SENATE AMENDMENT

Bill No. HB 59-E, 1st Eng.

Amendment No. ___ Barcode 934922

CHAMBER ACTION

Senate House

Senator Silver moved the following amendment:

Senate Amendment (with title amendment)

Delete everything after the enacting clause

and insert:

Section 1. Section 16.59, Florida Statutes, is amended to read:

16.59 Medicaid fraud control.--There is created in the Department of Legal Affairs the Medicaid Fraud Control Unit, which may investigate all violations of s. 409.920 and any criminal violations discovered during the course of those investigations. The Medicaid Fraud Control Unit may refer any criminal violation so uncovered to the appropriate prosecuting authority. Offices of the Medicaid Fraud Control Unit and the offices of the Agency for Health Care Administration Medicaid program integrity program shall, to the extent possible, be collocated. The agency and the Department of Legal Affairs shall conduct joint training and other joint activities designed to increase communication and coordination in recovering overpayments.

Section 2. Subsections (3), (5), and (7) of section 112.3187, Florida Statutes, are amended to read:

112.3187 Adverse action against employee for disclosing information of specified nature prohibited; employee remedy and relief.--

(3) DEFINITIONS.--As used in this act, unless otherwise specified, the following words or terms shall have the meanings indicated:

(a) "Agency" means any state, regional, county, local, or municipal government entity, whether executive, judicial, or legislative; any official, officer, department, division, bureau, commission, authority, or political subdivision therein; or any public school, community college, or state university.

(b) "Employee" means a person who performs services for, and under the control and direction of, or contracts with, an agency or independent contractor for wages or other remuneration.

(c) "Adverse personnel action" means the discharge, suspension, transfer, or demotion of any employee or the withholding of bonuses, the reduction in salary or benefits, or any other adverse action taken against an employee within the terms and conditions of employment by an agency or independent contractor.

(d) "Independent contractor" means a person, other than an agency, engaged in any business and who enters into a contract or provider agreement with an agency.

(e) "Gross mismanagement" means a continuous pattern of managerial abuses, wrongful or arbitrary and capricious actions, or fraudulent or criminal conduct which may have a substantial adverse economic impact.

(5) NATURE OF INFORMATION DISCLOSED.--The information disclosed under this section must include:

(a) Any violation or suspected violation of any federal, state, or local law, rule, or regulation committed by an employee or agent of an agency or independent contractor which creates and presents a substantial and specific danger to the public's health, safety, or welfare.

(b) Any act or suspected act of gross mismanagement, malfeasance, misfeasance, gross waste of public funds, suspected or actual Medicaid fraud or abuse, or gross neglect of duty committed by an employee or agent of an agency or independent contractor.

(7) EMPLOYEES AND PERSONS PROTECTED.--This section protects employees and persons who disclose information on their own initiative in a written and signed complaint; who are requested to participate in an investigation, hearing, or other inquiry conducted by any agency or federal government entity; who refuse to participate in any adverse action prohibited by this section; or who initiate a complaint through the whistle-blower's hotline or the hotline of the Medicaid Fraud Control Unit of the Department of Legal Affairs; or employees who file any written complaint to their supervisory officials or employees who submit a complaint to the Chief Inspector General in the Executive Office of the Governor, to the employee designated as agency inspector general under s. 112.3189(1), or to the Florida Commission on Human Relations. The provisions of this section may not be used by a person while he or she is under the care, custody, or control of the state correctional system or, after release from the care, custody, or control of the state correctional system, with respect to circumstances that occurred during any

period of incarceration. No remedy or other protection under ss. 112.3187-112.31895 applies to any person who has committed or intentionally participated in committing the violation or suspected violation for which protection under ss. 112.3187-112.31895 is being sought.

Section 3. 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.

6. Notwithstanding other provisions of this section, a lease agreement required as a condition of bond financing or refinancing under s. 154.213 by a health facilities authority or under s. 159.30 by a county or municipality is not considered as a leasehold and therefore, is not subject to the bond requirement of this paragraph.

Section 4. Section 408.831, Florida Statutes, is created to read:

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

(1) In addition to any other remedies provided by law, the agency may deny each application or suspend or revoke each license, registration, or certificate of entities regulated or licensed by it:

(a) If the applicant, licensee, registrant, or

certificateholder, or, in the case of a corporation, partnership, or other business entity, if any officer, director, agent, or managing employee of that business entity or any affiliated person, partner, or shareholder having an ownership interest equal to 5 percent or greater in that business entity, has failed to pay all outstanding fines, liens, or overpayments assessed by final order of the agency or final order of the Centers for Medicare and Medicaid Services, not subject to further appeal, unless a repayment plan is approved by the agency; or

(b) For failure to comply with any repayment plan.

(2) This section provides standards of enforcement applicable to all entities licensed or regulated by the Agency for Health Care Administration. This section controls over any conflicting provisions of chapters 39, 381, 383, 390, 391, 393, 394, 395, 400, 408, 468, 483, and 641 or rules adopted pursuant to those chapters.

Section 5. Section 409.8177, Florida Statutes, is amended to read:

409.8177 Program evaluation.--

(1) The agency, in consultation with the Department of Health, the Department of Children and Family Services, and the Florida Healthy Kids Corporation, shall contract for an evaluation of the Florida Kidcare program and shall by January 1 of each year submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives a report of the ~~Florida Kidcare~~ program. In addition to the items specified under s. 2108 of Title XXI of the Social Security Act, the report shall include an assessment of crowd-out and access to health care, as well as the following:

(a)~~(1)~~ An assessment of the operation of the program,

including the progress made in reducing the number of uncovered low-income children.

(b)~~(2)~~ An assessment of the effectiveness in increasing the number of children with creditable health coverage, including an assessment of the impact of outreach.

(c)~~(3)~~ The characteristics of the children and families assisted under the program, including ages of the children, family income, and access to or coverage by other health insurance prior to the program and after disenrollment from the program.

(d)~~(4)~~ The quality of health coverage provided, including the types of benefits provided.

(e)~~(5)~~ The amount and level, including payment of part or all of any premium, of assistance provided.

(f)~~(6)~~ The average length of coverage of a child under the program.

(g)~~(7)~~ The program's choice of health benefits coverage and other methods used for providing child health assistance.

(h)~~(8)~~ The sources of nonfederal funding used in the program.

(i)~~(9)~~ An assessment of the effectiveness of Medikids, Children's Medical Services network, and other public and private programs in the state in increasing the availability of affordable quality health insurance and health care for children.

(j)~~(10)~~ A review and assessment of state activities to coordinate the program with other public and private programs.

(k)~~(11)~~ An analysis of changes and trends in the state that affect the provision of health insurance and health care to children.

(l)~~(12)~~ A description of any plans the state has for improving the availability of health insurance and health care for children.

(m)~~(13)~~ Recommendations for improving the program.

(n)~~(14)~~ Other studies as necessary.

(2) The agency shall also submit each month to the Governor, the President of the Senate, and the Speaker of the House of Representatives a report of enrollment for each program component of the Florida Kidcare program.

Section 6. Section 409.902, Florida Statutes, is amended to read:

409.902 Designated single state agency; payment requirements; program title; release of medical records.--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. As a condition of Medicaid eligibility, the Agency for Health Care

Administration and the Department of Children and Family Services shall ensure that each recipient of Medicaid consents to the release of her or his medical records to the Agency for Health Care Administration and the Medicaid Fraud Control Unit of the Department of Legal Affairs.

Section 7. Effective July 1, 2002, subsection (2) of section 409.904, Florida Statutes, as amended by section 2 of chapter 2001-377, Laws of Florida, is amended to read:

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

(2)~~(a)~~ A caretaker relative/parent, a pregnant woman, a child under age 19 who would otherwise qualify for Florida Kidcare Medicaid, a child up to age 21 who would otherwise qualify under s. 409.903(1), a person age 65 or over, or a blind or disabled person who would otherwise be eligible for Florida Medicaid, except that the income or assets of such family or person exceed established limitations.~~A pregnant woman who would otherwise qualify for Medicaid under s. 409.903(5) except for her level of income and whose assets fall within the limits established by the Department of Children and Family Services for the medically needy. A pregnant woman who applies for medically needy eligibility may not be made presumptively eligible.~~

~~(b) A child under age 21 who would otherwise qualify for Medicaid or the Florida Kidcare program except for the~~

~~family's level of income and whose assets fall within the limits established by the Department of Children and Family Services for the medically needy.~~

For a family or person in one of these coverage groups ~~this group~~, medical expenses are deductible from income in accordance with federal requirements in order to make a determination of eligibility. Expenses used to meet spend-down liability are not reimbursable by Medicaid. Effective January 1, 2003, when determining the eligibility of a pregnant woman, a child, or an aged, blind, or disabled individual, $270 will be deducted from the countable income of the filing unit. When determining the eligibility of the parent or caretaker relative as defined by Title XIX of the Social Security Act, the additional income disregard of $270 does not apply.A family or person eligible under the coverage ~~in this group, which group is~~ known as the "medically needy," is eligible to receive the same services as other Medicaid recipients, with the exception of services in skilled nursing facilities and intermediate care facilities for the developmentally disabled.

Section 8. Paragraph (c) of subsection (5) of section 409.905, Florida Statutes, is amended to read:

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

restricted by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, number of services, or any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216.

(5) HOSPITAL INPATIENT SERVICES.--The agency shall pay for all covered services provided for the medical care and treatment of a recipient who is admitted as an inpatient by a licensed physician or dentist to a hospital licensed under part I of chapter 395. However, the agency shall limit the payment for inpatient hospital services for a Medicaid recipient 21 years of age or older to 45 days or the number of days necessary to comply with the General Appropriations Act.

(c) Agency for Health Care Administration shall adjust a hospital's current inpatient per diem rate to reflect the cost of serving the Medicaid population at that institution if:

1. The hospital experiences an increase in Medicaid caseload by more than 25 percent in any year, primarily resulting from the closure of a hospital in the same service area occurring after July 1, 1995; ~~or~~

2. The hospital's Medicaid per diem rate is at least 25 percent below the Medicaid per patient cost for that year; or~~.~~

3. The hospital is located in a county that has five or fewer hospitals, began offering obstetrical services on or after September 1999, and has submitted a request in writing to the agency for a rate adjustment after July 1, 2000, but before September 30, 2000, in which case such hospital's Medicaid inpatient per diem rate shall be adjusted to cost,

effective July 1, 2002.

No later than October 1 of each year ~~November 1, 2001~~, the agency must provide estimated costs for any adjustment in a hospital inpatient per diem pursuant to this paragraph to the Executive Office of the Governor, the House of Representatives General Appropriations Committee, and the Senate Appropriations Committee. Before the agency implements a change in a hospital's inpatient per diem rate pursuant to this paragraph, the Legislature must have specifically appropriated sufficient funds in the General Appropriations Act to support the increase in cost as estimated by the agency.

Section 9. Effective July 1, 2002, subsections (1), (12), and (23) of section 409.906, Florida Statutes, as amended by section 3 of chapter 2001-377, Laws of Florida, are amended to read:

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

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

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

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

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

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

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

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

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

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

Section 10. Subsection (2) of section 409.9065, Florida Statutes, as amended by section 5 of chapter 2001-377, Laws of Florida, is amended to read:

409.9065 Pharmaceutical expense assistance.--

(2) ELIGIBILITY.--Eligibility for the program is limited to those individuals who qualify for limited assistance under the Florida Medicaid program as a result of being dually eligible for both Medicare and Medicaid, but whose limited assistance or Medicare coverage does not include any pharmacy benefit. To the extent funds are appropriated, specifically eligible individuals are individuals ~~low-income senior citizens~~ who:

(a) Are Florida residents age 65 and over;

(b) Have an income:

1. Between 88 ~~90~~ and 120 percent of the federal poverty level;

2. Between 88 and 150 percent of the federal poverty level if the Federal Government increases the federal Medicaid match for persons between 100 and 150 percent of the federal

poverty level; or

3. Between 88 percent of the federal poverty level and a level that can be supported with funds provided in the General Appropriations Act for the program offered under this section along with federal matching funds approved by the Federal Government under a s. 1115 waiver. The agency is authorized to submit and implement a federal waiver pursuant to this subparagraph. The agency shall design a pharmacy benefit that includes annual per-member benefit limits and cost-sharing provisions and limits enrollment to available appropriations and matching federal funds. Prior to implementing this program, the agency must submit a budget amendment pursuant to chapter 216;

(c) Are eligible for both Medicare and Medicaid;

(d) Are not enrolled in a Medicare health maintenance organization that provides a pharmacy benefit; and

(e) Request to be enrolled in the program.

Section 11. Subsections (7) and (9) of section 409.907, Florida Statutes, as amended by section 6 of chapter 2001-377, Laws of Florida, are amended to read:

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

(7) The agency may require, as a condition of

participating in the Medicaid program and before entering into the provider agreement, that the provider submit information, in an initial and any required renewal applications, concerning the professional, business, and personal background of the provider and permit an onsite inspection of the provider's service location by agency staff or other personnel designated by the agency to perform this function. The agency shall perform a random onsite inspection, within 60 days after receipt of a fully complete new provider's application, of the provider's service location prior to making its first payment to the provider for Medicaid services to determine the applicant's ability to provide the services that the applicant is proposing to provide for Medicaid reimbursement. The agency is not required to perform an onsite inspection of a provider or program that is licensed by the agency, that provides services under waiver programs for home and community-based services, or that is licensed as a medical foster home by the Department of Children and Family Services.As a continuing condition of participation in the Medicaid program, a provider shall immediately notify the agency of any current or pending bankruptcy filing. Before entering into the provider agreement, or as a condition of continuing participation in the Medicaid program, the agency may also require that Medicaid providers reimbursed on a fee-for-services basis or fee schedule basis which is not cost-based, post a surety bond not to exceed $50,000 or the total amount billed by the provider to the program during the current or most recent calendar year, whichever is greater. For new providers, the amount of the surety bond shall be determined by the agency based on the provider's estimate of its first year's billing. If the provider's billing during the first year exceeds the

bond amount, the agency may require the provider to acquire an additional bond equal to the actual billing level of the provider. A provider's bond shall not exceed $50,000 if a physician or group of physicians licensed under chapter 458, chapter 459, or chapter 460 has a 50 percent or greater ownership interest in the provider or if the provider is an assisted living facility licensed under part III of chapter 400. The bonds permitted by this section are in addition to the bonds referenced in s. 400.179(4)(d). If the provider is a corporation, partnership, association, or other entity, the agency may require the provider to submit information concerning the background of that entity and of any principal of the entity, including any partner or shareholder having an ownership interest in the entity equal to 5 percent or greater, and any treating provider who participates in or intends to participate in Medicaid through the entity. The information must include:

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

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

(c) Full and accurate disclosure of any financial or

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

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

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

(a) Enroll the applicant as a Medicaid provider no earlier than the effective date of the approval of the provider application. With respect to providers who were recently granted a change of ownership and those who primarily provide emergency medical services transportation or emergency services and care pursuant to s. 401.45 or s. 395.1041, and out-of-state providers, upon approval of the provider application, the effective date of approval is considered to be the date the agency receives the provider application; or

(b) Deny the application if the agency finds that it is in the best interest of the Medicaid program to do so. The agency may consider the factors listed in subsection (10), as well as any other factor that could affect the effective and efficient administration of the program, including, but not limited to, the applicant's demonstrated ability to provide services, conduct business, and operate a financially viable concern;the current availability of medical care, services, or supplies to recipients, taking into account geographic location and reasonable travel time; the number of providers

of the same type already enrolled in the same geographic area; and the credentials, experience, success, and patient outcomes of the provider for the services that it is making application to provide in the Medicaid program. The agency shall deny the application if the agency finds that a provider; 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 failed to pay all outstanding fines or overpayments assessed by final order of the agency or final order of the Centers for Medicare and Medicaid Services, not subject to further appeal, unless the provider agrees to a repayment plan that includes withholding Medicaid reimbursement until the amount due is paid in full.

Section 12. Section 409.908, Florida Statutes, as amended by section 7 of chapter 2001-377, Laws of Florida, 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. If a provider is reimbursed based on cost reporting and submits a cost report late and that cost report would have been used to set a lower reimbursement rate for a

rate semester, then the provider's rate for that semester shall be retroactively calculated using the new cost report, and full payment at the recalculated rate shall be effected retroactively. Medicare granted extensions for filing cost reports, if applicable, shall also apply to Medicaid cost reports.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), except for:

1. The raising of rate reimbursement caps, excluding rural hospitals.

2. Recognition of the costs of graduate medical education.

3. Other methodologies recognized in the General Appropriations Act.

4. Hospital inpatient rates shall be reduced by 6 percent effective July 1, 2001, and restored effective April 1, 2002.

During the years funds are transferred from the Department of Health, any reimbursement supported by such funds shall be subject to certification by the Department of Health that the hospital has complied with s. 381.0403. The agency is authorized to receive funds from state entities, including, but not limited to, the Department of Health, 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. The agency may certify all local governmental funds used as state match under Title XIX of the Social Security Act, to the extent that the identified local health care provider that is otherwise entitled to and is contracted to receive such local funds is the benefactor under the state's Medicaid program as determined under the General Appropriations Act and pursuant to an agreement between the Agency for Health Care Administration and the local governmental entity. The local governmental entity shall use a certification form prescribed by the agency. At a minimum, the certification form shall identify the amount being certified and describe the relationship between the certifying local governmental entity and the local health care provider. The agency shall prepare an annual statement of impact which documents the specific activities undertaken during the previous fiscal year pursuant to this paragraph, to be submitted to the Legislature no later than January 1, annually.

(b) Reimbursement for hospital outpatient care is

limited to $1,500 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.

3. Other exceptions made by the agency.

The agency is authorized to receive funds from state entities, including, but not limited to, the Department of Health, 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) 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 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) The agency is authorized to limit inflationary increases for outpatient hospital services as directed by the General Appropriations Act.

(2)(a)1. Reimbursement to nursing homes licensed under part II of chapter 400 and state-owned-and-operated intermediate care facilities for the developmentally disabled licensed under chapter 393 must be made prospectively.

2. Unless otherwise limited or directed in the General Appropriations Act, reimbursement to hospitals licensed under part I of chapter 395 for the provision of swing-bed nursing home services must be made on the basis of the average statewide nursing home payment, and reimbursement to a hospital licensed under part I of chapter 395 for the provision of skilled nursing services must be made on the basis of the average nursing home payment for those services in the county in which the hospital is located. When a hospital is located in a county that does not have any community nursing homes, reimbursement must be determined by averaging the nursing home payments, in counties that surround the county in which the hospital is located. Reimbursement to hospitals, including Medicaid payment of Medicare copayments, for skilled nursing services shall be limited to 30 days, unless a prior authorization has been obtained from the agency. Medicaid reimbursement may be extended by the agency beyond 30 days, and approval must be based upon verification by the patient's physician that the patient requires short-term rehabilitative and recuperative services only, in which case an extension of no more than 15 days may be approved. Reimbursement to a hospital licensed under part I of chapter 395 for the temporary provision of skilled nursing services to nursing home residents who have been displaced as the result of a natural disaster or other emergency may not exceed the average county nursing home payment for those services in the county in which the hospital is located and is

limited to the period of time which the agency considers necessary for continued placement of the nursing home residents in the hospital.

(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.

1. Changes of ownership or of licensed operator do not qualify for increases in reimbursement rates associated with the change of ownership or of licensed operator. The agency shall amend the Title XIX Long Term Care Reimbursement Plan to provide that the initial nursing home reimbursement rates, for the operating, patient care, and MAR components, associated with related and unrelated party changes of ownership or licensed operator filed on or after September 1, 2001, are equivalent to the previous owner's reimbursement rate.

2. The agency shall amend the long-term care reimbursement plan and cost reporting system to create direct care and indirect care subcomponents of the patient care component of the per diem rate. These two subcomponents together shall equal the patient care component of the per diem rate. Separate cost-based ceilings shall be calculated for each patient care subcomponent. The direct care subcomponent of the per diem rate shall be limited by the cost-based class ceiling, and the indirect care subcomponent shall be limited by the lower of the cost-based class ceiling,

by the target rate class ceiling, or by the individual provider target. The agency shall adjust the patient care component effective January 1, 2002. The cost to adjust the direct care subcomponent shall be net of the total funds previously allocated for the case mix add-on. The agency shall make the required changes to the nursing home cost reporting forms to implement this requirement effective January 1, 2002.

3. The direct care subcomponent shall include salaries and benefits of direct care staff providing nursing services including registered nurses, licensed practical nurses, and certified nursing assistants who deliver care directly to residents in the nursing home facility. This excludes nursing administration, MDS, and care plan coordinators, staff development, and staffing coordinator.

4. All other patient care costs shall be included in the indirect care cost subcomponent of the patient care per diem rate. There shall be no costs directly or indirectly allocated to the direct care subcomponent from a home office or management company.

5. On July 1 of each year, the agency shall report to the Legislature direct and indirect care costs, including average direct and indirect care costs per resident per facility and direct care and indirect care salaries and benefits per category of staff member per facility.

6. 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 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 be implemented to the extent existing appropriations are available.

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.

(3) Subject to any limitations or directions provided for in the General Appropriations Act, the following Medicaid services and goods may be reimbursed on a fee-for-service basis. For each allowable service or goods furnished in accordance with Medicaid rules, policy manuals, handbooks, and state and federal law, the payment shall be the amount billed by the provider, the provider's usual and customary charge, or the maximum allowable fee established by the agency, whichever amount is less, with the exception of those services or goods for which the agency makes payment using a methodology based on capitation rates, average costs, or negotiated fees.

(a) Advanced registered nurse practitioner services.

(b) Birth center services.

(c) Chiropractic services.

(d) Community mental health services.

(e) Dental services, including oral and maxillofacial surgery.

(f) Durable medical equipment.

(g) Hearing services.

(h) Occupational therapy for Medicaid recipients under age 21.

(i) Optometric services.

(j) Orthodontic services.

(k) Personal care for Medicaid recipients under age 21.

(l) Physical therapy for Medicaid recipients under age 21.

(m) Physician assistant services.

(n) Podiatric services.

(o) Portable X-ray services.

(p) Private-duty nursing for Medicaid recipients under age 21.

(q) Registered nurse first assistant services.

(r) Respiratory therapy for Medicaid recipients under age 21.

(s) Speech therapy for Medicaid recipients under age 21.

(t) Visual services.

(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(16), 409.9128(5), and 641.513(6).

(5) An ambulatory surgical center shall be reimbursed the lesser of the amount billed by the provider or the Medicare-established allowable amount for the facility.

(6) A provider of early and periodic screening, diagnosis, and treatment services to Medicaid recipients who are children under age 21 shall be reimbursed using an all-inclusive rate stipulated in a fee schedule established by the agency. A provider of the visual, dental, and hearing components of such services shall be reimbursed the lesser of the amount billed by the provider or the Medicaid maximum allowable fee established by the agency.

(7) A provider of family planning services shall be

reimbursed the lesser of the amount billed by the provider or an all-inclusive amount per type of visit for physicians and advanced registered nurse practitioners, as established by the agency in a fee schedule.

(8) A provider of home-based or community-based services rendered pursuant to a federally approved waiver shall be reimbursed based on an established or negotiated rate for each service. These rates shall be established according to an analysis of the expenditure history and prospective budget developed by each contract provider participating in the waiver program, or under any other methodology adopted by the agency and approved by the Federal Government in accordance with the waiver. Effective July 1, 1996, privately owned and operated community-based residential facilities which meet agency requirements and which formerly received Medicaid reimbursement for the optional intermediate care facility for the mentally retarded service may participate in the developmental services waiver as part of a home-and-community-based continuum of care for Medicaid recipients who receive waiver services.

(9) A provider of home health care services or of medical supplies and appliances shall be reimbursed on the basis of competitive bidding or for the lesser of the amount billed by the provider or the agency's established maximum allowable amount, except that, in the case of the rental of durable medical equipment, the total rental payments may not exceed the purchase price of the equipment over its expected useful life or the agency's established maximum allowable amount, whichever amount is less.

(10) A hospice shall be reimbursed through a prospective system for each Medicaid hospice patient at

Medicaid rates using the methodology established for hospice reimbursement pursuant to Title XVIII of the federal Social Security Act.

(11) A provider of independent laboratory services shall be reimbursed on the basis of competitive bidding or for the least of the amount billed by the provider, the provider's usual and customary charge, or the Medicaid maximum allowable fee established by the agency.

(12)(a) A physician shall be reimbursed the lesser of the amount billed by the provider or the Medicaid maximum allowable fee established by the agency.

(b) The agency shall adopt a fee schedule, subject to any limitations or directions provided for in the General Appropriations Act, based on a resource-based relative value scale for pricing Medicaid physician services. Under this fee schedule, physicians shall be paid a dollar amount for each service based on the average resources required to provide the service, including, but not limited to, estimates of average physician time and effort, practice expense, and the costs of professional liability insurance. The fee schedule shall provide increased reimbursement for preventive and primary care services and lowered reimbursement for specialty services by using at least two conversion factors, one for cognitive services and another for procedural services. The fee schedule shall not increase total Medicaid physician expenditures unless moneys are available, and shall be phased in over a 2-year period beginning on July 1, 1994. The Agency for Health Care Administration shall seek the advice of a 16-member advisory panel in formulating and adopting the fee schedule. The panel shall consist of Medicaid physicians licensed under chapters 458 and 459 and shall be composed of

50 percent primary care physicians and 50 percent specialty care physicians.

(c) Notwithstanding paragraph (b), reimbursement fees to physicians for providing total obstetrical services to Medicaid recipients, which include prenatal, delivery, and postpartum care, shall be at least $1,500 per delivery for a pregnant woman with low medical risk and at least $2,000 per delivery for a pregnant woman with high medical risk. However, reimbursement to physicians working in Regional Perinatal Intensive Care Centers designated pursuant to chapter 383, for services to certain pregnant Medicaid recipients with a high medical risk, may be made according to obstetrical care and neonatal care groupings and rates established by the agency. Nurse midwives licensed under part I of chapter 464 or midwives licensed under chapter 467 shall be reimbursed at no less than 80 percent of the low medical risk fee. The agency shall by rule determine, for the purpose of this paragraph, what constitutes a high or low medical risk pregnant woman and shall not pay more based solely on the fact that a caesarean section was performed, rather than a vaginal delivery. The agency shall by rule determine a prorated payment for obstetrical services in cases where only part of the total prenatal, delivery, or postpartum care was performed. The Department of Health shall adopt rules for appropriate insurance coverage for midwives licensed under chapter 467. Prior to the issuance and renewal of an active license, or reactivation of an inactive license for midwives licensed under chapter 467, such licensees shall submit proof of coverage with each application.

(d) For fiscal years 2001-2002 and 2002-2003 ~~the 2001-2002 fiscal year~~ only and if necessary to meet the

requirements for grants and donations for the special Medicaid payments authorized in the 2001-2002 and 2002-2003 General Appropriations Acts ~~Act~~, the agency may make special Medicaid payments to qualified Medicaid providers designated by the agency, notwithstanding any provision of this subsection to the contrary, and may use intergovernmental transfers from state entities or other governmental entities to serve as the state share of such payments.

(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:

(a) Medicaid shall make no payment toward deductibles and coinsurance for any service that is not covered by Medicaid.

(b) Medicaid's financial obligation for deductibles and coinsurance payments shall be based on Medicare allowable fees, not on a provider's billed charges.

(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, 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 this section, and that is pending as of, or is initiated after, the effective date of this act.

(d) Notwithstanding paragraphs (a)-(c):

1. Medicaid payments for Nursing Home Medicare part A coinsurance shall be the lesser of the Medicare coinsurance amount or the Medicaid nursing home per diem rate.

2. Medicaid shall pay all deductibles and coinsurance for Medicare-eligible recipients receiving freestanding end stage renal dialysis center services.

3. Medicaid payments for general hospital inpatient services shall be limited to the Medicare deductible per spell of illness. Medicaid shall make no payment toward coinsurance for Medicare general hospital inpatient services.

4. Medicaid shall pay all deductibles and coinsurance for Medicare emergency transportation services provided by ambulances licensed pursuant to chapter 401.

(14) A provider of prescribed drugs shall be reimbursed the least of the amount billed by the provider, the provider's usual and customary charge, or the Medicaid maximum allowable fee established by the agency, plus a dispensing fee. The agency is directed to implement a variable dispensing fee for payments for prescribed medicines while ensuring continued access for Medicaid recipients. The variable dispensing fee may be based upon, but not limited to, either or both the volume of prescriptions dispensed by a specific pharmacy provider, the volume of prescriptions dispensed to an individual recipient, and dispensing of preferred-drug-list products. The agency shall increase the pharmacy dispensing fee authorized by statute and in the annual General Appropriations Act by $0.50 for the dispensing of a Medicaid preferred-drug-list product and reduce the pharmacy dispensing fee by $0.50 for the dispensing of a Medicaid product that is not included on the preferred-drug list. The agency is authorized to limit reimbursement for prescribed medicine in order to comply with any limitations or directions provided for in the General Appropriations Act, which may include implementing a prospective or concurrent utilization review program.

(15) A provider of primary care case management services rendered pursuant to a federally approved waiver

shall be reimbursed by payment of a fixed, prepaid monthly sum for each Medicaid recipient enrolled with the provider.

(16) A provider of rural health clinic services and federally qualified health center services shall be reimbursed a rate per visit based on total reasonable costs of the clinic, as determined by the agency in accordance with federal regulations.

(17) A provider of targeted case management services shall be reimbursed pursuant to an established fee, except where the Federal Government requires a public provider be reimbursed on the basis of average actual costs.

(18) Unless otherwise provided for in the General Appropriations Act, a provider of transportation services shall be reimbursed the lesser of the amount billed by the provider or the Medicaid maximum allowable fee established by the agency, except when the agency has entered into a direct contract with the provider, or with a community transportation coordinator, for the provision of an all-inclusive service, or when services are provided pursuant to an agreement negotiated between the agency and the provider. The agency, as provided for in s. 427.0135, shall purchase transportation services through the community coordinated transportation system, if available, unless the agency determines a more cost-effective method for Medicaid clients. Nothing in this subsection shall be construed to limit or preclude the agency from contracting for services using a prepaid capitation rate or from establishing maximum fee schedules, individualized reimbursement policies by provider type, negotiated fees, prior authorization, competitive bidding, increased use of mass transit, or any other mechanism that the agency considers efficient and effective for the purchase of services on behalf

of Medicaid clients, including implementing a transportation eligibility process. The agency shall not be required to contract with any community transportation coordinator or transportation operator that has been determined by the agency, the Department of Legal Affairs Medicaid Fraud Control Unit, or any other state or federal agency to have engaged in any abusive or fraudulent billing activities. The agency is authorized to competitively procure transportation services or make other changes necessary to secure approval of federal waivers needed to permit federal financing of Medicaid transportation services at the service matching rate rather than the administrative matching rate.

(19) County health department services may be reimbursed a rate per visit based on total reasonable costs of the clinic, as determined by the agency in accordance with federal regulations under the authority of 42 C.F.R. s. 431.615.

(20) A renal dialysis facility that provides dialysis services under s. 409.906(9) must be reimbursed the lesser of the amount billed by the provider, the provider's usual and customary charge, or the maximum allowable fee established by the agency, whichever amount is less.

(21) The agency shall reimburse school districts which certify the state match pursuant to ss. 236.0812 and 409.9071 for the federal portion of the school district's allowable costs to deliver the services, based on the reimbursement schedule. The school district shall determine the costs for delivering services as authorized in ss. 236.0812 and 409.9071 for which the state match will be certified. Reimbursement of school-based providers is contingent on such providers being enrolled as Medicaid providers and meeting the qualifications

contained in 42 C.F.R. s. 440.110, unless otherwise waived by the federal Health Care Financing Administration. Speech therapy providers who are certified through the Department of Education pursuant to rule 6A-4.0176, Florida Administrative Code, are eligible for reimbursement for services that are provided on school premises. Any employee of the school district who has been fingerprinted and has received a criminal background check in accordance with Department of Education rules and guidelines shall be exempt from any agency requirements relating to criminal background checks.

(22) The agency shall request and implement Medicaid waivers from the federal Health Care Financing Administration to advance and treat a portion of the Medicaid nursing home per diem as capital for creating and operating a risk-retention group for self-insurance purposes, consistent with federal and state laws and rules.

Section 13. Paragraph (b) of subsection (7) of section 409.910, Florida Statutes, is amended to read:

409.910 Responsibility for payments on behalf of Medicaid-eligible persons when other parties are liable.--

(7) The agency shall recover the full amount of all medical assistance provided by Medicaid on behalf of the recipient to the full extent of third-party benefits.

(b) Upon receipt of any recovery or other collection pursuant to this section, the agency shall distribute the amount collected as follows:

1. To itself, an amount equal to the state Medicaid expenditures for the recipient plus any incentive payment made in accordance with paragraph (14)(a). From this share the agency shall credit a county on its county billing invoice the county's proportionate share of Medicaid third-party

recoveries in the areas of estate recoveries and casualty claims, minus the agency's cost of recovering the third-party payments, based on the county's percentage of the sum of total county billing divided by total Medicaid expenditures. However, if a county has been billed for its participation but has not paid the amount due, the agency shall offset that amount and notify the county of the amount of the offset. If the county has divided its financial responsibility between the county and a special taxing district or authority as contemplated in s. 409.915(6), the county must proportionately divide any refund or offset in accordance with the proration that it has established.

2. To the Federal Government, the federal share of the state Medicaid expenditures minus any incentive payment made in accordance with paragraph (14)(a) and federal law, and minus any other amount permitted by federal law to be deducted.

3. To the recipient, after deducting any known amounts owed to the agency for any related medical assistance or to health care providers, any remaining amount. This amount shall be treated as income or resources in determining eligibility for Medicaid.

The provisions of this subsection do not apply to any proceeds received by the state, or any agency thereof, pursuant to a final order, judgment, or settlement agreement, in any matter in which the state asserts claims brought on its own behalf, and not as a subrogee of a recipient, or under other theories of liability. The provisions of this subsection do not apply to any proceeds received by the state, or an agency thereof, pursuant to a final order, judgment, or settlement agreement,

in any matter in which the state asserted both claims as a subrogee and additional claims, except as to those sums specifically identified in the final order, judgment, or settlement agreement as reimbursements to the recipient as expenditures for the named recipient on the subrogation claim.

Section 14. Paragraph (g) of subsection (3) and paragraph (c) of subsection (37) of section 409.912, Florida Statutes, as amended by sections 8 and 9 of chapter 2001-377, Laws of Florida, are 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:

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

(37)

(c) The agency shall submit quarterly reports ~~a report~~ to the Governor, the President of the Senate, and the Speaker of the House of Representatives which ~~by January 15 of each year. The report~~ must include, but need not be limited to, the progress made in implementing this subsection and its ~~Medicaid cost-containment measures and their~~ effect on Medicaid prescribed-drug expenditures.

Section 15. Subsection (7) of section 409.9116, Florida Statutes, is amended to read:

409.9116 Disproportionate share/financial assistance program for rural hospitals.--In addition to the payments made under s. 409.911, the Agency for Health Care Administration shall administer a federally matched disproportionate share program and a state-funded financial assistance program for statutory rural hospitals. The agency shall make disproportionate share payments to statutory rural hospitals that qualify for such payments and financial assistance payments to statutory rural hospitals that do not qualify for disproportionate share payments. The disproportionate share

program payments shall be limited by and conform with federal requirements. Funds shall be distributed quarterly in each fiscal year for which an appropriation is made. Notwithstanding the provisions of s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients.

(7) This section applies only to hospitals that were defined as statutory rural hospitals, or their successor-in-interest hospital, prior to January 1, 2001 ~~July 1, 1998~~. Any additional hospital that is defined as a statutory rural hospital, or its successor-in-interest hospital, on or after January 1, 2001 ~~July 1, 1998~~, is not eligible for programs under this section unless additional funds are appropriated each fiscal year specifically to the rural hospital disproportionate share and financial assistance programs in an amount necessary to prevent any hospital, or its successor-in-interest hospital, eligible for the programs prior to January 1, 2001 ~~July 1, 1998~~, from incurring a reduction in payments because of the eligibility of an additional hospital to participate in the programs. A hospital, or its successor-in-interest hospital, which received funds pursuant to this section before January 1, 2001 ~~July 1, 1998~~, and which qualifies under s. 395.602(2)(e), shall be included in the programs under this section and is not required to seek additional appropriations under this subsection.

Section 16. Paragraphs (f) and (k) of subsection (2) of section 409.9122, Florida Statutes, as amended by section 11 of chapter 2001-377, Laws of Florida, are amended to read:

409.9122 Mandatory Medicaid managed care enrollment;

programs and procedures.--

(2)

(f) When a Medicaid recipient does not choose a managed care plan or MediPass provider, the agency shall assign the Medicaid recipient to a managed care plan or MediPass provider. Medicaid recipients who are subject to mandatory assignment but who fail to make a choice shall be assigned to managed care plans ~~or provider service networks~~ until an ~~equal~~ enrollment of 45 ~~50~~ percent in MediPass and 55 ~~50~~ percent in managed care plans is achieved. Once that ~~equal~~ enrollment is achieved, the assignments shall be divided in order to maintain an ~~equal~~ enrollment in MediPass and managed care plans which is in a 45 percent and 55 percent proportion, respectively. Thereafter, assignment of Medicaid recipients who fail to make a choice shall be based proportionally on the preferences of recipients who have made a choice in the previous period. Such proportions shall be revised at least quarterly to reflect an update of the preferences of Medicaid recipients. The agency shall also disproportionately assign Medicaid-eligible children in families who are required to but have failed to make a choice of managed care plan or MediPass for their child and who are to be assigned to the MediPass program or managed care plans to children's networks as described in s. 409.912(3)(g) and where available. The disproportionate assignment of children to children's networks shall be made until the agency has determined that the children's networks have sufficient numbers to be economically operated. For purposes of this section ~~paragraph, when referring to assignment~~, the term "managed care plans" includes health maintenance organizations,exclusive provider organizations, provider service networks, minority physician

networks, children's medical service networks,and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act. When making assignments, the agency shall take into account the following criteria:

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

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

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

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

(k) When a Medicaid recipient does not choose a managed care plan or MediPass provider, the agency shall assign the Medicaid recipient to a managed care plan, except in those counties in which there are fewer than two managed care plans accepting Medicaid enrollees, in which case assignment shall be to a managed care plan or a MediPass provider. Medicaid recipients in counties with fewer than two managed care plans accepting Medicaid enrollees who are subject to mandatory assignment but who fail to make a choice shall be assigned to managed care plans until an ~~equal~~ enrollment of 45 ~~50~~ percent in MediPass ~~and provider service networks~~ and 55 ~~50~~ percent in managed care plans is achieved. Once that ~~equal~~ enrollment is achieved, the assignments shall

be divided in order to maintain an ~~equal~~ enrollment in MediPass and managed care plans which is in a 45 percent and 55 percent proportion, respectively. When making assignments, the agency shall take into account the following criteria:

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

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

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

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

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

Section 17. Section 409.913, Florida Statutes, as amended by section 12 of chapter 2001-377, Laws of Florida, is amended to read:

409.913 Oversight of the integrity of the Medicaid program.--The agency shall operate a program to oversee the activities of Florida Medicaid recipients, and providers and their representatives, to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible, and to recover overpayments and impose sanctions as appropriate. Beginning January 1, 2003, and each year thereafter, the agency and the Medicaid Fraud Control Unit of

the Department of Legal Affairs shall submit a joint report to the Legislature documenting the effectiveness of the state's efforts to control Medicaid fraud and abuse and to recover Medicaid overpayments during the previous fiscal year. The report must describe the number of cases opened and investigated each year; the sources of the cases opened; the disposition of the cases closed each year; the amount of overpayments alleged in preliminary and final audit letters; the number and amount of fines or penalties imposed; any reductions in overpayment amounts negotiated in settlement agreements or by other means; the amount of final agency determinations of overpayments; the amount deducted from federal claiming as a result of overpayments; the amount of overpayments recovered each year; the amount of cost of investigation recovered each year; the average length of time to collect from the time the case was opened until the overpayment is paid in full; the amount determined as uncollectible and the portion of the uncollectible amount subsequently reclaimed from the Federal Government; the number of providers, by type, that are terminated from participation in the Medicaid program as a result of fraud and abuse; and all costs associated with discovering and prosecuting cases of Medicaid overpayments and making recoveries in such cases. The report must also document actions taken to prevent overpayments and the number of providers prevented from enrolling in or reenrolling in the Medicaid program as a result of documented Medicaid fraud and abuse and must recommend changes necessary to prevent or recover overpayments. For the 2001-2002 fiscal year, the agency shall prepare a report that contains as much of this information as is available to it.

(1) For the purposes of this section, the term:

(a) "Abuse" means:

1. Provider practices that are inconsistent with generally accepted business or medical practices and that result in an unnecessary cost to the Medicaid program or in reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for health care.

2. Recipient practices that result in unnecessary cost to the Medicaid program.

(b) "Complaint" means an allegation that fraud, abuse or an overpayment has occurred.

(c)~~(b)~~ "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to herself or himself or another person. The term includes any act that constitutes fraud under applicable federal or state law.

(d)~~(c)~~ "Medical necessity" or "medically necessary" means any goods or services necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice. For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. Determinations of medical necessity must be made by a licensed physician employed by or under contract with the agency and must be based upon information available at the time the goods or services are provided.

(e)~~(d)~~ "Overpayment" includes any amount that is not

authorized to be paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake.

(f)~~(e)~~ "Person" means any natural person, corporation, partnership, association, clinic, group, or other entity, whether or not such person is enrolled in the Medicaid program or is a provider of health care.

(2) The agency shall conduct, or cause to be conducted by contract or otherwise, reviews, investigations, analyses, audits, or any combination thereof, to determine possible fraud, abuse, overpayment, or recipient neglect in the Medicaid program and shall report the findings of any overpayments in audit reports as appropriate.

(3) The agency may conduct, or may contract for, prepayment review of provider claims to ensure cost-effective purchasing, billing, and provision of care to Medicaid recipients. Such prepayment reviews may be conducted as determined appropriate by the agency, without any suspicion or allegation of fraud, abuse, or neglect.

(4) Any suspected criminal violation identified by the agency must be referred to the Medicaid Fraud Control Unit of the Office of the Attorney General for investigation. The agency and the Attorney General shall enter into a memorandum of understanding, which must include, but need not be limited to, a protocol for regularly sharing information and coordinating casework. The protocol must establish a procedure for the referral by the agency of cases involving suspected Medicaid fraud to the Medicaid Fraud Control Unit for investigation, and the return to the agency of those cases where investigation determines that administrative action by the agency is appropriate. Offices of the Medicaid program

integrity program and the Medicaid Fraud Control Unit of the Department of Legal Affairs, shall, to the extent possible, be collocated. The agency and the Department of Legal Affairs shall periodically conduct joint training and other joint activities designed to increase communication and coordination in recovering overpayments.

(5) A Medicaid provider is subject to having goods and services that are paid for by the Medicaid program reviewed by an appropriate peer-review organization designated by the agency. The written findings of the applicable peer-review organization are admissible in any court or administrative proceeding as evidence of medical necessity or the lack thereof.

(6) Any notice required to be given to a provider under this section is presumed to be sufficient notice if sent to the address last shown on the provider enrollment file. It is the responsibility of the provider to furnish and keep the agency informed of the provider's current address. United States Postal Service proof of mailing or certified or registered mailing of such notice to the provider at the address shown on the provider enrollment file constitutes sufficient proof of notice. Any notice required to be given to the agency by this section must be sent to the agency at an address designated by rule.

(7) When presenting a claim for payment under the Medicaid program, a provider has an affirmative duty to supervise the provision of, and be responsible for, goods and services claimed to have been provided, to supervise and be responsible for preparation and submission of the claim, and to present a claim that is true and accurate and that is for goods and services that:

(a) Have actually been furnished to the recipient by the provider prior to submitting the claim.

(b) Are Medicaid-covered goods or services that are medically necessary.

(c) Are of a quality comparable to those furnished to the general public by the provider's peers.

(d) Have not been billed in whole or in part to a recipient or a recipient's responsible party, except for such copayments, coinsurance, or deductibles as are authorized by the agency.

(e) Are provided in accord with applicable provisions of all Medicaid rules, regulations, handbooks, and policies and in accordance with federal, state, and local law.

(f) Are documented by records made at the time the goods or services were provided, demonstrating the medical necessity for the goods or services rendered. Medicaid goods or services are excessive or not medically necessary unless both the medical basis and the specific need for them are fully and properly documented in the recipient's medical record.

(8) A Medicaid provider shall retain medical, professional, financial, and business records pertaining to services and goods furnished to a Medicaid recipient and billed to Medicaid for a period of 5 years after the date of furnishing such services or goods. The agency may investigate, review, or analyze such records, which must be made available during normal business hours. However, 24-hour notice must be provided if patient treatment would be disrupted. The provider is responsible for furnishing to the agency, and keeping the agency informed of the location of, the provider's Medicaid-related records. The authority of the agency to

obtain Medicaid-related records from a provider is neither curtailed nor limited during a period of litigation between the agency and the provider.

(9) Payments for the services of billing agents or persons participating in the preparation of a Medicaid claim shall not be based on amounts for which they bill nor based on the amount a provider receives from the Medicaid program.

(10) The agency may require repayment for inappropriate, medically unnecessary, or excessive goods or services from the person furnishing them, the person under whose supervision they were furnished, or the person causing them to be furnished.

(11) The complaint and all information obtained pursuant to an investigation of a Medicaid provider, or the authorized representative or agent of a provider, relating to an allegation of fraud, abuse, or neglect are confidential and exempt from the provisions of s. 119.07(1):

(a) Until the agency takes final agency action with respect to the provider and requires repayment of any overpayment, or imposes an administrative sanction;

(b) Until the Attorney General refers the case for criminal prosecution;

(c) Until 10 days after the complaint is determined without merit; or

(d) At all times if the complaint or information is otherwise protected by law.

(12) The agency may terminate participation of a Medicaid provider in the Medicaid program and may seek civil remedies or impose other administrative sanctions against a Medicaid provider, if the provider has been:

(a) Convicted of a criminal offense related to the

delivery of any health care goods or services, including the performance of management or administrative functions relating to the delivery of health care goods or services;

(b) Convicted of a criminal offense under federal law or the law of any state relating to the practice of the provider's profession; or

(c) Found by a court of competent jurisdiction to have neglected or physically abused a patient in connection with the delivery of health care goods or services.

(13) If the provider has been suspended or terminated from participation in the Medicaid program or the Medicare program by the Federal Government or any state, the agency must immediately suspend or terminate, as appropriate, the provider's participation in the Florida Medicaid program for a period no less than that imposed by the Federal Government or any other state, and may not enroll such provider in the Florida Medicaid program while such foreign suspension or termination remains in effect. This sanction is in addition to all other remedies provided by law.

(14) The agency may seek any remedy provided by law, including, but not limited to, the remedies provided in subsections (12) and (15) and s. 812.035, if:

(a) The provider's license has not been renewed, or has been revoked, suspended, or terminated, for cause, by the licensing agency of any state;

(b) The provider has failed to make available or has refused access to Medicaid-related records to an auditor, investigator, or other authorized employee or agent of the agency, the Attorney General, a state attorney, or the Federal Government;

(c) The provider has not furnished or has failed to

make available such Medicaid-related records as the agency has found necessary to determine whether Medicaid payments are or were due and the amounts thereof;

(d) The provider has failed to maintain medical records made at the time of service, or prior to service if prior authorization is required, demonstrating the necessity and appropriateness of the goods or services rendered;

(e) The provider is not in compliance with provisions of Medicaid provider publications that have been adopted by reference as rules in the Florida Administrative Code; with provisions of state or federal laws, rules, or regulations; with provisions of the provider agreement between the agency and the provider; or with certifications found on claim forms or on transmittal forms for electronically submitted claims that are submitted by the provider or authorized representative, as such provisions apply to the Medicaid program;

(f) The provider or person who ordered or prescribed the care, services, or supplies has furnished, or ordered the furnishing of, goods or services to a recipient which are inappropriate, unnecessary, excessive, or harmful to the recipient or are of inferior quality;

(g) The provider has demonstrated a pattern of failure to provide goods or services that are medically necessary;

(h) The provider or an authorized representative of the provider, or a person who ordered or prescribed the goods or services, has submitted or caused to be submitted false or a pattern of erroneous Medicaid claims that have resulted in overpayments to a provider or that exceed those to which the provider was entitled under the Medicaid program;

(i) The provider or an authorized representative of

the provider, or a person who has ordered or prescribed the goods or services, has submitted or caused to be submitted a Medicaid provider enrollment application, a request for prior authorization for Medicaid services, a drug exception request, or a Medicaid cost report that contains materially false or incorrect information;

(j) The provider or an authorized representative of the provider has collected from or billed a recipient or a recipient's responsible party improperly for amounts that should not have been so collected or billed by reason of the provider's billing the Medicaid program for the same service;

(k) The provider or an authorized representative of the provider has included in a cost report costs that are not allowable under a Florida Title XIX reimbursement plan, after the provider or authorized representative had been advised in an audit exit conference or audit report that the costs were not allowable;

(l) The provider is charged by information or indictment with fraudulent billing practices. The sanction applied for this reason is limited to suspension of the provider's participation in the Medicaid program for the duration of the indictment unless the provider is found guilty pursuant to the information or indictment;

(m) The provider or a person who has ordered, or prescribed the goods or services is found liable for negligent practice resulting in death or injury to the provider's patient;

(n) The provider fails to demonstrate that it had available during a specific audit or review period sufficient quantities of goods, or sufficient time in the case of services, to support the provider's billings to the Medicaid

program;

(o) The provider has failed to comply with the notice and reporting requirements of s. 409.907; ~~or~~

(p) The agency has received reliable information of patient abuse or neglect or of any act prohibited by s. 409.920; or~~.~~

(q) The provider has failed to comply with an agreed-upon repayment schedule.

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

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

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

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

request, or cost report; each instance of inappropriate prescribing of drugs for a Medicaid recipient as determined by competent peer judgment; and each false or erroneous Medicaid claim leading to an overpayment to a provider is considered, for the purposes of this section, to be a separate violation.

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

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

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

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

(h) Comprehensive follow-up reviews of providers every 6 months to ensure that they are billing Medicaid correctly.

(i) Corrective-action plans that would remain in effect for providers for up to 3 years and that would be monitored by the agency every 6 months while in effect.

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

The Secretary of Health Care Administration may make a determination that imposition of a sanction or disincentive is not in the best interest of the Medicaid program, in which case a sanction or disincentive shall not be imposed.

(16) In determining the appropriate administrative

sanction to be applied, or the duration of any suspension or termination, the agency shall consider:

(a) The seriousness and extent of the violation or violations.

(b) Any prior history of violations by the provider relating to the delivery of health care programs which resulted in either a criminal conviction or in administrative sanction or penalty.

(c) Evidence of continued violation within the provider's management control of Medicaid statutes, rules, regulations, or policies after written notification to the provider of improper practice or instance of violation.

(d) The effect, if any, on the quality of medical care provided to Medicaid recipients as a result of the acts of the provider.

(e) Any action by a licensing agency respecting the provider in any state in which the provider operates or has operated.

(f) The apparent impact on access by recipients to Medicaid services if the provider is suspended or terminated, in the best judgment of the agency.

The agency shall document the basis for all sanctioning actions and recommendations.

(17) The agency may take action to sanction, suspend, or terminate a particular provider working for a group provider, and may suspend or terminate Medicaid participation at a specific location, rather than or in addition to taking action against an entire group.

(18) The agency shall establish a process for conducting followup reviews of a sampling of providers who

have a history of overpayment under the Medicaid program. This process must consider the magnitude of previous fraud or abuse and the potential effect of continued fraud or abuse on Medicaid costs.

(19) In making a determination of overpayment to a provider, the agency must use accepted and valid auditing, accounting, analytical, statistical, or peer-review methods, or combinations thereof. Appropriate statistical methods may include, but are not limited to, sampling and extension to the population, parametric and nonparametric statistics, tests of hypotheses, and other generally accepted statistical methods. Appropriate analytical methods may include, but are not limited to, reviews to determine variances between the quantities of products that a provider had on hand and available to be purveyed to Medicaid recipients during the review period and the quantities of the same products paid for by the Medicaid program for the same period, taking into appropriate consideration sales of the same products to non-Medicaid customers during the same period. In meeting its burden of proof in any administrative or court proceeding, the agency may introduce the results of such statistical methods as evidence of overpayment.

(20) When making a determination that an overpayment has occurred, the agency shall prepare and issue an audit report to the provider showing the calculation of overpayments.

(21) The audit report, supported by agency work papers, showing an overpayment to a provider constitutes evidence of the overpayment. A provider may not present or elicit testimony, either on direct examination or cross-examination in any court or administrative proceeding,

regarding the purchase or acquisition by any means of drugs, goods, or supplies; sales or divestment by any means of drugs, goods, or supplies; or inventory of drugs, goods, or supplies, unless such acquisition, sales, divestment, or inventory is documented by written invoices, written inventory records, or other competent written documentary evidence maintained in the normal course of the provider's business. Notwithstanding the applicable rules of discovery, all documentation that will be offered as evidence at an administrative hearing on a Medicaid overpayment must be exchanged by all parties at least 14 days before the administrative hearing or must be excluded from consideration.

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

(b) The agency has the burden of documenting the costs, which include salaries and employee benefits and out-of-pocket expenses. The amount of costs that may be recovered must be reasonable in relation to the seriousness of the violation and must be set taking into consideration the financial resources, earning ability, and needs of the provider, who has the burden of demonstrating such factors.

(c) The provider may pay the costs over a period to be determined by the agency if the agency determines that an extreme hardship would result to the provider from immediate full payment. Any default in payment of costs may be collected by any means authorized by law.

(23) If the agency imposes an administrative sanction

under this section upon any provider or other person who is regulated by another state entity, the agency shall notify that other entity of the imposition of the sanction. Such notification must include the provider's or person's name and license number and the specific reasons for sanction.

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

(b) Overpayments owed to the agency bear interest at the rate of 10 percent per year from the date of determination of the overpayment by the agency, and payment arrangements must be made at the conclusion of legal proceedings. A provider who does not enter into or adhere to an agreed-upon repayment schedule may be terminated by the agency for nonpayment or partial payment.

(c) The agency, upon entry of a final agency order, a judgment or order of a court of competent jurisdiction, or a stipulation or settlement, may collect the moneys owed by all means allowable by law, including, but not limited to, notifying any fiscal intermediary of Medicare benefits that

the state has a superior right of payment. Upon receipt of such written notification, the Medicare fiscal intermediary shall remit to the state the sum claimed.

(25) The agency may impose administrative sanctions against a Medicaid recipient, or the agency may seek any other remedy provided by law, including, but not limited to, the remedies provided in s. 812.035, if the agency finds that a recipient has engaged in solicitation in violation of s. 409.920 or that the recipient has otherwise abused the Medicaid program.

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

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

1. Makes repayment in full; or

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

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

~~If a provider requests an administrative hearing pursuant to chapter 120, such hearing must be conducted within 90 days following receipt by the provider of the final audit report, absent exceptionally good cause shown as determined by the~~

~~administrative law judge or hearing officer. Upon issuance of a final order, the balance outstanding of the amount determined to constitute the overpayment shall become due. Any withholding of payments by the Agency for Health Care Administration pursuant to this section shall be limited so that the monthly medical assistance payment is not reduced by more than 10 percent.~~

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

(28) Notwithstanding other provisions of law, the agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs may review a provider's Medicaid-related records in order to determine the total output of a provider's practice to reconcile quantities of goods or services billed to Medicaid against quantities of goods or services used in the provider's total practice.

(29) The agency may terminate a provider's participation in the Medicaid program if the provider fails to reimburse an overpayment that has been determined by final order, not subject to further appeal, within 35 days after the date of the final order, unless the provider and the agency have entered into a repayment agreement.

(30) If a provider requests an administrative hearing pursuant to chapter 120, such hearing must be conducted within 90 days following assignment of an administrative law judge, absent exceptionally good cause shown as determined by the administrative law judge or hearing officer. Upon issuance of a final order, the outstanding balance of the amount determined to constitute the overpayment shall become due. If a provider fails to make payments in full, fails to enter into

a satisfactory repayment plan, or fails to comply with the terms of a repayment plan or settlement agreement, the agency may withhold medical-assistance-reimbursement payments until the amount due is paid in full.

(31) Duly authorized agents and employees of the agency shall have the power to inspect, during normal business hours, the records of any pharmacy, wholesale establishment, or manufacturer, or any other place in which drugs and medical supplies are manufactured, packed, packaged, made, stored, sold, or kept for sale, for the purpose of verifying the amount of drugs and medical supplies ordered, delivered, or purchased by a provider. The agency shall provide at least 2 business days' prior notice of any such inspection. The notice must identify the provider whose records will be inspected, and the inspection shall include only records specifically related to that provider.

(32) With respect to recoveries of Medicaid overpayments collected by the agency, by September 30 each year the agency shall credit a county on its county billing invoices for the county's proportionate share of Medicaid overpayments recovered during the previous fiscal year from hospitals for inpatient services and from nursing homes. However, if a county has been billed for its participation but has not paid the amount due, the agency shall offset that amount and notify the county of the amount of the offset. If the county has divided its financial responsibility between the county and a special taxing district or authority as provided in s. 409.915(6), the county must proportionately divide any credit or offset in accordance with the proration that it has established. The credit or offset shall be calculated separately for inpatient and nursing home services

as follows:

(a) The state share of the amount recovered from hospitals for inpatient services and from nursing homes for which the county has not previously received credit;

(b) Less the state share of the agency's cost of recovering such payment; and

(c) Multiplied by the total county share. The total county share shall be calculated as the sum of total county billing for inpatient services and nursing home services, respectively, divided by the state share of Medicaid expenditures for inpatient services and nursing home services, respectively.

The credit given to each county shall be its proportionate share of the total county share calculated under paragraph (c).

Section 18. Subsections (7) and (8) of section 409.920, Florida Statutes, are amended to read:

409.920 Medicaid provider fraud.--

(7) The Attorney General shall conduct a statewide program of Medicaid fraud control. To accomplish this purpose, the Attorney General shall:

(a) Investigate the possible criminal violation of any applicable state law pertaining to fraud in the administration of the Medicaid program, in the provision of medical assistance, or in the activities of providers of health care under the Medicaid program.

(b) Investigate the alleged abuse or neglect of patients in health care facilities receiving payments under the Medicaid program, in coordination with the agency.

(c) Investigate the alleged misappropriation of

patients' private funds in health care facilities receiving payments under the Medicaid program.

(d) Refer to the Office of Statewide Prosecution or the appropriate state attorney all violations indicating a substantial potential for criminal prosecution.

(e) Refer to the agency all suspected abusive activities not of a criminal or fraudulent nature.

~~(f) Refer to the agency for collection each instance of overpayment to a provider of health care under the Medicaid program which is discovered during the course of an investigation.~~

(f)~~(g)~~ Safeguard the privacy rights of all individuals and provide safeguards to prevent the use of patient medical records for any reason beyond the scope of a specific investigation for fraud or abuse, or both, without the patient's written consent.

(g) Publicize to state employees and the public the ability of persons to bring suit under the provisions of the Florida False Claims Act and the potential for the persons bring a civil action under the Florida False Claims Act to obtain a monetary award.

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

(a) Enter upon the premises of any health care provider, excluding a physician, participating in the Medicaid program to examine all accounts and records that may, in any manner, be relevant in determining the existence of fraud in the Medicaid program, to investigate alleged abuse or neglect of patients, or to investigate alleged misappropriation of patients' private funds. A participating physician is required to make available any accounts or records that may, in any

manner, be relevant in determining the existence of fraud in the Medicaid program. The accounts or records of a non-Medicaid patient may not be reviewed by, or turned over to, the Attorney General without the patient's written consent.

(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.

(c) Request and receive the assistance of any state attorney or law enforcement agency in the investigation and prosecution of any violation of this section.

(d) Seek any civil remedy provided by law, including, but not limited to, the remedies provided in ss. 68.081-68.092, s. 812.035, and this chapter.

(e) Refer to the agency for collection each instance of overpayment to a provider of health care under the Medicaid program which is discovered during the course of an investigation.

Section 19. Paragraph (a) of subsection (1) of section 499.012, Florida Statutes, is amended to read:

499.012 Wholesale distribution; definitions; permits; general requirements.--

(1) As used in this section, the term:

(a) "Wholesale distribution" means distribution of prescription drugs to persons other than a consumer or patient, but does not include:

1. Any of the following activities, which is not a violation of s. 499.005(21) if such activity is conducted in accordance with s. 499.014:

a. The purchase or other acquisition by a hospital or other health care entity that is a member of a group purchasing organization of a prescription drug for its own use from the group purchasing organization or from other hospitals or health care entities that are members of that organization.

b. The sale, purchase, or trade of a prescription drug or an offer to sell, purchase, or trade a prescription drug by a charitable organization described in s. 501(c)(3) of the Internal Revenue Code of 1986, as amended and revised, to a nonprofit affiliate of the organization to the extent otherwise permitted by law.

c. The sale, purchase, or trade of a prescription drug or an offer to sell, purchase, or trade a prescription drug among hospitals or other health care entities that are under common control. For purposes of this section, "common control" means the power to direct or cause the direction of the management and policies of a person or an organization, whether by ownership of stock, by voting rights, by contract, or otherwise.

d. The sale, purchase, trade, or other transfer of a prescription drug from or for any federal, state, or local government agency or any entity eligible to purchase prescription drugs at public health services prices pursuant to Pub. L. No. 102-585, s. 602 to a contract provider or its subcontractor for eligible patients of the agency or entity under the following conditions:

(I) The agency or entity must obtain written authorization for the sale, purchase, trade, or other transfer of a prescription drug under this sub-subparagraph from the Secretary of Health or his or her designee.

(II) The contract provider or subcontractor must be

authorized by law to administer or dispense prescription drugs.

(III) In the case of a subcontractor, the agency or entity must be a party to and execute the subcontract.

(IV) A contract provider or subcontractor must maintain separate and apart from other prescription drug inventory any prescription drugs of the agency or entity in its possession.

(V) The contract provider and subcontractor must maintain and produce immediately for inspection all records of movement or transfer of all the prescription drugs belonging to the agency or entity, including, but not limited to, the records of receipt and disposition of prescription drugs. Each contractor and subcontractor dispensing or administering these drugs must maintain and produce records documenting the dispensing or administration. Records that are required to be maintained include, but are not limited to, a perpetual inventory itemizing drugs received and drugs dispensed by prescription number or administered by patient identifier, which must be submitted to the agency or entity quarterly.

(VI) The contract provider or subcontractor may administer or dispense the prescription drugs only to the eligible patients of the agency or entity or must return the prescription drugs for or to the agency or entity. The contract provider or subcontractor must require proof from each person seeking to fill a prescription or obtain treatment that the person is an eligible patient of the agency or entity and must, at a minimum, maintain a copy of this proof as part of the records of the contractor or subcontractor required under sub-sub-subparagraph (V).

~~(VII) The prescription drugs transferred pursuant to~~

~~this sub-subparagraph may not be billed to Medicaid.~~

(VII)~~(VIII)~~ In addition to the departmental inspection authority set forth in s. 499.051, the establishment of the contract provider and subcontractor and all records pertaining to prescription drugs subject to this sub-subparagraph shall be subject to inspection by the agency or entity. All records relating to prescription drugs of a manufacturer under this sub-subparagraph shall be subject to audit by the manufacturer of those drugs, without identifying individual patient information.

2. Any of the following activities, which is not a violation of s. 499.005(21) if such activity is conducted in accordance with rules established by the department:

a. The sale, purchase, or trade of a prescription drug among federal, state, or local government health care entities that are under common control and are authorized to purchase such prescription drug.

b. The sale, purchase, or trade of a prescription drug or an offer to sell, purchase, or trade a prescription drug for emergency medical reasons. For purposes of this sub-subparagraph, the term "emergency medical reasons" includes transfers of prescription drugs by a retail pharmacy to another retail pharmacy to alleviate a temporary shortage.

c. The transfer of a prescription drug acquired by a medical director on behalf of a licensed emergency medical services provider to that emergency medical services provider and its transport vehicles for use in accordance with the provider's license under chapter 401.

d. The revocation of a sale or the return of a prescription drug to the person's prescription drug wholesale supplier.

e. The donation of a prescription drug by a health care entity to a charitable organization that has been granted an exemption under s. 501(c)(3) of the Internal Revenue Code of 1986, as amended, and that is authorized to possess prescription drugs.

f. The transfer of a prescription drug by a person authorized to purchase or receive prescription drugs to a person licensed or permitted to handle reverse distributions or destruction under the laws of the jurisdiction in which the person handling the reverse distribution or destruction receives the drug.

3. The distribution of prescription drug samples by manufacturers' representatives or distributors' representatives conducted in accordance with s. 499.028.

4. The sale, purchase, or trade of blood and blood components intended for transfusion. As used in this subparagraph, the term "blood" means whole blood collected from a single donor and processed either for transfusion or further manufacturing, and the term "blood components" means that part of the blood separated by physical or mechanical means.

5. The lawful dispensing of a prescription drug in accordance with chapter 465.

Section 20. (1) The Agency for Health Care Administration shall conduct a study of health care services provided to the medically fragile or medical-technology-dependent children in the state and conduct a pilot program in Miami-Dade County to provide subacute pediatric transitional care to a maximum of 30 children at any one time. The purposes of the study and the pilot program are to determine ways to permit medically fragile or

medical-technology-dependent children to successfully make a transition from acute care in a health care institution to live with their families when possible, and to provide cost-effective, subacute transitional care services.

(2) The Agency for Health Care Administration, in cooperation with the Children's Medical Services Program in the Department of Health, shall conduct a study to identify the total number of medically fragile or medical-technology-dependent children, from birth through age 21, in the state. By January 1, 2003, the agency must report to the Legislature regarding the children's ages, the locations where the children are served, the types of services received, itemized costs of the services, and the sources of funding that pay for the services, including the proportional share when more than one funding source pays for a service. The study must include information regarding medically fragile or medical-technology-dependent children residing in hospitals, nursing homes, and medical foster care, and those who live with their parents. The study must describe children served in prescribed pediatric extended-care centers, including their ages and the services they receive. The report must identify the total services provided for each child and the method for paying for those services. The report must also identify the number of such children who could, if appropriate transitional services were available, return home or move to a less-institutional setting.

(3) Within 30 days after the effective date of this act, the agency shall establish minimum staffing standards and quality requirements for a subacute pediatric transitional care center to be operated as a 2-year pilot program in Dade County. The pilot program must operate under the license of a

hospital licensed under chapter 395, Florida Statutes, or a nursing home licensed under chapter 400, Florida Statutes, and shall use existing beds in the hospital or nursing home. A child's placement in the subacute pediatric transitional care center may not exceed 90 days. The center shall arrange for an alternative placement at the end of a child's stay and a transitional plan for children expected to remain in the facility for the maximum allowed stay.

(4) Within 60 days after the effective date of this act, the agency must amend the state Medicaid plan and request any federal waivers necessary to implement and fund the pilot program.

(5) The subacute pediatric transitional care center must require level I background screening as provided in chapter 435, Florida Statutes, for all employees or prospective employees of the center who are expected to, or whose responsibilities may require them to, provide personal care or services to children, have access to children's living areas, or have access to children's funds or personal property.

(6) The subacute pediatric transitional care center must have an advisory board. Membership on the advisory board must include, but need not be limited to:

(a) A physician and an advanced registered nurse practitioner who is familiar with services for medically fragile or medical-technology-dependent children;

(b) A registered nurse who has experience in the care of medically fragile or medical-technology-dependent children;

(c) A child development specialist who has experience in the care of medically fragile or medical-technology-dependent children and their families;

(d) A social worker who has experience in the care of medically fragile or medical-technology-dependent children and their families; and

(e) A consumer representative who is a parent or guardian of a child placed in the center.

(7) The advisory board shall:

(a) Review the policy and procedure components of the center to assure conformance with applicable standards developed by the Agency for Health Care Administration; and

(b) Provide consultation with respect to the operational and programmatic components of the center.

(8) The subacute pediatric transitional care center must have written policies and procedures governing the admission, transfer, and discharge of children.

(9) The admission of each child to the center must be under the supervision of the center nursing administrator or his or her designee, and must be in accordance with the center's policies and procedures. Each Medicaid admission must be approved as appropriate for placement in the facility by the Children's Medical Services Multidisciplinary Assessment Team of the Department of Health, in conjunction with the Agency for Health Care Administration.

(10) Each child admitted to the center shall be admitted upon prescription of the medical director of the center, licensed pursuant to chapter 458 or chapter 459, Florida Statutes, and the child shall remain under the care of the medical director and the advanced registered nurse practitioner for the duration of his or her stay in the center.

(11) Each child admitted to the center must meet at least the following criteria:

(a) The child must be medically fragile or medical-technology-dependent.

(b) The child may not, prior to admission, present significant risk of infection to other children or personnel. The medical and nursing directors shall review, on a case-by-case basis, the condition of any child who is suspected of having an infectious disease to determine whether admission is appropriate.

(c) The child must be medically stabilized and require skilled nursing care or other interventions.

(12) If the child meets the criteria specified in paragraphs (11)(a), (b), and (c), the medical director or nursing director of the center shall implement a preadmission plan that delineates services to be provided and appropriate sources for such services.

(a) If the child is hospitalized at the time of referral, preadmission planning must include the participation of the child's parent or guardian and relevant medical, nursing, social services, and developmental staff to assure that the hospital's discharge plans will be implemented following the child's placement in the center.

(b) A consent form, outlining the purpose of the center, family responsibilities, authorized treatment, appropriate release of liability, and emergency disposition plans, must be signed by the parent or guardian and witnessed before the child is admitted to the center. The parent or guardian shall be provided a copy of the consent form.

(13) By January 1, 2003, the Agency for Health Care Administration shall report to the Legislature concerning the progress of the pilot program. By January 1, 2004, the agency shall submit to the Legislature a report on the success of the

pilot program.

Section 21. The Office of Legislative Services shall contract for a business case study of the feasibility of outsourcing the administrative, investigative, legal, and prosecutorial functions and other tasks and services that are necessary to carry out the regulatory responsibilities of the Board of Dentistry, employing its own executive director and other staff, and obtaining authority over collections and expenditures of funds paid by professions regulated by the board into the Medical Quality Assurance Trust Fund. This feasibility study must include a business plan and an assessment of the direct and indirect costs associated with outsourcing these functions. The sum of $50,000 is appropriated from the Board of Dentistry account within the Medical Quality Assurance Trust Fund to the Office of Legislative Services for the purpose of contracting for the study. The Office of Legislative Services shall submit the completed study to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 1, 2003.

Section 22. (1) Notwithstanding section 409.911(3), Florida Statutes, for the state fiscal year 2002-2003 only, the agency shall distribute moneys under the regular disproportionate share program only to hospitals that meet the federal minimum requirements and to public hospitals. Public hospitals are defined as those hospitals identified as government owned or operated in the Financial Hospital Uniform Reporting System (FHURS) data available to the agency as of January 1, 2002. The following methodology shall be used to distribute disproportionate share dollars to hospitals that meet the federal minimum requirements and to the public

hospitals:

(a) For hospitals that meet the federal minimum requirements, the following formula shall be used:

TAA = TA * (1/5.5)

DSHP = (HMD/TMSD)*TA

TAA = total amount available.

TA = total appropriation.

DSHP = disproportionate share hospital payment.

HMD = hospital Medicaid days.

TSD = total state Medicaid days.

(b) The following formulas shall be used to pay disproportionate share dollars to public hospitals:

1. For state mental health hospitals:

DSHP = (HMD/TMD) * TAAMH

The total amount available for the state mental health hospitals shall be the difference between the federal cap for Institutions for Mental Diseases and the amounts paid under the mental health disproportionate share program.

2. For non-state government owned or operated hospitals with 3,200 or more Medicaid days:

DSHP = [(.85*HCCD/TCCD) + (.15*HMD/TMD)] * TAAPH

TAAPH = TAA - TAAMH

3. For non-state government owned or operated hospitals with less than 3,200 Medicaid days, a total of $400,000 shall be distributed equally among these hospitals.

Where:

TAA = total available appropriation.
TAAPH = total amount available for public hospitals.
TAAMH = total amount available for mental health hospitals.
DSHP = disproportionate share hospital payments.
HMD = hospital Medicaid days.
TMD = total state Medicaid days for public hospitals.
HCCD = hospital charity care dollars.
TCCD = total state charity care dollars for public hospitals.

In computing the above amounts for public hospitals and hospitals that qualify under the federal minimum requirements, the agency shall use the 1997 audited data. In the event there is no 1997 audited data for a hospital, the agency shall use the 1994 audited data.

(2) Notwithstanding section 409.9112, Florida Statutes, for state fiscal year 2002-2003, only disproportionate share payments to regional perinatal intensive care centers shall be distributed in the same proportion as the disproportionate share payments made to the regional perinatal intensive care centers in the state fiscal

year 2001-2002.

(3) Notwithstanding section 409.9117, Florida Statutes, for state fiscal year 2002-2003 only, disproportionate share payments to hospitals that qualify for primary care disproportionate share payments shall be distributed in the same proportion as the primary care disproportionate share payments made to those hospitals in the state fiscal year 2001-2002.

(4) In the event the Centers for Medicare and Medicaid Services does not approve Florida's inpatient hospital state plan amendment for the public disproportionate share program by November 1, 2002, the agency may make payments to hospitals under the regular disproportionate share program, regional perinatal intensive care centers disproportionate share program, and the primary care disproportionate share program using the same methodologies used in state fiscal year 2001-2002.

(5) For state fiscal year 2002-2003 only, no disproportionate share payments shall be made to specialty hospitals for children under the provisions of section 409.9119, Florida Statutes.

(6) This section expires July 1, 2003.

Section 23. The Agency for Health Care Administration may conduct a 2-year pilot project to authorize overnight stays in one ambulatory surgical center located in Acute Care Subdistrict 9-1. An overnight stay shall be permitted only to perform plastic and reconstructive surgeries defined by current procedural terminology code numbers 13000-19999. The total time a patient is at the ambulatory surgical center shall not exceed 23 hours and 59 minutes, including the surgery time, and the maximum planned duration of all surgical

procedures combined shall not exceed 8 hours. Prior to implementation of the pilot project, the agency shall establish minimum requirements for protecting the health, safety, and welfare of patients receiving overnight care. These shall include, at a minimum, compliance with all statutes and rules applicable to ambulatory surgical centers and the requirements set forth in Rule 64B8-9.009, F.A.C., relating to Level II and Level III procedures. If the agency implements the pilot project, it shall, within 6 months after its completion, submit a report to the Legislature on whether to expand the pilot to include all ambulatory surgical centers. The recommendation shall be based on consideration of the efficacy and impact to patient safety and quality of patient care of providing plastic and reconstructive surgeries in the ambulatory surgical center setting. The agency is authorized to obtain such data as necessary to implement this section.

Section 24. Section 624.91, Florida Statutes, is amended to read:

624.91 The Florida Healthy Kids Corporation Act.--

(1) SHORT TITLE.--This section may be cited as the "William G. 'Doc' Myers Healthy Kids Corporation Act."

(2) LEGISLATIVE INTENT.--

(a) The Legislature finds that increased access to health care services could improve children's health and reduce the incidence and costs of childhood illness and disabilities among children in this state. Many children do not have comprehensive, affordable health care services available. It is the intent of the Legislature that the Florida Healthy Kids Corporation provide comprehensive health insurance coverage to such children. The corporation is

encouraged to cooperate with any existing health service programs funded by the public or the private sector and to work cooperatively with the Florida Partnership for School Readiness.

(b) It is the intent of the Legislature that the Florida Healthy Kids Corporation serve as one of several providers of services to children eligible for medical assistance under Title XXI of the Social Security Act. Although the corporation may serve other children, the Legislature intends the primary recipients of services provided through the corporation be school-age children with a family income below 200 percent of the federal poverty level, who do not qualify for Medicaid. It is also the intent of the Legislature that state and local government Florida Healthy Kids funds, ~~to the extent permissible under federal law,~~ be used to continue and expand coverage, within available appropriations, to children not eligible for federal matching funds under Title XXI ~~obtain matching federal dollars~~.

(3) NONENTITLEMENT.--Nothing in this section shall be construed as providing an individual with an entitlement to health care services. No cause of action shall arise against the state, the Florida Healthy Kids Corporation, or a unit of local government for failure to make health services available under this section.

(4) CORPORATION AUTHORIZATION, DUTIES, POWERS.--

(a) There is created the Florida Healthy Kids Corporation, a not-for-profit corporation ~~which operates on sites designated by the corporation~~.

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

1. Organize school children groups to facilitate the

provision of comprehensive health insurance coverage to children;

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

3. Arrange for the collection of any voluntary contributions to provide for payment of premiums for children who are not eligible for medical assistance under Title XXI of the Social Security Act. Each fiscal year, the corporation shall establish a local-match policy for the enrollment of non-Title XXI eligible children in the Healthy Kids program. By May 1 of each year, the corporation shall provide written notification of the amount to be remitted to the corporation for the following fiscal year under that policy. Local-match sources may include, but are not limited to, funds provided by municipalities, counties, school boards, hospitals, health care providers, charitable organizations, special taxing districts, and private organizations. The minimum local-match cash contributions required each fiscal year and local-match credits shall be determined by the General Appropriations Act. The corporation shall calculate a county's local-match rate based upon that county's percentage of the state's total non-Title XXI expenditures as reported in the corporation's most recently audited financial statement. In awarding the local-match credits, the corporation may consider factors including, but not limited to, population density, per-capita income, existing child-health-related expenditures and services in awarding the credits.

4. Accept voluntary supplemental local-match

contributions that comply with the requirements of Title XXI of the Social Security Act for the purpose of providing additional coverage in contributing counties under Title XXI.

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

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

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

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

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

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

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

12.~~10.~~ Contract with authorized insurers or any

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

13. Establish disenrollment criteria in the event local matching funds are insufficient to cover enrollments.

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

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

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

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

Minority Leaders of the Senate and the House of Representatives;

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

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

(c) Coverage under the corporation's program is secondary to any other available private coverage held by the participant child or family member. The corporation may establish procedures for coordinating benefits under this program with benefits under other public and private coverage.

(d) The Florida Healthy Kids Corporation shall be a private corporation not for profit, organized pursuant to chapter 617, and shall have all powers necessary to carry out the purposes of this act, including, but not limited to, the power to receive and accept grants, loans, or advances of funds from any public or private agency and to receive and accept from any source contributions of money, property,

labor, or any other thing of value, to be held, used, and applied for the purposes of this act.

(5) BOARD OF DIRECTORS.--

(a) The Florida Healthy Kids Corporation shall operate subject to the supervision and approval of a board of directors chaired by the Insurance Commissioner or her or his designee, and composed of 14 ~~12~~ other members selected for 3-year terms of office as follows:

1. One member appointed by the Commissioner of Education from among three persons nominated by the Florida Association of School Administrators;

2. One member appointed by the Commissioner of Education from among three persons nominated by the Florida Association of School Boards;

3. One member appointed by the Commissioner of Education from the Office of School Health Programs of the Florida Department of Education;

4. One member appointed by the Governor from among three members nominated by the Florida Pediatric Society;

5. One member, appointed by the Governor, who represents the Children's Medical Services Program;

6. One member appointed by the Insurance Commissioner from among three members nominated by the Florida Hospital Association;

7. Two members, appointed by the Insurance Commissioner, who are representatives of authorized health care insurers or health maintenance organizations;

8. One member, appointed by the Insurance Commissioner, who represents the Institute for Child Health Policy;

9. One member, appointed by the Governor, from among

three members nominated by the Florida Academy of Family Physicians;

10. One member, appointed by the Governor, who represents the Agency for Health Care Administration; ~~and~~

11. The State Health Officer or her or his designee;~~.~~

12. One member, appointed by the Insurance Commissioner from among three members nominated by the Florida Association of Counties, representing rural counties; and

13. One member, appointed by the Governor from among three members nominated by the Florida Association of Counties, representing urban counties.

(b) A member of the board of directors may be removed by the official who appointed that member. The board shall appoint an executive director, who is responsible for other staff authorized by the board.

(c) Board members are entitled to receive, from funds of the corporation, reimbursement for per diem and travel expenses as provided by s. 112.061.

(d) There shall be no liability on the part of, and no cause of action shall arise against, any member of the board of directors, or its employees or agents, for any action they take in the performance of their powers and duties under this act.

(6) LICENSING NOT REQUIRED; FISCAL OPERATION.--

(a) The corporation shall not be deemed an insurer. The officers, directors, and employees of the corporation shall not be deemed to be agents of an insurer. Neither the corporation nor any officer, director, or employee of the corporation is subject to the licensing requirements of the insurance code or the rules of the Department of Insurance. However, any marketing representative utilized and compensated

by the corporation must be appointed as a representative of the insurers or health services providers with which the corporation contracts.

(b) The board has complete fiscal control over the corporation and is responsible for all corporate operations.

(c) The Department of Insurance shall supervise any liquidation or dissolution of the corporation and shall have, with respect to such liquidation or dissolution, all power granted to it pursuant to the insurance code.

(7) ACCESS TO RECORDS; CONFIDENTIALITY; PENALTIES.--Notwithstanding any other laws to the contrary, the Florida Healthy Kids Corporation shall have access to the medical records of a student upon receipt of permission from a parent or guardian of the student. Such medical records may be maintained by state and local agencies. Any identifying information, including medical records and family financial information, obtained by the corporation pursuant to this subsection is confidential and is exempt from the provisions of s. 119.07(1). Neither the corporation nor the staff or agents of the corporation may release, without the written consent of the participant or the parent or guardian of the participant, to any state or federal agency, to any private business or person, or to any other entity, any confidential information received pursuant to this subsection. A violation of this subsection is a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

Section 25. Subsection (5) of section 414.41, Florida Statutes, is repealed.

Section 26. If any law that is amended by this act was also amended by a law enacted at the 2002 Regular Session of the Legislature, such laws shall be construed as if they had

been enacted at the same session of the Legislature, and full effect should be given to each if that is possible.

Section 27. Except as otherwise provided in this act, this act shall take effect upon becoming a law.

================ T I T L E A M E N D M E N T ================

And the title is amended as follows:

Delete everything before the enacting clause

and insert:

A bill to be entitled

An act relating to health care; amending s. 16.59, F.S.; specifying additional requirements for the Medicaid Fraud Control Unit of the Department of Legal Affairs and the Medicaid program integrity program; amending s. 112.3187, F.S.; extending whistle-blower protection to employees of Medicaid providers reporting Medicaid fraud or abuse; amending s. 400.179, F.S.; providing exceptions to bond requirements; creating s. 408.831, F.S.; allowing the Agency for Health Care Administration to take action against a licensee in certain circumstances; amending s. 409.8177, F.S.; requiring the Agency for Health Care Administration to contract for an evaluation of the Florida Kidcare program; amending s. 409.902, F.S.; prescribing an additional condition on Medicaid eligibility; amending s. 409.904, F.S.; revising provisions

governing optional payments for medical assistance and related services; amending s. 409.905, F.S.; providing additional criteria for the agency to adjust a hospital's inpatient per diem rate for Medicaid; amending s. 409.906, F.S.; authorizing the agency to make payments for specified services which are optional under Title XIX of the Social Security Act; amending s. 409.9065, F.S.; revising standards for pharmaceutical expense assistance; amending s. 409.907, F.S.; prescribing additional requirements with respect to provider enrollment; requiring that the Agency for Health Care Administration deny a provider's application under certain circumstances; amending s. 409.908, F.S.; providing additional requirements for cost-reporting; amending s. 409.910, F.S.; revising requirements for the distribution of funds recovered from third parties that are liable for making payments for medical care furnished to Medicaid recipients and in the case of recoveries of overpayments; amending s. 409.912, F.S.; revising provisions governing the purchase of goods and services for Medicaid recipients; providing for quarterly reports to the Governor and presiding officers of the Legislature; amending s. 409.9116, F.S.; revising the disproportionate share/financial assistance program for rural hospitals; amending s. 409.9122, F.S.; revising provisions

governing mandatory Medicaid managed care enrollment; amending s. 409.913, F.S.; requiring that the agency and Medicaid Fraud Control Unit annually submit a report to the Legislature; defining the term "complaint"; specifying additional requirements for the Medicaid program integrity program and the Medicaid Fraud Control Unit of the Department of Legal Affairs; requiring imposition of sanctions or disincentives, except under certain circumstances; providing additional sanctions and disincentives; providing additional grounds under which the agency may terminate a provider's participation in the Medicaid program; providing additional requirements for administrative hearings; providing additional grounds for withholding payments to a provider; authorizing the agency and the Medicaid Fraud Control Unit to review certain records; requiring review by the Attorney General of certain settlements; requiring review by the Auditor General of certain cost reports; requiring that the agency refund to a county any recovery of Medicaid overpayment received for hospital inpatient and nursing home services; providing a formula for calculating the credit; amending s. 409.920, F.S.; providing additional duties of the Medicaid Fraud Control Unit; amending s. 499.012, F.S.; redefining the term "wholesale distribution" with respect to regulation of

distribution of prescription drugs; requiring the Agency for Health Care Administration to conduct a study of health care services provided to medically fragile or medical-technology-dependent children; requiring the Agency for Health Care Administration to conduct a pilot program for a subacute pediatric transitional care center; requiring background screening of center personnel; requiring the agency to amend the Medicaid state plan and seek federal waivers as necessary; requiring the center to have an advisory board; providing for membership on the advisory board; providing requirements for the admission, transfer, and discharge of a child to the center; requiring the agency to submit certain reports to the Legislature; providing guidelines for the agency to distribute disproportionate share funds during the 2002-2003 fiscal year; authorizing the Agency for Health Care Administration to conduct a pilot project on overnight stays in an ambulatory surgical center; amending s. 624.91, F.S.; revising duties of the Florida Healthy Kids Corporation with respect to annual determination of participation in the Healthy Kids Program; prescribing duties of the corporation in establishing local match requirements; revising the composition of the board of directors; requiring recommendations to the Legislature; repealing s. 414.41(5),

F.S., relating to interest imposed upon the recovery amount of medical assistance overpayments; providing for construction of laws enacted at the 2002 Regular Session in relation to this act; providing effective dates.