising over jurisdiction related to 211 numbers.

Section 8. Subsection (3) 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.

(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. 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) 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 in Pasco County or Pinellas County that provides in-home physician services to Medicaid recipients with degenerative neurological diseases in order to test the cost-effectiveness of enhanced home-based medical care. The entity providing the services shall be reimbursed on a fee-for-service basis at a rate not less than comparable Medicare reimbursement rates. The agency may apply for waivers of federal regulations necessary to implement such program. This paragraph expires ~~shall be repealed on~~ July 1, 2002.

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

(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 healthcare 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.

Section 9. Section 430.205, Florida Statutes is amended to read:

430.205 Community care service system.—

(1)(a) The department, through the area agency on aging, shall fund in each planning and service area at least one community care service system that provides case management and other in-home and community services

as needed to help the older person maintain independence and prevent or delay more costly institutional care.

(b) For fiscal year 2001-2002 only, in each county having a population over 2 million, the department, through the area agency on aging, shall fund in each planning and service area more than one community care service system that provides case management and other in-home and community services as needed to help elderly persons maintain independence and prevent or delay more costly institutional care. This paragraph expires July 1, 2002.

(2) Core services and other support services may be furnished by public or private agencies or organizations. Each community care service system must be under the direction of a lead agency that coordinates the activities of individual contracting agencies providing community-care-for-the-elderly services. When practicable, the activities of a community care service area must be directed from a multiservice senior center and coordinated with other services offered therein. This subsection does not require programs in existence prior to the effective date of this act to be relocated.

(3) The department shall define each core service that is to be provided or coordinated within a community care service area and establish rules and minimum standards for the delivery of core services. The department may conduct or contract for demonstration projects to determine the desirability of new concepts of organization, administration, or service delivery designed to prevent the institutionalization of functionally impaired elderly persons. Evaluations shall be made of the cost-avoidance of such demonstration projects, the ability of the projects to reduce the rate of placement of functionally impaired elderly persons in institutions, and the impact of projects on the use of institutional services and facilities.

(4) A preservice and inservice training program for community-care-for-the-elderly service providers and staff may be designed and implemented to help assure the delivery of quality services. The department shall specify in rules the training standards and requirements for the community-care-for-the-elderly service providers and staff. Training must be sufficient to ensure that quality services are provided to clients and that appropriate skills are developed to conduct the program.

(5) Any person who has been classified as a functionally impaired elderly person is eligible to receive community-care-for-the-elderly core services. Those elderly persons who are determined by protective investigations to be vulnerable adults in need of services, pursuant to s. 415.104(3)(b), or to be victims of abuse, neglect, or exploitation who are in need of immediate services to prevent further harm and are referred by the adult protective services program, shall be given primary consideration for receiving community-care-for-the-elderly services. As used in this subsection, "primary consideration" means that an assessment and services must commence within 72 hours after referral to the department or as established in accordance with department contracts by local protocols developed between department service providers and the adult protective services program.

(6) Notwithstanding other requirements of this chapter, the Department of Elderly Affairs and the Agency for Health Care Administration shall develop a model system to transition all state-funded services for elderly individuals in one of the department's planning and service areas to a managed, integrated long-term-care delivery system under the direction of a single entity.

(a) The duties of the model system shall include organizing and administering service delivery for the elderly; obtaining contracts for services with providers in the area; monitoring the quality of services provided; determining levels of need and disability for payment purposes; and other activities determined by the department and the agency in order to operate the model system.

(b) The agency and the department shall integrate all funding for services to individuals over the age of 65 in the model planning and service areas into a single per-person per-month payment rate, except that funds for Medicaid behavioral health care services are exempt from this section. The funds to be integrated shall include:

1. Community-care-for-the-elderly funds;

2. Home-care-for-the-elderly funds;

3. Local services program funds;

4. Contracted services funds;

5. Alzheimer's disease initiative funds;

6. Medicaid home and community-based waiver services funds;

7. Funds for all Medicaid services authorized in ss. 409.905 and 409.906, including Medicaid nursing home services; and

8. Funds paid for Medicare premiums, coinsurance and deductibles for persons dually eligible for Medicaid and Medicare as prescribed in s. 409.908(13).

The department and the agency shall not make payments for services for people age 65 and older except through the model delivery system.

(c) The entity selected to administer the model system shall develop a comprehensive health and long-term-care service delivery system through contracts with providers of medical, social, and long-term-care services sufficient to meet the needs of the population age 65 and older. The entity selected to administer the model system shall not directly provide services other than intake, assessment, and referral services.

(d) The department shall determine which of the department's planning and services areas is to be designated as a model area by means of a request for proposals. The department shall select an area to be designated as a model area and the entity to administer the model system based on demonstration of capacity of the entity to:

1. Develop contracts with providers currently under contract with the department, area agencies on aging, or community-care-for-the-elderly lead agencies;

2. Provide a comprehensive system of appropriate medical and long-term-care services that provides high-quality medical and social services to assist older individuals in remaining in the least-restrictive setting;

3. Demonstrate a quality assurance and quality improvement system satisfactory to the department and the agency;

4. Develop a system to identify participants who have special health care needs such as polypharmacy, mental health and substance abuse problems, falls, chronic pain, nutritional deficits, and cognitive deficits, in order to respond to and meet these needs;

5. Use a multi-discliplinary team approach to participant management which ensures that information is shared among providers responsible for delivering care to a participant;

6. Ensure medical oversight of care plans and service delivery, regular medical evaluation of care plans, and the availability of medical consultation for case managers and service coordinators;

7. Develop, monitor, and enforce quality-of-care requirements;

8. Secure subcontracts with providers of medical, nursing home, and community-based long-term-care services sufficient to assure access to and choice of providers;

9. Ensure a system of case management and service coordination which includes educational and training standards for case managers and service coordinators;

10. Develop a business plan that considers the ability of the applicant to organize and operate a risk-bearing entity;

11. Furnish evidence 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; and

12. Provide, through contract or otherwise, for periodic review of its medical facilities as required by the department and the agency.

The department shall give preference in selecting an area to be designated as a model area to that in which the administering entity is an existing area agency on aging or community-care-for-the-elderly lead agency demonstrating the ability to perform the functions described in this paragraph.

(e) The department in consultation with the selected entity shall develop a statewide proposal regarding the long-term use and structure of a program that addresses a risk pool to reduce financial risk.

(f) The department and the agency shall develop capitation rates based on the historical cost experience of the state in providing acute and long-term-care services to the population over 65 years of age in the area served.

1. Payment rates in the first 2 years of operation shall be set at no more than 100 percent of the costs to the state of providing equivalent services to the population of the model area for the year prior to the year in which the model system is implemented, adjusted forward to account for inflation and population growth. In subsequent years, the rate shall be negotiated based on the cost experience of the model system in providing contracted services, but may not exceed 95 percent of the amount that would have been paid by the state in the model planning and service area absent the model integrated service delivery system.

2. The agency and the department may develop innovative risk-sharing agreements that limit the level of custodial nursing home risk that the administering entity assumes, consistent with the intent of the Legislature to reduce the use and cost of nursing home care. Under risk-sharing arrangements, the agency and the department may reimburse the administering entity for the cost of providing nursing home care for Medicaid-eligible participants who have been permanently placed and remain in nursing home care for more than 1 year.

(g) The department and the Agency for Health Care Administration shall seek federal waivers necessary to implement the requirements of this section.

(h) The Department of Children and Family Services shall develop a streamlined and simplified eligibility system and shall outstation a sufficient number and quality of eligibility-determination staff with the administering entity to assure determination of Medicaid eligibility for the integrated service delivery system in the model planning and service area within 10 days after receipt of a complete application.

(i) The Department of Elderly Affairs shall make arrangements to outstation a sufficient number of nursing home preadmission screening staff with the administering entity to assure timely assessment of level of need for long-term-care services in the model area.

(j) The Department of Elderly Affairs shall conduct or contract for an evaluation of the pilot project. The department shall submit the evaluation to the Governor and the Legislature by January 1, 2005. The evaluation must address the effects of the pilot project on the effectiveness of the entity providing a comprehensive system of appropriate and high-quality medical and long-term-care services to elders in the least-restrictive setting and make recommendations on a phased-in implementation expansion for the rest of the state.

Section 10. Section 430.041, Florida Statutes, is created to read:

430.041 Office of Long-Term-Care Policy.—

(1) There is established in the Department of Elderly Affairs the Office of Long-Term-Care Policy to evaluate the state's long-term-care service de-

livery system and make recommendations to increase the availability and the use of noninstitutional settings to provide care to the elderly and ensure coordination among the agencies responsible for the long-term-care continuum.

(2) The purpose of the Office of Long-Term-Care Policy is to:

(a) Ensure close communication and coordination among state agencies involved in developing and administering a more efficient and coordinated long-term-care service delivery system in this state;

(b) Identify duplication and unnecessary service provision in the long-term-care system and make recommendations to decrease inappropriate service provision;

(c) Review current programs providing long-term-care services to determine whether the programs are cost effective, of high quality, and operating efficiently and make recommendations to increase consistency and effectiveness in the state's long-term-care programs;

(d) Develop strategies for promoting and implementing cost-effective home and community-based services as an alternative to institutional care which coordinate and integrate the continuum of care needs of the elderly; and

(e) Assist the Office of Long-Term-Care Policy Advisory Council as necessary to help implement this section.

(3) The Director of the Office of Long-Term-Care Policy shall be appointed by, and serve at the pleasure of, the Governor. The director shall report to, and be under the general supervision of, the Secretary of Elderly Affairs and shall not be subject to supervision by any other employee of the department.

(4) The Office of Long-Term-Care Policy shall have an advisory council, whose chair shall be the Director of the Office of Long-Term-Care Policy. The purposes of the advisory council are to provide assistance and direction to the office and to ensure that the appropriate state agencies are properly implementing recommendations from the office.

(a) The advisory council shall consist of:

1. A member of the Senate, appointed by the President of the Senate;

2. A member of the House of Representatives, appointed by the Speaker of the House of Representatives;

3. The Director of the Office of Long-Term-Care Policy;

4. The Secretary of Health Care Administration;

5. The Secretary of Elderly Affairs;

6. The Secretary of Children and Family Services;

7. The Secretary of Health;

8. The Executive Director of the Department of Veterans' Affairs;

9. Three people with broad knowledge and experience in the delivery of long-term care services, appointed by the Governor from groups representing elderly persons; and

10. Two representatives of people using long-term-care services, appointed by the Governor from groups representing elderly persons.

(b) Members shall serve without compensation, but are entitled to receive reimbursement for travel and per diem as provided in s. 112.061.

(c) The advisory council shall meet at the call of its chair or at the request of a majority of its members. During its first year of existence, the advisory council shall meet at least monthly.

(d) Members of the advisory council appointed by the Governor shall serve at the pleasure of the Governor and shall be appointed to 4-year staggered terms in accordance with s. 20.052.

(5)(a) The Department of Elderly Affairs shall provide administrative support and services to the Office of Long-Term-Care Policy.

(b) The office shall call upon appropriate agencies of state government, including the centers on aging in the State University System, for assistance needed in discharging its duties.

(c) Each state agency represented on the Office of Long-Term-Care Policy Advisory Council shall make at least one employee available to work with the Office of Long-Term-Care Policy. All state agencies and universities shall assist the office in carrying out its responsibilities prescribed by this section.

(d) Each state agency shall pay from its own funds any expenses related to its support of the Office of Long-Term-Care Policy and its participation on the advisory council. The Department of Elderly Affairs shall be responsible for expenses related to participation on the advisory council by members appointed by the Governor.

(6)(a) By December 1, 2002, the office shall submit to the advisory council a preliminary report of its findings and recommendations on improving the long-term-care continuum in this state. The report shall contain recommendations and implementation proposals for policy changes, as well as legislative and funding recommendations that will make the system more effective and efficient. The report shall contain a specific plan for accomplishing the recommendations and proposals. Thereafter, the office shall revise and update the report annually and resubmit it to the advisory council for review and comments by November 1 of each year.

(b) The advisory council shall review and recommend any suggested changes to the preliminary report, and each subsequent annual update of

the report, within 30 days after the receipt of the preliminary report. Suggested revisions, additions, or deletions shall be made to the Director of the Office of Long-Term-Care Policy.

(c) The office shall submit its final report, and each subsequent annual update of the report, to the Governor and the Legislature within 30 days after the receipt of any revisions, additions, or deletions suggested by the advisory council, or after the time such comments are due to the office.

Section 11. Section 409.221, Florida Statutes, is created to read:

409.221 Consumer-directed care program.—

(1) SHORT TITLE.—This section may be cited as the "Florida Consumer-Directed Care Act."

(2) LEGISLATIVE FINDINGS.—The Legislature finds that alternatives to institutional care, such as in-home and community-based care, should be encouraged. The Legislature finds that giving recipients of in-home and community-based services the opportunity to select the services they need and the providers they want, including family and friends, enhances their sense of dignity and autonomy. The Legislature also finds that providing consumers choice and control, as tested in current research and demonstration projects, has been beneficial and should be developed further and implemented statewide.

(3) LEGISLATIVE INTENT.—It is the intent of the Legislature to nurture the autonomy of those citizens of the state, of all ages, who have disabilities by providing the long-term care services they need in the least restrictive, appropriate setting. It is the intent of the Legislature to give such individuals more choices in and greater control over the purchased long-term care services they receive.

(4) CONSUMER-DIRECTED CARE.—

(a) Program established.—The Agency for Health Care Administration shall establish the consumer-directed care program which shall be based on the principles of consumer choice and control. The agency shall implement the program upon federal approval. The agency shall establish interagency cooperative agreements with and shall work with the Departments of Elderly Affairs, Health, and Children and Family Services to implement and administer the program. The program shall allow enrolled persons to choose the providers of services and to direct the delivery of services, to best meet their long-term care needs. The program must operate within the funds appropriated by the Legislature.

(b) Eligibility and enrollment.—Persons who are enrolled in one of the Medicaid home and community-based waiver programs and are able to direct their own care, or to designate an eligible representative, may choose to participate in the consumer-directed care program.

(c) Definitions.—For purposes of this section, the term:

1. "Budget allowance" means the amount of money made available each month to a consumer to purchase needed long-term care services, based on the results of a functional needs assessment.

2. "Consultant" means an individual who provides technical assistance to consumers in meeting their responsibilities under this section.

3. "Consumer" means a person who has chosen to participate in the program, has met the enrollment requirements, and has received an approved budget allowance.

4. "Fiscal intermediary" means an entity approved by the agency that helps the consumer manage the consumer's budget allowance, retains the funds, processes employment information, if any, and tax information, reviews records to ensure correctness, writes paychecks to providers, and delivers paychecks to the consumer for distribution to providers and caregivers.

5. "Provider" means:

a. A person licensed or otherwise permitted to render services eligible for reimbursement under this program for whom the consumer is not the employer of record; or

b. A consumer-employed caregiver for whom the consumer is the employer of record.

6. "Representative" means an uncompensated individual designated by the consumer to assist in managing the consumer's budget allowance and needed services.

(d) Budget allowances.—Consumers enrolled in the program shall be given a monthly budget allowance based on the results of their assessed functional needs and the financial resources of the program. Consumers shall receive the budget allowance directly from an agency-approved fiscal intermediary. Each department shall develop purchasing guidelines, approved by the agency, to assist consumers in using the budget allowance to purchase needed, cost-effective services.

(e) Services.—Consumers shall use the budget allowance only to pay for home and community-based services that meet the consumer's long-term care needs and are a cost-efficient use of funds. Such services may include, but are not limited to, the following:

1. Personal care.

2. Homemaking and chores, including housework, meals, shopping, and transportation.

3. Home modifications and assistive devices which may increase the consumer's independence or make it possible to avoid institutional placement.

4. Assistance in taking self-administered medication.

5. Day care and respite care services, including those provided by nursing home facilities pursuant to s. 400.141(6) or by adult day care facilities licensed pursuant to s. 400.554.

6. Personal care and support services provided in an assisted living facility.

(f) Consumer roles and responsibilities.—Consumers shall be allowed to choose the providers of services, as well as when and how the services are provided. Providers may include a consumer's neighbor, friend, spouse, or relative.

1. In cases where a consumer is the employer of record, the consumer's roles and responsibilities include, but are not limited to, the following:

a. Developing a job description.

b. Selecting caregivers and submitting information for the background screening as required in s. 435.05.

c. Communicating needs, preferences, and expectations about services being purchased.

d. Providing the fiscal intermediary with all information necessary for provider payments and tax requirements.

e. Ending the employment of an unsatisfactory caregiver.

2. In cases where a consumer is not the employer of record, the consumer's roles and responsibilities include, but are not limited to, the following:

a. Communicating needs, preferences, and expectations about services being purchased.

b. Ending the services of an unsatisfactory provider.

c. Providing the fiscal agent with all information necessary for provider payments and tax requirements.

(g) Agency and departments roles and responsibilities.—The agency's and the departments' roles and responsibilities include, but are not limited to, the following:

1. Assessing each consumer's functional needs, helping with the service plan, and providing ongoing assistance with the service plan.

2. Offering the services of consultants who shall provide training, technical assistance, and support to the consumer.

3. Completing the background screening for providers.

4. Approving fiscal intermediaries.

5. Establishing the minimum qualifications for all caregivers and providers and being the final arbiter of the fitness of any individual to be a caregiver or provider.

(h) Fiscal intermediary roles and responsibilities.—The fiscal intermediary's roles and responsibilities include, but are not limited to, the following:

1. Providing recordkeeping services.

2. Retaining the consumer-directed care funds, processing employment and tax information, if any, reviewing records to ensure correctness, writing paychecks to providers, and delivering paychecks to the consumer for distribution.

(i) Background screening requirements.—All persons who render care under this section shall comply with the requirements of s. 435.05. Persons shall be excluded from employment pursuant to s. 435.06.

1. Persons excluded from employment may request an exemption from disqualification, as provided in s. 435.07. Persons not subject to certification or professional licensure may request an exemption from the agency. In considering a request for an exemption, the agency shall comply with the provisions of s. 435.07.

2. The agency shall, as allowable, reimburse consumer-employed caregivers for the cost of conducting background screening as required by this section.

For purposes of this section, a person who has undergone screening, who is qualified for employment under this section and applicable rule, and who has not been unemployed for more than 180 days following such screening is not required to be rescreened. Such person must attest under penalty of perjury to not having been convicted of a disqualifying offense since completing such screening.

(j) Rules; federal waivers.—In order to implement this section:

1. The agency and the Departments of Elderly Affairs, Health, and Children and Family Services are authorized to adopt and enforce rules.

2. The agency shall take all necessary action to ensure state compliance with federal regulations. The agency shall apply for any necessary federal waivers or waiver amendments needed to implement the program.

(k) Reviews and reports.—The agency and the Departments of Elderly Affairs, Health, and Children and Family Services shall each, on an ongoing basis, review and assess the implementation of the consumer-directed care program. By January 15 of each year, the agency shall submit a written report to the Legislature that includes each department's review of the program and contains recommendations for improvements to the program.

Section 12. (1) Prior to December 1, 2002, the Agency for Health Care Administration, in consultation with the Department of Elderly Affairs, shall submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives a plan to reduce the number of nursing home bed days purchased by the state Medicaid program and to replace such nursing home care with care provided in less costly alternative settings.

(2) The plan must include specific goals for reducing Medicaid-funded bed days and recommend specific statutory and operational changes necessary to achieve such reduction.

(3) The plan must include an evaluation of the cost-effectiveness and the relative strengths and weaknesses of programs that serve as alternatives to nursing homes.

Section 13. Section 408.034, Florida Statutes, is amended to read:

408.034 Duties and responsibilities of agency; rules.—

(1) The agency is designated as the single state agency to issue, revoke, or deny certificates of need and to issue, revoke, or deny exemptions from certificate-of-need review in accordance with the district plans and present and future federal and state statutes. The agency is designated as the state health planning agency for purposes of federal law.

(2) In the exercise of its authority to issue licenses to health care facilities and health service providers, as provided under chapters 393, 395, and parts II and VI of chapter 400, the agency may not issue a license to any health care facility, health service provider, hospice, or part of a health care facility which fails to receive a certificate of need or an exemption for the licensed facility or service.

(3) The agency shall establish, by rule, uniform need methodologies for health services and health facilities. In developing uniform need methodologies, the agency shall, at a minimum, consider the demographic characteristics of the population, the health status of the population, service use patterns, standards and trends, geographic accessibility, and market economics.

(4) Prior to determining that there is a need for additional community nursing facility beds in any area of the state, the agency shall determine that the need cannot be met through the provision, enhancement, or expansion of home and community-based services. In determining such need, the agency shall examine nursing home placement patterns and demographic patterns of persons entering nursing homes and the availability of and effectiveness of existing home-based and community-based service delivery systems at meeting the long-term care needs of the population. The agency shall recommend to the Office of Long-Term Care Policy changes that could be made to existing home-based and community-based delivery systems to lessen the need for additional nursing facility beds.

(5)~~(4)~~ The agency shall establish by rule a nursing-home-bed-need methodology that reduces the community nursing home bed need for the areas of the state where the agency establishes pilot community diversion programs through the Title XIX aging waiver program.

(6)~~(5)~~ The agency may adopt rules necessary to implement ss. 408.031-408.045.

Section 14. Paragraph (f) of subsection (3) of section 409.912, Florida Statutes, is amended, and present subsections (13) through (39) of said

section are renumbered as subsections (14) through (40), respectively, and a new subsection (13) is added to that section, to read:

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

(3) The agency may contract with:

(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. ~~in Pasco County or Pinellas County that provides in-home physician services to Medicaid recipients with degenerative neurological diseases in order to test the cost-effectiveness of enhanced home-based medical care. The entity providing the services shall be reimbursed on a fee-for-service basis at a rate not less than comparable Medicare reimbursement rates. The agency may apply for waivers of federal regulations necessary to implement such program. This paragraph shall be repealed on July 1, 2002.~~

(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.

Section 15. Section 430.7031, Florida Statutes, is created to read:

430.7031 Nursing home transition program.—The department and the Agency for Health Care Administration:

(1) Shall implement a system of care designed to assist individuals residing in nursing homes to regain independence and to move to less costly settings.

(2) Shall collaboratively work to identify long-stay nursing home residents who are able to move to community placements, and to provide case management and supportive services to such individuals while they are in nursing homes to assist such individuals in moving to less expensive and less restrictive settings.

(3) Shall modify existing service delivery systems or develop new service delivery systems to economically and efficiently meet such individuals' care needs.

(4) Shall offer such individuals priority placement and services in all home-based and community-based care programs and shall ensure that funds are available to provide services to individuals to whom services are offered.

(5) May seek federal waivers necessary to administer this section.

Section 16. Subsection (4) of section 409.908, Florida Statutes, 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.

(4) Subject to any limitations or directions provided for in the General Appropriations Act, alternative health plans, health maintenance organizations, and prepaid health plans shall be reimbursed a fixed, prepaid amount negotiated, or competitively bid pursuant to s. 287.057, by the agency and prospectively paid to the provider monthly for each Medicaid recipient enrolled. The amount may not exceed the average amount the agency determines it would have paid, based on claims experience, for recipients in the same or similar category of eligibility. The agency shall calculate capitation rates on a regional basis and, beginning September 1, 1995, shall include age-band differentials in such calculations. Effective July 1, 2001, the cost of exempting statutory teaching hospitals, specialty hospitals, and community hospital education program hospitals from reimbursement ceilings and the cost of special Medicaid payments shall not be included in premiums paid to health maintenance organizations or prepaid health care plans. Each rate semester, the agency shall calculate and publish a Medicaid hospital rate schedule that does not reflect either special Medicaid payments or the elimination of rate reimbursement ceilings, to be used by hospitals and Medicaid health maintenance organizations, in order to determine the Medicaid rate referred to in ss. 409.912(17) ~~409.912(16)~~, 409.9128(5), and 641.513(6).

Section 17. Section 430.708, Florida Statutes, is amended to read:

430.708 Certificate of need.—To ensure that Medicaid community diversion pilot projects result in a reduction in the projected average monthly nursing home caseload, the agency shall, in accordance with the provisions of s. 408.034(5) ~~s. 408.034(4)~~:

(1) Reduce the projected nursing home bed need in each certificate-of-need batching cycle in the community diversion pilot project areas.

(2) Reduce the conditions imposed on existing nursing homes or those to be constructed, in accordance with the number of projected community diversion slots.

(3) Adopt rules to reduce the number of beds in Medicaid-participating nursing homes eligible for Medicaid, through a Medicaid-selective contracting process or some other appropriate method.

(4) Determine the feasibility of increasing the nursing home occupancy threshold used in determining nursing home bed needs under the certificate-of-need process.

Section 18. Subsection (4) of section 641.386, Florida Statutes, is amended to read:

641.386 Agent licensing and appointment required; exceptions.—

(4) All agents and health maintenance organizations shall comply with and be subject to the applicable provisions of ss. 641.309 and 409.912(19) ~~409.912(18)~~, and all companies and entities appointing agents shall comply with s. 626.451, when marketing for any health maintenance organization licensed pursuant to this part, including those organizations under contract with the Agency for Health Care Administration to provide health care services to Medicaid recipients or any private entity providing health care services to Medicaid recipients pursuant to a prepaid health plan contract with the Agency for Health Care Administration.

Section 19. Subsection (4) of section 20.41, Florida Statutes, is amended to read:

20.41 Department of Elderly Affairs.—There is created a Department of Elderly Affairs.

(4) The department shall administer ~~administratively house~~ the State Long-Term Care Ombudsman Council, created by s. 400.0067, and the local long-term care ombudsman councils, created by s. 400.0069 and shall, as required by s. 712 of the federal Older Americans Act of 1965, ensure that both the state and local long-term care ombudsman councils operate in compliance with the Older Americans Act. ~~The councils in performance of their duties shall not be subject to control, supervision, or direction by the department.~~

Section 20. Subsection (1) and paragraph (b) of subsection (2) of section 400.0063, Florida Statutes, are amended to read:

400.0063 Establishment of Office of State Long-Term Care Ombudsman; designation of ombudsman and legal advocate.—

(1) There is created an Office of State Long-Term Care Ombudsman~~,~~ ~~which shall be located for administrative purposes~~ in the Department of Elderly Affairs.

(2)

(b) The State Long-Term Care Ombudsman shall be appointed by and shall serve at the pleasure of the Secretary of Elderly Affairs ~~State Long-Term Care Ombudsman Council~~. No person who has a conflict of interest,

or has an immediate family member who has a conflict of interest, may be involved in the designation of the ombudsman.

Section 21. Paragraphs (c) and (f) of subsection (2) and subsection (3) of section 400.0065, Florida Statutes, are amended to read:

400.0065 State Long-Term Care Ombudsman; duties and responsibilities; conflict of interest.—

(2) The State Long-Term Care Ombudsman shall have the duty and authority to:

(c) Within the limits of federal and state funding authorized and appropriated, employ such personnel, including staff for local ombudsman councils, as are necessary to perform adequately the functions of the office and provide or contract for legal services to assist the state and local ombudsman councils in the performance of their duties. Staff positions for each local ombudsman council may be established as career service positions, and shall be filled by the ombudsman after approval by the secretary ~~consultation with the respective local ombudsman council~~.

~~(f) Annually prepare a budget request that shall be submitted to the Governor by the department for transmittal to the Legislature.~~

(3) The State Long-Term Care Ombudsman shall not:

(a) Have a direct involvement in the licensing or certification of, or an ownership or investment interest in, a long-term care facility or a provider of a long-term care service.

(b) Be employed by, or participate in the management of, a long-term care facility.

(c) Receive, or have a right to receive, directly or indirectly, remuneration, in cash or in kind, under a compensation agreement with the owner or operator of a long-term care facility.

The Department of Elderly Affairs~~, in consultation with the ombudsman,~~ shall adopt rules to establish procedures to identify and eliminate conflicts of interest as described in this subsection.

Section 22. Paragraphs (c), (d), (f), and (g) of subsection (2) and paragraph (b) of subsection (3) of section 400.0067, Florida Statutes, are amended to read:

400.0067 Establishment of State Long-Term Care Ombudsman Council; duties; membership.—

(2) The State Long-Term Care Ombudsman Council shall:

(c) Assist the ombudsman to discover, investigate, and determine the existence of abuse or neglect in any long-term care facility. ~~and to develop procedures, in consultation with~~ The Department of Elderly Affairs shall

develop procedures, relating to such investigations. Investigations may consist, in part, of one or more onsite administrative inspections.

(d) Assist the ombudsman in eliciting, receiving, responding to, and resolving complaints made by or on behalf of long-term care facility residents and in developing procedures, in consultation with the Department of Elderly Affairs, relating to the receipt and resolution of such complaints. The secretary shall approve all such procedures.

(f) Be authorized to call upon appropriate agencies of state government for such professional assistance as may be needed in the discharge of its duties, including assistance from the adult protective services program of the Department of Children and Family Services.

(f)(g) Prepare an annual report describing the activities carried out by the ombudsman and the State Long-Term Care Ombudsman Council in the year for which the report is prepared. The State Long-Term Care Ombudsman Council shall submit the report to the Secretary of Elderly Affairs. The secretary shall in turn submit the report to the Commissioner of the United States Administration on Aging, the Governor, the President of the Senate, the Speaker of the House of Representatives, the minority leaders of the House and Senate, the chairpersons of appropriate House and Senate committees, the Secretary of Secretaries of Elderly Affairs and Children and Family Services, and the Secretary of Health Care Administration. The report shall be submitted by the Secretary of Elderly Affairs at least 30 days before the convening of the regular session of the Legislature and shall, at a minimum:

1. Contain and analyze data collected concerning complaints about and conditions in long-term care facilities.

2. Evaluate the problems experienced by residents of long-term care facilities.

3. Contain recommendations for improving the quality of life of the residents and for protecting the health, safety, welfare, and rights of the residents.

4. Analyze the success of the ombudsman program during the preceding year and identify the barriers that prevent the optimal operation of the program. The report of the program's successes shall also address the relationship between the state long-term care ombudsman program, the Department of Elderly Affairs, the Agency for Health Care Administration, and the Department of Children and Family Services, and an assessment of how successfully the state long-term care ombudsman program has carried out its responsibilities under the Older Americans Act.

5. Provide policy and regulatory and legislative recommendations to solve identified problems; resolve residents' complaints; improve the quality of care and life of the residents; protect the health, safety, welfare, and rights of the residents; and remove the barriers to the optimal operation of the state long-term care ombudsman program.

6. Contain recommendations from the local ombudsman councils regarding program functions and activities.

7. Include a report on the activities of the legal advocate and other legal advocates acting on behalf of the local and state councils.

(3)

(b)1. The ombudsman, in consultation with the secretary ~~and the state ombudsman council~~, shall submit to the Governor a list of at least eight names of persons who are not serving on a local council.

2. The Governor shall appoint three members chosen from the list, at least one of whom must be over 60 years of age.

3. If the Governor's appointments are not made within 60 days after the ombudsman submits the list, the ombudsman, in consultation with the secretary ~~State Long-Term Care Ombudsman Council~~, shall appoint three members, one of whom must be over 60 years of age.

Section 23. Subsection (4) of section 400.0069, Florida Statutes, is amended to read:

400.0069 Local long-term care ombudsman councils; duties; membership.—

(4) Each local ombudsman council shall be composed of no less than 15 members and no more than 40 ~~30~~ members from the local planning and service area, to include the following: one medical or osteopathic physician whose practice includes or has included a substantial number of geriatric patients and who may have limited practice in a long-term care facility; one registered nurse who has geriatric experience, if possible; one licensed pharmacist; one registered dietitian; at least six nursing home residents or representative consumer advocates for nursing home residents; at least three residents of assisted living facilities or adult family-care homes or three representative consumer advocates for long-term care facility residents; one attorney; and one professional social worker. In no case shall the medical director of a long-term care facility or an employee of the Agency for Health Care Administration, the Department of Children and Family Services, or the Department of Elderly Affairs serve as a member or as an ex officio member of a council. Each member of the council shall certify that neither the council member nor any member of the council member's immediate family has any conflict of interest pursuant to subsection (10). Local ombudsman councils are encouraged to recruit council members who are 60 years of age or older.

Section 24. Subsection (1) of section 400.0071, Florida Statutes, is amended to read:

400.0071 Complaint procedures.—

(1) The state ombudsman council shall recommend to the ombudsman and the secretary ~~establish~~ state and local procedures for receiving complaints against a nursing home or long-term care facility or its employee.

The procedures shall be implemented after the approval of the ombudsman and the secretary.

Section 25. Subsections (1) and (2) of section 400.0087, Florida Statutes, are amended to read:

400.0087 Agency oversight.—

(1) The Department of Elderly Affairs shall monitor the local ombudsman councils responsible for carrying out the duties delegated by s. 400.0069 and federal law. The department, in consultation with the ombudsman ~~and the State Long-Term Care Ombudsman Council~~, shall adopt rules to establish the policies and procedures for the monitoring of local ombudsman councils.

(2) The department is responsible for ensuring that the Office of State Long-Term Care Ombudsman ~~prepares its annual report;~~ provides information to public and private agencies, legislators, and others; provides appropriate training to representatives of the office or of the state or local long-term care ombudsman councils; and coordinates ombudsman services with the Advocacy Center for Persons with Disabilities and with providers of legal services to residents of long-term care facilities in compliance with state and federal laws.

Section 26. Section 400.0089, Florida Statutes, is amended to read:

400.0089 Agency reports.—The ~~State Long-Term Care Ombudsman Council, shall, in cooperation with the~~ Department of Elderly Affairs shall~~,~~ maintain a statewide uniform reporting system to collect and analyze data relating to complaints and conditions in long-term care facilities and to residents, for the purpose of identifying and resolving significant problems. The department and the State Long-Term Care Ombudsman Council shall submit such data as part of its annual report required pursuant to s. 400.0067(2)(g) to the Agency for Health Care Administration, the Department of Children and Family Services, the Florida Statewide Advocacy Council, the Advocacy Center for Persons with Disabilities, the Commissioner for the United States Administration on Aging, the National Ombudsman Resource Center, and any other state or federal entities that the ombudsman determines appropriate. The State Long-Term Care Ombudsman Council shall publish quarterly and make readily available information pertaining to the number and types of complaints received by the long-term care ombudsman program.

Section 27. Section 400.0091, Florida Statutes, is amended to read:

400.0091 Training.—The ombudsman shall provide appropriate training to all employees of the Office of State Long-Term Care Ombudsman and to the state and local long-term care ombudsman councils, including all unpaid volunteers. All volunteers and appropriate employees of the Office of the State Long-Term Care Ombudsman must be given a minimum of 20 hours of training upon employment or enrollment as a volunteer and 10 hours of continuing education annually thereafter. Training must cover, at a minimum, guardianships and powers of attorney, medication administration,

care and medication of residents with dementia and Alzheimer's disease, accounting for residents' funds, discharge rights and responsibilities, and cultural sensitivity. No employee, officer, or representative of the office or of the state or local long-term care ombudsman councils, other than the ombudsman, may carry out any authorized ombudsman duty or responsibility unless the person has received the training required by this section and has been approved by the ombudsman as qualified to carry out ombudsman activities on behalf of the office or the state or local long-term care ombudsman councils.

Section 28. Paragraph (d) of subsection (5) of section 400.179, Florida Statutes, is amended to read:

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

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

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

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

2. The leasehold operator may meet the bond requirement through other arrangements acceptable to the department.

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

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

5. Any failure of the nursing facility operator to acquire, maintain, renew annually, or provide proof to the agency shall be grounds for the agency to deny, cancel, revoke, or suspend the facility license to operate such facility and to take any further action, including, but not limited to, enjoining the facility, asserting a moratorium, or applying for a receiver, deemed necessary to ensure compliance with this section and to safeguard and protect the health, safety, and welfare of the facility's residents. A lease agreement required as a condition of bond financing or refinancing under s. 154.213 by a health facilities authority or required under s. 159.30 by a county or

municipality is not a leasehold for purposes of this paragraph and is not subject to the bond requirement of this paragraph.

Section 29. Subsection (20) of section 400.141, Florida Statutes, is amended to read:

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

(20) Maintain liability insurance coverage that is in force at all times. In lieu of general and professional liability insurance coverage, a state-designated teaching nursing home and its affiliated assisted living facilities created under s. 430.80 may demonstrate proof of financial responsibility as provided in s. 430.80(3)(h); the exception provided in this paragraph shall expire July 1, 2005.

Section 30. Paragraph (h) is added to subsection (3) of section 430.80, Florida Statutes, to read:

430.80 Implementation of a teaching nursing home pilot project.—

(3) To be designated as a teaching nursing home, a nursing home licensee must, at a minimum:

(h) Maintain insurance coverage pursuant to s. 400.141(20) or proof of financial responsibility in a minimum amount of $750,000. Such proof of financial responsibility may include:

1. Maintaining an escrow account consisting of cash or assets eligible for deposit in accordance with s. 625.52; or

2. Obtaining and maintaining pursuant to chapter 675 an unexpired, irrevocable, nontransferable and nonassignable letter of credit issued by any bank or savings association organized and existing under the laws of this state or any bank or savings association organized under the laws of the United States that has its principal place of business in this state or has a branch office which is authorized to receive deposits in this state. The letter of credit shall be used to satisfy the obligation of the facility to the claimant upon presentment of a final judgment indicating liability and awarding damages to be paid by the facility or upon presentment of a settlement agreement signed by all parties to the agreement when such final judgment or settlement is a result of a liability claim against the facility.

Section 31. Subsection (1) of section 477.025, Florida Statutes, is amended, and subsection (11) is added to said section, to read:

477.025 Cosmetology salons; specialty salons; requisites; licensure; inspection; mobile cosmetology salons.—

(1) No cosmetology salon or specialty salon shall be permitted to operate without a license issued by the department except as provided in subsection (11).

(11) Facilities licensed under part II or part III of chapter 400 shall be exempt from the provisions of this section and a cosmetologist licensed pursuant to s. 477.019 may provide salon services exclusively for facility residents.

Section 32. Section 627.9408, Florida Statutes, is amended to read:

627.9408 Rules.—

(1) The department has authority to adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this part.

(2) The department may adopt by rule the provisions of the Long-Term Care Insurance Model Regulation adopted by the National Association of Insurance Commissioners in the second quarter of the year 2000 which are not in conflict with the Florida Insurance Code.

Section 33. Subsections (2) and (3) of section 400.0066, Florida Statutes, are repealed.

Section 34. This act shall take effect upon becoming a law.

Approved by the Governor May 1, 2002.

Filed in Office Secretary of State May 1, 2002.