An act relating to health care; amending s. 394.4615, F.S.; requiring that clinical records be furnished to the unit upon request; amending s. 395.3025, F.S.; allowing patient records to be furnished to the unit; amending s. 400.0077, F.S.; providing that certain confidentiality provisions do not limit the subpoena power of the Attorney General; amending s. 400.494, F.S.; providing that certain confidentiality provisions relating to home health agencies do not apply to information requested by the unit; amending s. 409.9071, F.S.; waiving confidentiality and requiring that certain information regarding Medicaid provider agreements with school districts be provided to the unit; amending s. 409.920, F.S.; clarifying the Attorney General's power to subpoena medical records relating to Medicaid recipients; amending s. 409.9205, F.S.; authorizing investigators employed by the unit to serve process; amending s. 430.608, F.S.; providing that certain confidentiality provisions pertaining to the Department of Elderly Affairs do not limit the subpoena authority of the unit; amending s. 455.667, F.S.; providing that certain confidential records held by the Department of Health must be provided to the unit; amending s. 409.212, F.S.; providing for periodic increase in the optional state supplementation rate; amending

s. 409.901, F.S.; amending definitions of terms used in ss. 409.910-409.920, F.S.; amending s. 409.902, F.S.; providing that the Department of Children and Family Services is responsible for Medicaid eligibility determinations; amending s. 409.903, F.S.; providing responsibility for determinations of eligibility for payments for medical assistance and related services; amending s. 409.905, F.S.; increasing the maximum amount that may be paid under Medicaid for hospital outpatient services; amending s. 409.906, F.S.; allowing the Department of Children and Family Services to transfer funds to the Agency for Health Care Administration to cover state match requirements as specified; amending s. 409.907, F.S.; revising requirements relating to the minimum amount of the surety bond which each provider is required to maintain; specifying grounds on which provider applications may be denied; amending s. 409.908, F.S.; increasing the maximum amount of reimbursement allowable to Medicaid providers for hospital inpatient care; prohibiting interim rate adjustments that reflect increases in the cost of general or professional liability insurance; providing legislative findings, intent, and clarification; relating to reimbursement for services to dually eligible Medicare beneficiaries; providing applicability; creating s. 409.9119, F.S.; creating a

disproportionate share program for specialty hospitals for children; providing formulas governing payments made to hospitals under the program; providing for withholding payments from a hospital that is not complying with agency rules; amending s. 409.912, F.S.; providing for the transfer of certain unexpended Medicaid funds from the Department of Elderly Affairs to the Agency for Health Care Administration; authorizing the agency to renew certain contracts for certain services under certain circumstances; amending s. 409.919, F.S.; providing for the adoption and the transfer of certain rules relating to the determination of Medicaid eligibility; authorizing developmental research schools to participate in the Medicaid certified school match program; providing for the Agency for Health Care Administration to seek a federal waiver allowing the agency to undertake a pilot project that involves contracting with skilled nursing facilities for the provision of rehabilitation services to adult ventilator dependent patients; providing for evaluation of the pilot program; providing for a report; designating Florida Alzheimer's Disease Day; repealing s. 409.912(4)(b), F.S., relating to the authorization of the agency to contract with certain prepaid health care services providers; amending s. 381.0403, F.S.; placing an emphasis on primary care physicians rather

than family physicians; modifying the provisions relating to the funding of graduate medical education; defining primary care specialties; establishing a program for graduate medical education innovations; creating a process regarding the release of funds; requiring an annual report on graduate medical education; establishing a committee for report purposes; providing requirements for the report; amending s. 408.07, F.S.; modifying the definition of "teaching hospital"; amending s. 409.905, F.S.; increasing the Medicaid reimbursement limitation for certain hospital outpatient services; amending s. 409.908, F.S.; providing exceptions to Medicaid reimbursement limitations for certain hospital inpatient care; authorizing the agency to receive certain funds for such exceptional reimbursements; providing an exemption from county contribution requirements; increasing the Medicaid reimbursement limitation for certain hospital outpatient care; authorizing the agency to receive certain funds for such outpatient care; removing authority for additional reimbursement for hospitals participating in the extraordinary disproportionate share program; providing an exemption from county contribution requirements; providing an effective date.

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

Section 1. Present subsections (6) through (10) of section 394.4615, Florida Statutes, are redesignated as subsections (7) through (11), respectively, and a new subsection (6) is added to that section to read:

394.4615 Clinical records; confidentiality.--

(6) Clinical records relating to a Medicaid recipient shall be furnished to the Medicaid Fraud Control Unit in the Department of Legal Affairs, upon request.

Section 2. Paragraph (k) is added to subsection (4) of section 395.3025, Florida Statutes, to read:

395.3025 Patient and personnel records; copies; examination.--

(4) Patient records are confidential and must not be disclosed without the consent of the person to whom they pertain, but appropriate disclosure may be made without such consent to:

(k) The Medicaid Fraud Control Unit in the Department of Legal Affairs pursuant to s. 409.920.

Section 3. Subsection (6) is added to section 400.0077, Florida Statutes, to read:

400.0077 Confidentiality.--

(6) This section does not limit the subpoena power of the Attorney General pursuant to s. 409.920(8)(b).

Section 4. Section 400.494, Florida Statutes, is amended to read:

400.494 Information about patients confidential.--

(1) Information about patients received by persons employed by, or providing services to, a home health agency or received by the licensing agency through reports or inspection shall be confidential and exempt from the provisions of s. 119.07(1) and shall not be disclosed to any person other than

the patient without the written consent of that patient or the patient's guardian.

(2) This section does not apply to information lawfully requested by the Medicaid Fraud Control Unit of the Department of Legal Affairs.

Section 5. Subsection (7) is added to section 409.9071, Florida Statutes, to read:

409.9071 Medicaid provider agreements for school districts certifying state match.--

(7) The agency's and school districts' confidentiality is waived. They shall provide any information or documents relating to this section to the Medicaid Fraud Control Unit in the Department of Legal Affairs, upon request pursuant to its authority under s. 409.920.

Section 6. Paragraph (b) of subsection (8) of section 409.920, Florida Statutes, is amended to read:

409.920 Medicaid provider fraud.--

(8) In carrying out the duties and responsibilities under this subsection, the Attorney General may:

(b) Subpoena witnesses or materials, including medical records relating to Medicaid recipients, within or outside the state and, through any duly designated employee, administer oaths and affirmations and collect evidence for possible use in either civil or criminal judicial proceedings.

Section 7. Section 409.9205, Florida Statutes, is amended to read:

409.9205 Medicaid Fraud Control Unit; law enforcement officers.--All investigators employed by the Medicaid Fraud Control Unit who have been certified under s. 943.1395 are law enforcement officers of the state. Such investigators have the authority to conduct criminal investigations, bear arms,

make arrests, and apply for, serve, and execute search warrants, arrest warrants, ~~and~~ capias, and other process throughout the state pertaining to Medicaid fraud as described in this chapter. The Attorney General shall provide reasonable notice of criminal investigations conducted by the Medicaid Fraud Control Unit to, and coordinate those investigations with, the sheriffs of the respective counties. Investigators employed by the Medicaid Fraud Control Unit are not eligible for membership in the Special Risk Class of the Florida Retirement System under s. 121.0515.

Section 8. Section 430.608, Florida Statutes, is amended to read:

430.608 Confidentiality of information.--Identifying information about elderly persons who receive services under ss. 430.601-430.606, which is received through files, reports, inspection, or otherwise by the department or by authorized departmental employees, by persons who volunteer services, or by persons who provide services to elderly persons under ss. 430.601-430.606 through contracts with the department, is confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution. Such information may not be disclosed publicly in such a manner as to identify an elderly person, unless that person or the person's legal guardian provides written consent.

(2) This section does not, however, limit the subpoena authority of the Medicaid Fraud Control Unit of the Department of Legal Affairs pursuant to s. 409.920(8)(b).

Section 9. Subsection (8) of subsection 455.667, Florida Statutes, is amended to read:

455.667 Ownership and control of patient records; report or copies of records to be furnished.--

(8)(a) All patient records obtained by the department and any other documents maintained by the department which identify the patient by name are confidential and exempt from s. 119.07(1) and shall be used solely for the purpose of the department and the appropriate regulatory board in its investigation, prosecution, and appeal of disciplinary proceedings. The records shall not be available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the department or the appropriate board.

(b) Notwithstanding paragraph (a), all patient records obtained by the department and any other documents maintained by the department which relate to a current or former Medicaid recipient shall be provided to the Medicaid Fraud Control Unit in the Department of Legal Affairs, upon request.

Section 10. Subsection (6) of section 409.212, Florida Statutes, is renumbered as subsection (7) and a new subsection (6) is added to said section, to read:

409.212 Optional supplementation.--

(6) The optional state supplementation rate shall be increased by the cost-of-living adjustment to the federal benefits rate provided the average state optional supplementation contribution does not increase as a result.

Section 11. Subsections (3), (15), and (18) of section 409.901, Florida Statutes, are amended to read:

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

(3) "Applicant" means an individual whose written application for medical assistance provided by Medicaid under ss. 409.903-409.906 has been submitted to the Department of Children and Family Services ~~agency~~, or to the Social Security

Administration if the application is for Supplemental Security Income, but has not received final action. This term includes an individual, who need not be alive at the time of application, whose application is submitted through a representative or a person acting for the individual.

(15) "Medicaid program" means the program authorized under Title XIX of the federal Social Security Act which provides for payments for medical items or services, or both, on behalf of any person who is determined by the Department of Children and Family Services, or, for Supplemental Security Income, by the Social Security Administration, to be eligible on the date of service for Medicaid assistance.

(18) "Medicaid recipient" or "recipient" means an individual whom the Department of Children and Family Services, or, for Supplemental Security Income, by the Social Security Administration, determines is eligible, pursuant to federal and state law, to receive medical assistance and related services for which the agency may make payments under the Medicaid program. For the purposes of determining third-party liability, the term includes an individual formerly determined to be eligible for Medicaid, an individual who has received medical assistance under the Medicaid program, or an individual on whose behalf Medicaid has become obligated.

Section 12. Section 409.902, Florida Statutes, is amended to read:

409.902 Designated single state agency; payment requirements; program title.--The Agency for Health Care Administration is designated as the single state agency authorized to make payments for medical assistance and related services under Title XIX of the Social Security Act. These

payments shall be made, subject to any limitations or directions provided for in the General Appropriations Act, only for services included in the program, shall be made only on behalf of eligible individuals, and shall be made only to qualified providers in accordance with federal requirements for Title XIX of the Social Security Act and the provisions of state law. This program of medical assistance is designated the "Medicaid program." The Department of Children and Family Services is responsible for Medicaid eligibility determinations, including, but not limited to, policy, rules, and the agreement with the Social Security Administration for Medicaid eligibility determinations for Supplemental Security Income recipients, as well as the actual determination of eligibility.

Section 13. Section 409.903, Florida Statutes, is amended to read:

409.903 Mandatory payments for eligible persons.--The agency shall make payments for medical assistance and related services on behalf of the following persons who the department, or the Social Security Administration by contract with the Department of Children and Family Services, ~~agency~~ determines 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) Low-income families with children are eligible for Medicaid provided they meet the following requirements:

(a) The family includes a dependent child who is living with a caretaker relative.

(b) The family's income does not exceed the gross income test limit.

(c) The family's countable income and resources do not exceed the applicable Aid to Families with Dependent Children (AFDC) income and resource standards under the AFDC state plan in effect in July 1996, except as amended in the Medicaid state plan to conform as closely as possible to the requirements of the WAGES Program as created in s. 414.015, to the extent permitted by federal law.

(2) A person who receives payments from, who is determined eligible for, or who was eligible for but lost cash benefits from the federal program known as the Supplemental Security Income program (SSI). This category includes a low-income person age 65 or over and a low-income person under age 65 considered to be permanently and totally disabled.

(3) A child under age 21 living in a low-income, two-parent family, and a child under age 7 living with a nonrelative, if the income and assets of the family or child, as applicable, do not exceed the resource limits under the WAGES Program.

(4) A child who is eligible under Title IV-E of the Social Security Act for subsidized board payments, foster care, or adoption subsidies, and a child for whom the state has assumed temporary or permanent responsibility and who does not qualify for Title IV-E assistance but is in foster care, shelter or emergency shelter care, or subsidized adoption.

(5) A pregnant woman for the duration of her pregnancy and for the post partum period as defined in federal law and rule, or a child under age 1, if either is living in a family that has an income which is at or below 150 percent of the most current federal poverty level, or, effective January 1,

1992, that has an income which is at or below 185 percent of the most current federal poverty level. Such a person is not subject to an assets test. Further, a pregnant woman who applies for eligibility for the Medicaid program through a qualified Medicaid provider must be offered the opportunity, subject to federal rules, to be made presumptively eligible for the Medicaid program.

(6) A child born after September 30, 1983, living in a family that has an income which is at or below 100 percent of the current federal poverty level, who has attained the age of 6, but has not attained the age of 19. In determining the eligibility of such a child, an assets test is not required.

(7) A child living in a family that has an income which is at or below 133 percent of the current federal poverty level, who has attained the age of 1, but has not attained the age of 6. In determining the eligibility of such a child, an assets test is not required.

(8) A person who is age 65 or over or is determined by the agency to be disabled, whose income is at or below 100 percent of the most current federal poverty level and whose assets do not exceed limitations established by the agency. However, the agency may only pay for premiums, coinsurance, and deductibles, as required by federal law, unless additional coverage is provided for any or all members of this group by s. 409.904(1).

Section 14. Subsection (6) of section 409.905, Florida Statutes, is amended to read:

409.905 Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are

determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, number of services, or any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216.

(6) HOSPITAL OUTPATIENT SERVICES.--The agency shall pay for preventive, diagnostic, therapeutic, or palliative care and other services provided to a recipient in the outpatient portion of a hospital licensed under part I of chapter 395, and provided under the direction of a licensed physician or licensed dentist, except that payment for such care and services is limited to $1,500~~$1,000~~ per state fiscal year per recipient, unless an exception has been made by the agency, and with the exception of a Medicaid recipient under age 21, in which case the only limitation is medical necessity.

Section 15. Subsection (5) 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. 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:

(5) CASE MANAGEMENT SERVICES.--The agency may pay for primary care case management services rendered to a recipient pursuant to a federally approved waiver, and targeted case management services for specific groups of targeted recipients, for which funding has been provided and which are rendered pursuant to federal guidelines. The agency is authorized to limit reimbursement for targeted case management services in order to comply with any limitations or directions provided for in the General Appropriations Act. Notwithstanding s. 216.292, the Department of Children and Family Services may transfer general funds to the Agency for Health Care Administration to fund state match requirements exceeding the amount specified in the General Appropriations Act for targeted case management services.

Section 16. Subsections (7), (9), and (10) 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 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 ~~assist in~~ this function. Before entering into the provider agreement, or as a condition of continuing participation in the Medicaid program, the agency ~~and~~ 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 ~~from the provider~~ 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; or

(b) Deny the application if the agency finds that~~,~~ ~~based on the grounds listed in subsection (10),~~ it is in the best interest of the Medicaid program to do so~~, specifying the reasons for denial~~. 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.

(10) The agency may consider whether ~~deny enrollment in the Medicaid program to a provider if~~ the provider, or any officer, director, agent, managing employee, or affiliated person, or any partner or shareholder having an ownership interest equal to 5 percent or greater in the provider if the provider is a corporation, partnership, or other business entity, has:

(a) Made a false representation or omission of any material fact in making the application, including the submission of an application that conceals the controlling or ownership interest of any officer, director, agent, managing employee, affiliated person, or partner or shareholder who may not be eligible to participate;

(b) Been or is currently excluded, suspended, terminated from, or has involuntarily withdrawn from participation in, Florida's Medicaid program or any other state's Medicaid program, or from participation in any other governmental or private health care or health insurance program;

(c) Been convicted of a criminal offense relating to the delivery of any goods or services under Medicaid or Medicare or any other public or private health care or health insurance program including the performance of management or administrative services relating to the delivery of goods or services under any such program;

(d) Been convicted under federal or state law of a criminal offense related to the neglect or abuse of a patient in connection with the delivery of any health care goods or services;

(e) Been convicted under federal or state law of a criminal offense relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance;

(f) Been convicted of any criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct;

(g) Been convicted under federal or state law of a crime punishable by imprisonment of a year or more which involves moral turpitude;

(h) Been convicted in connection with the interference or obstruction of any investigation into any criminal offense listed in this subsection;

(i) Been found to have violated federal or state laws, rules, or regulations governing Florida's Medicaid program or

any other state's Medicaid program, the Medicare program, or any other publicly funded federal or state health care or health insurance program, and been sanctioned accordingly;

(j) Been previously found by a licensing, certifying, or professional standards board or agency to have violated the standards or conditions relating to licensure or certification or the quality of services provided; or

(k) Failed to pay any fine or overpayment properly assessed under the Medicaid program in which no appeal is pending or after resolution of the proceeding by stipulation or agreement, unless the agency has issued a specific letter of forgiveness or has approved a repayment schedule to which the provider agrees to adhere.

Section 17. Paragraph (a) of subsection (1), paragraph (b) of subsection (2), and paragraph (c) of subsection (13) of section 409.908, Florida Statutes, are 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.

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

(a) Reimbursement for inpatient care is limited as provided for in s. 409.905(5). Reimbursement for hospital outpatient care is limited to $1,500 ~~$1,000~~ per state fiscal year per recipient, except for:

1. Such care provided to a Medicaid recipient under age 21, in which case the only limitation is medical necessity;

2. Renal dialysis services; and

3. Other exceptions made by the agency.

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

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

(2)

(b) Subject to any limitations or directions provided for in the General Appropriations Act, the agency shall establish and implement a Florida Title XIX Long-Term Care Reimbursement Plan (Medicaid) for nursing home care in order to provide care and services in conformance with the applicable state and federal laws, rules, regulations, and quality and safety standards and to ensure that individuals eligible for medical assistance have reasonable geographic access to such care. Under the plan, interim rate adjustments shall not be granted to reflect increases in the cost of general or professional liability insurance for nursing homes unless the following criteria are met: have at least a 65 percent Medicaid utilization in the the most recent cost report submitted to the agency, and the increase in general or professional liability costs to the facility for the most recent policy period affects the total Medicaid per diem by at least 5 percent. This rate adjustment shall not result in the per diem exceeding the class ceiling. This provision shall apply only to fiscal year 2000-2001 and shall be implemented to the extent existing appropriations are available. The agency shall report to the Governor, the Speaker of the House of Representatives, and the President of the Senate by December 31, 2000 on the cost of liability insurance for Florida nursing homes for fiscal years 1999 and 2000 and the extent to which these costs are not being compensated by the Medicaid program. Medicaid participating nursing homes shall be required to report to the agency information necessary to

compile this report.Effective no earlier than the rate-setting period beginning April 1, 1999, the agency shall establish a case-mix reimbursement methodology for the rate of payment for long-term care services for nursing home residents. The agency shall compute a per diem rate for Medicaid residents, adjusted for case mix, which is based on a resident classification system that accounts for the relative resource utilization by different types of residents and which is based on level-of-care data and other appropriate data. The case-mix methodology developed by the agency shall take into account the medical, behavioral, and cognitive deficits of residents. In developing the reimbursement methodology, the agency shall evaluate and modify other aspects of the reimbursement plan as necessary to improve the overall effectiveness of the plan with respect to the costs of patient care, operating costs, and property costs. In the event adequate data are not available, the agency is authorized to adjust the patient's care component or the per diem rate to more adequately cover the cost of services provided in the patient's care component. The agency shall work with the Department of Elderly Affairs, the Florida Health Care Association, and the Florida Association of Homes for the Aging in developing the methodology. It is the intent of the Legislature that the reimbursement plan achieve the goal of providing access to health care for nursing home residents who require large amounts of care while encouraging diversion services as an alternative to nursing home care for residents who can be served within the community. The agency shall base the establishment of any maximum rate of payment, whether overall or component, on the available moneys as provided for in the General Appropriations Act. The agency may base the

maximum rate of payment on the results of scientifically valid analysis and conclusions derived from objective statistical data pertinent to the particular maximum rate of payment.

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

(c) Medicaid will pay no portion of Medicare deductibles and coinsurance when payment that Medicare has made for the service equals or exceeds what Medicaid would have paid if it had been the sole payor. The combined payment of Medicare and Medicaid shall not exceed the amount Medicaid would have paid had it been the sole payor. The Legislature finds that there has been confusion regarding the reimbursement for services rendered to dually eligible Medicare beneficiaries. Accordingly, the Legislature clarifies that it has always been the intent of the legislature before and after 1991 that, in reimbursing in accordance with fees established by Title XVIII for premiums, deductibles, and coinsurance for Medicare services rendered by physicians to Medicaid eligible persons, that physicians be reimbursed at the lesser of the amount billed by the physician or the Medicaid maximum allowable fee established by the Agency for Health Care Administration, as is permitted by federal law. It has never been the intent of the Legislature with regard to such services rendered by physicians that Medicaid be required to provide any payment for deductibles, coinsurance, or copayments for Medicare cost-sharing, or any expenses incurred relating thereto, in excess of the payment amount provided for

under the State Medicaid plan for such service. This payment methodology is applicable even in those situations in which the payment for Medicare cost-sharing for a qualified Medicare beneficiary with respect to an item or service is reduced or eliminated. This expression of the Legislature is in clarification of existing law and shall apply to payment for, and with respect to provider agreements with respect to, items or services furnished on or after the effective date of this act. This paragraph applies to payment by Medicaid for items and services furnished before the effective date of this act if such payment is the subject of a lawsuit that is based on the provisions of s. 409.908, and that is pending as of, or is initiated after, the effective date of this act.

Section 18. Section 409.9119, Florida Statutes, is created to read:

409.9119 Disproportionate share program for specialty hospitals for children.--In addition to the payments made under s. 409.911, the Agency for Health Care Administration shall develop and implement a system under which disproportionate share payments are made to those hospitals that are licensed by the state as specialty hospitals for children and were licensed on January 1, 2000, as specialty hospitals for children. This system of payments must conform to federal requirements and must distribute funds in each fiscal year for which an appropriation is made by making quarterly Medicaid payments. Notwithstanding s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals that serve a disproportionate share of low-income patients.

(1) The agency shall use the following formula to calculate the total amount earned for hospitals that

participate in the specialty hospital for children disproportionate share program:

$$TAE = DSR \times BMPD \times MD$$

Where:

TAE = total amount earned by a specialty hospital for children.

DSR = disproportionate share rate.

BMPD = base Medicaid per diem.

MD = Medicaid days.

(2) The agency shall calculate the total additional payment for hospitals that participate in the specialty hospital for children disproportionate share program as follows:

$$TAP = \frac{(TAE \times TA)}{STAE}$$

Where:

TAP = total additional payment for a specialty hospital for children.

TAE = total amount earned by a specialty hospital for children.

TA = total appropriation for the specialty hospital for children disproportionate share program.

STAE = sum of total amount earned by each hospital that participates in the specialty hospital for children disproportionate share program.

(3) A hospital may not receive any payments under this section until it achieves full compliance with the applicable rules of the agency. A hospital that is not in compliance for

two or more consecutive quarters may not receive its share of the funds. Any forfeited funds must be distributed to the remaining participating specialty hospitals for children that are in compliance.

Section 19. Subsection (9) of section 409.912, Florida Statutes, is amended, and subsection (37) is added to said section, to read:

409.912 Cost-effective purchasing of health care.--The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. The agency shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services.

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

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

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

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

Section 20. Section 409.919, Florida Statutes, is amended to read:

409.919 Rules.--The agency shall adopt any rules necessary to comply with or administer ss. 409.901-409.920 and all rules necessary to comply with federal requirements. In addition, the Department of Children and Family Services shall adopt and accept transfer of any rules necessary to carry out its responsibilities for receiving and processing Medicaid applications and determining Medicaid eligibility, and for assuring compliance with and administering ss. 409.901-409.906 and any other provisions related to responsibility for the determination of Medicaid eligibility.

Section 21. Notwithstanding the provisions of ss. 236.0812, 409.9071, and 409.908(21), Florida Statutes, developmental research schools, as authorized under s. 228.053, Florida Statutes, shall be authorized to participate in the Medicaid certified school match program subject to the provisions of ss. 236.0812, 409.9071, and 409.908(21), Florida Statutes.

Section 22. (1) The Agency for Health Care Administration is directed to submit to the Health Care Financing Administration a request for a waiver that will allow the agency to undertake a pilot project that would implement a coordinated system of care for adult ventilator dependent patients. Under this pilot program, the agency shall identify a network of skilled nursing facilities that have respiratory departments geared towards intensive treatment and rehabilitation of adult ventilator patients and will contract with such a network for respiratory services under a capitation arrangement. The pilot project must allow the agency to evaluate a coordinated and focused system of care for adult ventilator dependent patients to determine the overall cost-effectiveness and improved outcomes for participants.

(2) The agency shall submit the waiver by September 1, 2000. The agency shall forward a preliminary report of the pilot project's findings to the Governor, the Speaker of the House of Representatives, and the President of the Senate 6 months after project implementation. The agency shall submit a final report of the pilot project's findings to the Governor, the Speaker of the House of Representatives, and the President of the Senate no later than February 15, 2002.

Section 23. Subsection (7) of section 430.703, Florida Statutes, is renumbered as subsection (8), and a new subsection (7) is added to said section to read:

430.703 Definitions.--As used in this act, the term:

(7) "Other qualified provider" means an entity licensed under chapter 400 that demonstrates a long-term care continuum, posts a $500,000 performance bond, and meets all the financial and quality assurance requirements for a provider service network as specified in s. 409.912 and all requirements pursuant to an interagency agreement between the agency and the department.

Section 24. Subsection (1) of section 430.707, Florida Statutes, is amended to read:

430.707 Contracts.--

(1) The department, in consultation with the agency, shall select and contract with managed care organizations and, on a prepaid basis, with other qualified providers as defined in s. 430.703(7)to provide long-term care within community diversion pilot project areas. The agency shall evaluate and report quarterly to the department the compliance by other qualified providers with all the financial and quality assurance requirements of the contract.

Section 25. February 6th of each year is designated as Florida Alzheimer's Disease Day.

Section 26. Paragraph (b) of subsection (4) of section 409.912, Florida Statutes, is repealed.

Section 27. Section 381.0403, Florida Statutes, is amended to read:

381.0403 The Community Hospital Education Act.--

(1) SHORT TITLE.--This section shall be known and cited as "The Community Hospital Education Act."

(2) LEGISLATIVE INTENT.--

(a) It is the intent of the Legislature that health care services for the citizens of this state be upgraded and that a program for continuing these services be maintained through a plan for community medical education. The program is intended to provide additional outpatient and inpatient services, a continuing supply of highly trained physicians, and graduate medical education.

(b) The Legislature further acknowledges the critical need for increased numbers of primary care ~~family~~ physicians to provide the necessary current and projected health and medical services. In order to meet both present and anticipated needs, the Legislature supports an expansion in the number of family practice residency positions. The Legislature intends that the funding for graduate education in family practice be maintained and that funding for all primary care specialties be provided at a minimum of $10,000 per resident per year. Should funding for this act remain constant or be reduced, it is intended that all programs funded by this act be maintained or reduced proportionately.

(3) PROGRAM FOR COMMUNITY HOSPITAL EDUCATION; STATE AND LOCAL PLANNING.--

(a) There is established under the Board of Regents a program for statewide graduate medical education. It is intended that continuing graduate medical education programs for interns and residents be established on a statewide basis. The program shall provide financial support for primary care specialty interns and residents based on policies recommended and approved by the Community Hospital Education Council, herein established, and the Board of Regents. Only those programs with at least three residents or interns in each year

of the training program are qualified to apply for financial support. Programs with fewer than three residents or interns per training year are qualified to apply for financial support, but only if the appropriate accrediting entity for the particular specialty has approved the program for fewer positions. Programs added after fiscal year 1997-1998 shall have 5 years to attain the requisite number of residents or interns. When feasible and to the extent allowed through the General Appropriations Act, state funds shall be used to generate federal matching funds under Medicaid, or other federal programs, and the resulting combined state and federal funds shall be allocated to participating hospitals for the support of graduate medical education, for administrative costs associated with the production of the annual report as specified in subsection (9), and for administration of the council.

(b) For the purposes of this section, primary care specialties include emergency medicine, family practice, internal medicine, pediatrics, psychiatry, obstetrics/gynecology, and combined pediatrics and internal medicine, and other primary care specialties as may be included by the council and Board of Regents.

(c)~~(b)~~ Medical institutions throughout the state may apply to the Community Hospital Education Council for grants-in-aid for financial support of their approved programs. Recommendations for funding of approved programs shall be forwarded to the Board of Regents.

(d)~~(c)~~ The program shall provide a plan for community clinical teaching and training with the cooperation of the medical profession, hospitals, and clinics. The plan shall also include formal teaching opportunities for intern and

resident training. In addition, the plan shall establish an off-campus medical faculty with university faculty review to be located throughout the state in local communities.

(4) PROGRAM FOR GRADUATE MEDICAL EDUCATION INNOVATIONS.--

(a) There is established under the Board of Regents a program for fostering graduate medical education innovations. Funds appropriated annually by the Legislature for this purpose shall be distributed to participating hospitals or consortia of participating hospitals and Florida medical schools on a competitive grant or formula basis to achieve state health care workforce policy objectives, including, but not limited to:

1. Increasing the number of residents in primary care and other high demand specialties or fellowships;

2. Enhancing retention of primary care physicians in Florida practice;

3. Promoting practice in medically underserved areas of the state;

4. Encouraging racial and ethnic diversity within the state's physician workforce; and

5. Encouraging increased production of geriatricians.

(b) Participating hospitals or consortia of participating hospitals and Florida medical schools may apply to the Community Hospital Education Council for funding under this innovations program. Innovations program funding shall provide funding based on policies recommended and approved by the Community Hospital Education Council and the Board of Regents.

(c) Participating hospitals or consortia of participating hospitals and Florida medical schools awarded an

innovations grant shall provide the Community Hospital Education Council and Board of Regents with an annual report on their project.

(5)~~(4)~~ FAMILY PRACTICE RESIDENCIES.--In addition to the programs established in subsection (3), the Community Hospital Education Council and the Board of Regents shall establish an ongoing statewide program of family practice residencies. The administration of this program shall be in the manner described in this section.

(6)~~(5)~~ COUNCIL AND DIRECTOR.--

(a) There is established the Community Hospital Education Council, hereinafter referred to as the council, which shall consist of eleven members, as follows:

1. Seven members must be program directors of accredited graduate medical education programs or practicing physicians who have faculty appointments in accredited graduate medical education programs. Six of these members must be board certified or board eligible in family practice, internal medicine, pediatrics, emergency medicine, obstetrics-gynecology, and psychiatry, respectively, and licensed pursuant to chapter 458. No more than one of these members may be appointed from any one specialty. One member must be licensed pursuant to chapter 459.

2. One member must be a representative of the administration of a hospital with an approved community hospital medical education program;

3. One member must be the dean of a medical school in this state; and

4. Two members must be consumer representatives.

All of the members shall be appointed by the Governor for terms of 4 years each.

(b) Council membership shall cease when a member's representative status no longer exists. Members of similar representative status shall be appointed to replace retiring or resigning members of the council.

(c) The Chancellor of the State University System shall designate an administrator to serve as staff director. The council shall elect a chair from among its membership. Such other personnel as may be necessary to carry out the program shall be employed as authorized by the Board of Regents.

(7)~~(6)~~ BOARD OF REGENTS; STANDARDS.--

(a) The Board of Regents, with recommendations from the council, shall establish standards and policies for the use and expenditure of graduate medical education funds appropriated pursuant to subsection(8)~~(7)~~for a program of community hospital education. The board shall establish requirements for hospitals to be qualified for participation in the program which shall include, but not be limited to:

1. Submission of an educational plan and a training schedule.

2. A determination by the council to ascertain that each portion of the program of the hospital provides a high degree of academic excellence and is accredited by the Accreditation Council for Graduate Medical Education of the American Medical Association or is accredited by the American Osteopathic Association.

3. Supervision of the educational program of the hospital by a physician who is not the hospital administrator.

(b) The Board of Regents shall periodically review the educational program provided by a participating hospital to assure that the program includes a reasonable amount of both formal and practical training and that the formal sessions are presented as scheduled in the plan submitted by each hospital.

(c) In years that funds are transferred to the Agency for Health Care Administration, the Board of Regents shall certify to the Agency for Health Care Administration on a quarterly basis the number of primary care specialty residents and interns at each of the participating hospitals for which the Community Hospital Education Council and the board recommends funding.

(8)~~(7)~~ MATCHING FUNDS.--State funds shall be used to match funds from any local governmental or hospital source. The state shall provide up to 50 percent of the funds, and the community hospital medical education program shall provide the remainder. However, except for fixed capital outlay, the provisions of this subsection shall not apply to any program authorized under the provisions of subsection(5)~~(4)~~for the first 3 years after such program is in operation.

(9) ANNUAL REPORT ON GRADUATE MEDICAL EDUCATION; COMMITTEE.--The Board of Regents, the Executive Office of the Governor, the Department of Health, and the Agency for Health Care Administration shall collaborate to establish a committee that shall produce an annual report on graduate medical education. To the maximum extent feasible, the committee shall have the same membership as the Graduate Medical Education Study Committee, established by proviso accompanying Specific Appropriation 191 of the 1999-2000 General Appropriations Act. The report shall be provided to the Governor, the President of Senate, and the Speaker of the House of Representatives by

January 15 annually. Committee members shall serve without compensation. From the funds provided pursuant to s. 381.0403(3), the committee is authorized to expend a maximum of $75,000 per year to provide for administrative costs and contractual services. The report shall address the following:

(a) The role of residents and medical faculty in the provision of health care.

(b) The relationship of graduate medical education to the state's physician workforce.

(c) The costs of training medical residents for hospitals, medical schools, teaching hospitals, including all hospital-medical affiliations, practice plans at all of the medical schools, and municipalities.

(d) The availability and adequacy of all sources of revenue to support graduate medical education and recommend alternative sources of funding for graduate medical education.

(e) The use of state and federal appropriated funds for graduate medical education by hospitals receiving such funds.

Section 28. Subsection (44) of section 408.07, Florida Statutes, is amended to read:

408.07 Definitions.--As used in this chapter, with the exception of ss. 408.031-408.045, the term:

(44) "Teaching hospital" means any Florida hospital officially ~~formally~~ affiliated with an accredited Florida medical school which exhibits activity in the area of graduate medical education as reflected by at least seven different graduate medical education programs accredited by the Accreditation Council for Graduate Medical Education or the Council on Postdoctoral Training of the American Osteopathic Association ~~resident physician specialties~~ and the presence of

100 or more full-time equivalent resident physicians. The Director of the Agency for Health Care Administration shall be responsible for determining which hospitals meet this definition.

Section 29. Subsection (6) of section 409.905, Florida Statutes, is amended to read:

409.905 Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, number of services, or any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216.

(6) HOSPITAL OUTPATIENT SERVICES.--The agency shall pay for preventive, diagnostic, therapeutic, or palliative care and other services provided to a recipient in the outpatient portion of a hospital licensed under part I of chapter 395, and provided under the direction of a licensed physician or licensed dentist, except that payment for such care and services is limited to $1,500~~$1,000~~ per state fiscal year per recipient, unless an exception has been made by the agency, and with the exception of a Medicaid recipient under age 21, in which case the only limitation is medical necessity.

Section 30. Subsection (1) 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.

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

(a) Reimbursement for inpatient care is limited as provided for in s. 409.905(5)<u>, except for:</u>~~.~~

<u>1. The raising of rate reimbursement caps, excluding rural hospitals.</u>

2. Recognition of the costs of graduate medical education.

3. Other methodologies recognized in the General Appropriations Act.

During the years funds are transferred from the Board of Regents, any reimbursement supported by such funds shall be subject to certification by the Board of Regents that the hospital has complied with s. 381.0403. The agency is authorized to receive funds from state entities, including, but limited to, the Board of Regents, local governments, and other local political subdivisions, for the purpose of making special exception payments, including federal matching funds, through the Medicaid inpatient reimbursement methodologies. Funds received from state entities or local governments for this purpose shall be separately accounted for and shall not be commingled with other state or local funds in any manner. Notwithstanding this section and s. 409.915, counties are exempt from contributing toward the cost of the special exception reimbursement for hospitals serving a disproportionate share of low-income persons and providing graduate medical education.

(b) Reimbursement for hospital outpatient care is limited to $1,500~~$1,000~~ per state fiscal year per recipient, except for:

1. Such care provided to a Medicaid recipient under age 21, in which case the only limitation is medical necessity.~~;~~

2. Renal dialysis services.~~; and~~

3. Other exceptions made by the agency.

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

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

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

Section 31. This act shall take effect July 1, 2000.