Amendment No. (for drafter's use only)

CHAMBER ACTION

Senate		House
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Representative Green offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause, and insert:

Section 1. Effective upon this act becoming a law, 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:

27 (d) Where the transfer involves a facility that has been
28 leased by the transferor:
29 1. The transferee shall, as a condition to being issued a
30 license by the agency, acquire, maintain, and provide proof to
31 the agency of a bond with a term of 30 months, renewable
32 annually, in an amount not less than the total of 3 months
33 Medicaid payments to the facility computed on the basis of the
34 preceding 12-month average Medicaid payments to the facility.
35 2. A leasehold licensee may meet the requirements of
36 subparagraph 1. by payment of a nonrefundable fee, paid at
37 initial licensure, paid at the time of any subsequent change of
38 ownership, and paid at the time of any subsequent annual license
39 renewal, in the amount of 2 percent of the total of 3 months'
40 Medicaid payments to the facility computed on the basis of the
41 preceding 12-month average Medicaid payments to the facility. If
42 a preceding 12-month average is not available, projected
43 Medicaid payments may be used. The fee shall be deposited into
44 the Health Care Trust Fund and shall be accounted for separately
45 as a Medicaid nursing home overpayment account. These fees shall
46 be used at the sole discretion of the agency to repay nursing
47 home Medicaid overpayments. Payment of this fee shall not
48 release the licensee from any liability for any Medicaid
49 overpayments, nor shall payment bar the agency from seeking to
50 recoup overpayments from the licensee and any other liable
51 party. As a condition of exercising this lease bond alternative,
52 licensees paying this fee must maintain an existing lease bond
53 through the end of the 30-month term period of that bond. The
54 agency is herein granted specific authority to promulgate all
55 rules pertaining to the administration and management of this

account, including withdrawals from the account, subject to federal review and approval. ~~This subparagraph is repealed on June 30, 2003.~~ This provision shall take effect upon becoming law and shall apply to any leasehold license application.

a. The financial viability of the Medicaid nursing home overpayment account shall be determined by the agency through annual review of the account balance and the amount of total outstanding, unpaid Medicaid overpayments owing from leasehold licensees to the agency as determined by final agency audits.

b. The agency, in consultation with the Florida Health Care Association and the Florida Association of Homes for the Aging, shall study and make recommendations on the minimum amount to be held in reserve to protect against Medicaid overpayments to leasehold licensees and on the issue of successor liability for Medicaid overpayments upon sale or transfer of ownership of a nursing facility. The agency shall submit the findings and recommendations of the study to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 1, 2003.

3. The leasehold licensee may meet the bond requirement through other arrangements acceptable to the agency. The agency is herein granted specific authority to promulgate rules pertaining to lease bond arrangements.

4. 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.

84 5. It shall be the responsibility of all nursing facility
85 operators, operating the facility as a leasehold, to renew the
86 30-month bond and to provide proof of such renewal to the agency
87 annually at the time of application for license renewal.
88 6. Any failure of the nursing facility operator to
89 acquire, maintain, renew annually, or provide proof to the
90 agency shall be grounds for the agency to deny, cancel, revoke,
91 or suspend the facility license to operate such facility and to
92 take any further action, including, but not limited to,
93 enjoining the facility, asserting a moratorium, or applying for
94 a receiver, deemed necessary to ensure compliance with this
95 section and to safeguard and protect the health, safety, and
96 welfare of the facility's residents. A lease agreement required
97 as a condition of bond financing or refinancing under s. 154.213
98 by a health facilities authority or required under s. 159.30 by
99 a county or municipality is not a leasehold for purposes of this
100 paragraph and is not subject to the bond requirement of this
101 paragraph.
102 Section 2. Subsections (17), (18), (19), (20), (21), (22),
103 (23), (24), (25), (26), and (27) of section 409.811, Florida
104 Statutes, are renumbered as subsections (18), (19), (20), (21),
105 (22), (23), (24), (25), (26), (27), and (28), respectively, and
106 a new subsection (17) is added to said section to read:
107 409.811 Definitions relating to Florida Kidcare Act.--As
108 used in ss. 409.810-409.820, the term:
109 <u>(17) "Managed care plan" means a health maintenance</u>
110 <u>organization authorized pursuant to chapter 641 or a prepaid</u>
111 <u>health plan authorized pursuant to s. 409.912.</u>

112 Section 3. Subsection (7) of section 409.8132, Florida
113 Statutes, is amended to read:
114 409.8132 Medikids program component.--
115 (7) ENROLLMENT.--Enrollment in the Medikids program
116 component may only occur during periodic open enrollment periods
117 as specified by the agency. An applicant may apply for
118 enrollment in the Medikids program component and proceed through
119 the eligibility determination process at any time throughout the
120 year. However, enrollment in Medikids shall not begin until the
121 next open enrollment period; and a child may not receive
122 services under the Medikids program until the child is enrolled
123 in a managed care plan as defined in s. 409.811 or in MediPass.
124 In addition, once determined eligible, an applicant may receive
125 choice counseling and select a managed care plan or MediPass.
126 The agency may initiate mandatory assignment for a Medikids
127 applicant who has not chosen a managed care plan or MediPass
128 provider after the applicant's voluntary choice period ends. An
129 applicant may select MediPass under the Medikids program
130 component only in counties that have fewer than two managed care
131 plans available to serve Medicaid recipients and only if the
132 federal Health Care Financing Administration determines that
133 MediPass constitutes "health insurance coverage" as defined in
134 Title XXI of the Social Security Act.
135 Section 4. Subsection (25) of section 409.901, Florida
136 Statutes, is amended to read:
137 409.901 Definitions; ss. 409.901-409.920.--As used in ss.
138 409.901-409.920, except as otherwise specifically provided, the
139 term:

140 (25) "Third party" means an individual, entity, or
141 program, excluding Medicaid, that is, may be, could be, should
142 be, or has been liable for all or part of the cost of medical
143 services related to any medical assistance <u>provided</u> ~~covered by~~
144 ~~Medicaid~~. <u>Third party includes a third-party administrator or</u>
145 <u>TPA and a pharmacy benefits manager or PBM.</u>
146 Section 5. Subsection (2) of section 409.904, Florida
147 Statutes, as amended by section 1 of chapter 2003-9, Laws of
148 Florida, is amended to read:
149 409.904 Optional payments for eligible persons.--The
150 agency may make payments for medical assistance and related
151 services on behalf of the following persons who are determined
152 to be eligible subject to the income, assets, and categorical
153 eligibility tests set forth in federal and state law. Payment on
154 behalf of these Medicaid eligible persons is subject to the
155 availability of moneys and any limitations established by the
156 General Appropriations Act or chapter 216.
157 (2) A caretaker relative or parent, a pregnant woman, a
158 child under age 19 who would otherwise qualify for Florida
159 Kidcare Medicaid, a child up to age 21 who would otherwise
160 qualify under s. 409.903(1), a person age 65 or over, or a blind
161 or disabled person, who would otherwise be eligible for Florida
162 Medicaid, except that the income or assets of such family or
163 person exceed established limitations. For a family or person in
164 one of these coverage groups, medical expenses are deductible
165 from income in accordance with federal requirements in order to
166 make a determination of eligibility. ~~Expenses used to meet~~
167 ~~spend-down liability are not reimbursable by Medicaid. Effective~~
168 ~~July 1, 2003, when determining the eligibility of a pregnant~~

169 ~~woman, a child, or an aged, blind, or disabled individual, $270~~
170 ~~shall be deducted from the countable income of the filing unit.~~
171 ~~When determining the eligibility of the parent or caretaker~~
172 ~~relative as defined by Title XIX of the Social Security Act, the~~
173 ~~additional income disregard of $270 does not apply.~~ A family or
174 person eligible under the coverage known as the "medically
175 needy," is eligible to receive the same services as other
176 Medicaid recipients, with the exception of services in skilled
177 nursing facilities and intermediate care facilities for the
178 developmentally disabled.
179 Section 6. Subsections (1), (12), and (23) of section
180 409.906, Florida Statutes, are amended to read:
181 409.906 Optional Medicaid services.--Subject to specific
182 appropriations, the agency may make payments for services which
183 are optional to the state under Title XIX of the Social Security
184 Act and are furnished by Medicaid providers to recipients who
185 are determined to be eligible on the dates on which the services
186 were provided. Any optional service that is provided shall be
187 provided only when medically necessary and in accordance with
188 state and federal law. Optional services rendered by providers
189 in mobile units to Medicaid recipients may be restricted or
190 prohibited by the agency. Nothing in this section shall be
191 construed to prevent or limit the agency from adjusting fees,
192 reimbursement rates, lengths of stay, number of visits, or
193 number of services, or making any other adjustments necessary to
194 comply with the availability of moneys and any limitations or
195 directions provided for in the General Appropriations Act or
196 chapter 216. If necessary to safeguard the state's systems of
197 providing services to elderly and disabled persons and subject

198 to the notice and review provisions of s. 216.177, the Governor
199 may direct the Agency for Health Care Administration to amend
200 the Medicaid state plan to delete the optional Medicaid service
201 known as "Intermediate Care Facilities for the Developmentally
202 Disabled." Optional services may include:

203 (1) ADULT DENTAL SERVICES.--The agency may pay for
204 dentures, the procedures required to seat dentures, the repair
205 and reline of dentures, emergency dental procedures necessary to
206 alleviate pain or infection, and basic dental preventive
207 procedures provided by or under the direction of a licensed
208 dentist for a recipient who is age 65 or older ~~medically~~
209 ~~necessary, emergency dental procedures to alleviate pain or~~
210 ~~infection. Emergency dental care shall be limited to emergency~~
211 ~~oral examinations, necessary radiographs, extractions, and~~
212 ~~incision and drainage of abscess, for a recipient who is age 21~~
213 ~~or older~~. However, Medicaid will not provide reimbursement for
214 dental services provided in a mobile dental unit, except for a
215 mobile dental unit:

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

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

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

227 (d) Owned by, operated by, or having a contractual
228 agreement with a state-approved dental educational institution.
229 (12) CHILDREN'S HEARING SERVICES.--The agency may pay for
230 hearing and related services, including hearing evaluations,
231 hearing aid devices, dispensing of the hearing aid, and related
232 repairs, if provided to a recipient younger than 21 years of age
233 by a licensed hearing aid specialist, otolaryngologist,
234 otologist, audiologist, or physician.
235 (23) CHILDREN'S VISUAL SERVICES.--The agency may pay for
236 visual examinations, eyeglasses, and eyeglass repairs for a
237 recipient younger than 21 years of age, if they are prescribed
238 by a licensed physician specializing in diseases of the eye or
239 by a licensed optometrist.
240 Section 7. Paragraphs (c) and (d) are added to subsection
241 (1) of section 409.9081, Florida Statutes, to read:
242 409.9081 Copayments.--
243 (1) The agency shall require, subject to federal
244 regulations and limitations, each Medicaid recipient to pay at
245 the time of service a nominal copayment for the following
246 Medicaid services:
247 (c) Prescription drugs: a coinsurance equal to 5 percent
248 of the Medicaid cost of the prescription drug at the time of
249 purchase. The maximum coinsurance shall be $15 per prescription
250 drug purchased.
251 (d) Hospital outpatient services, emergency department: up
252 to $15 for each hospital outpatient emergency department
253 encounter that is for nonemergency purposes.
254 Section 8. Section 409.911, Florida Statutes, is amended
255 to read:

256 409.911 Disproportionate share program.--Subject to
257 specific allocations established within the General
258 Appropriations Act and any limitations established pursuant to
259 chapter 216, the agency shall distribute, pursuant to this
260 section, moneys to hospitals providing a disproportionate share
261 of Medicaid or charity care services by making quarterly
262 Medicaid payments as required. Notwithstanding the provisions of
263 s. 409.915, counties are exempt from contributing toward the
264 cost of this special reimbursement for hospitals serving a
265 disproportionate share of low-income patients.

266 (1) Definitions.--As used in this section, s. 409.9112,
267 and the Florida Hospital Uniform Reporting System manual:

268 (a) "Adjusted patient days" means the sum of acute care
269 patient days and intensive care patient days as reported to the
270 Agency for Health Care Administration, divided by the ratio of
271 inpatient revenues generated from acute, intensive, ambulatory,
272 and ancillary patient services to gross revenues.

273 (b) "Actual audited data" or "actual audited experience"
274 means data reported to the Agency for Health Care Administration
275 which has been audited in accordance with generally accepted
276 auditing standards by the agency or representatives under
277 contract with the agency.

278 ~~(c) "Base Medicaid per diem" means the hospital's Medicaid~~
279 ~~per diem rate initially established by the Agency for Health~~
280 ~~Care Administration on January 1, 1999. The base Medicaid per~~
281 ~~diem rate shall not include any additional per diem increases~~
282 ~~received as a result of the disproportionate share distribution.~~

283 (c)~~(d)~~ "Charity care" or "uncompensated charity care"
284 means that portion of hospital charges reported to the Agency

285 for Health Care Administration for which there is no
286 compensation, other than restricted or unrestricted revenues
287 provided to a hospital by local governments or tax districts
288 regardless of the method of payment, for care provided to a
289 patient whose family income for the 12 months preceding the
290 determination is less than or equal to 200 percent of the
291 federal poverty level, unless the amount of hospital charges due
292 from the patient exceeds 25 percent of the annual family income.
293 However, in no case shall the hospital charges for a patient
294 whose family income exceeds four times the federal poverty level
295 for a family of four be considered charity.

296 <u>(d)</u>~~(e)~~ "Charity care days" means the sum of the deductions
297 from revenues for charity care minus 50 percent of restricted
298 and unrestricted revenues provided to a hospital by local
299 governments or tax districts, divided by gross revenues per
300 adjusted patient day.

301 ~~(f) "Disproportionate share percentage" means a rate of~~
302 ~~increase in the Medicaid per diem rate as calculated under this~~
303 ~~section.~~

304 <u>(e)</u>~~(g)~~ "Hospital" means a health care institution licensed
305 as a hospital pursuant to chapter 395, but does not include
306 ambulatory surgical centers.

307 <u>(f)</u>~~(h)~~ "Medicaid days" means the number of actual days
308 attributable to Medicaid patients as determined by the Agency
309 for Health Care Administration.

310 (2) The Agency for Health Care Administration shall
311 utilize the following <u>actual audited data</u> ~~criteria~~ to determine
312 <u>the Medicaid days and charity care to be used in the calculation</u>

313 of the ~~if a hospital qualifies for a~~ disproportionate share
314 payment:
315 (a) The Agency for Health Care Administration shall use
316 the average of the 1997, 1998, and 1999 audited data to
317 determine each hospital's Medicaid days and charity care ~~A~~
318 ~~hospital's total Medicaid days when combined with its total~~
319 ~~charity care days must equal or exceed 7 percent of its total~~
320 ~~adjusted patient days~~.
321 (b) In the event the Agency for Health Care Administration
322 does not have the prescribed 3 years of audited disproportionate
323 share data for a hospital, the Agency for Health Care
324 Administration shall use the average of the audited
325 disproportionate share data for the years available ~~A hospital's~~
326 ~~total charity care days weighted by a factor of 4.5, plus its~~
327 ~~total Medicaid days weighted by a factor of 1, shall be equal to~~
328 ~~or greater than 10 percent of its total adjusted patient days~~.
329 (c) ~~Additionally,~~ In accordance with s. 1923(b) of the
330 Social Security Act ~~the seventh federal Omnibus Budget~~
331 ~~Reconciliation Act~~, a hospital with a Medicaid inpatient
332 utilization rate greater than one standard deviation above the
333 statewide mean or a hospital with a low-income utilization rate
334 of 25 percent or greater shall qualify for reimbursement.
335 ~~(3) In computing the disproportionate share rate:~~
336 ~~(a) Per diem increases earned from disproportionate share~~
337 ~~shall be applied to each hospital's base Medicaid per diem rate~~
338 ~~and shall be capped at 170 percent.~~
339 ~~(b) The agency shall use 1994 audited financial data for~~
340 ~~the calculation of disproportionate share payments under this~~
341 ~~section.~~

342 ~~(c) If the total amount earned by all hospitals under this~~
343 ~~section exceeds the amount appropriated, each hospital's share~~
344 ~~shall be reduced on a pro rata basis so that the total dollars~~
345 ~~distributed from the trust fund do not exceed the total amount~~
346 ~~appropriated.~~
347 ~~(d) The total amount calculated to be distributed under~~
348 ~~this section shall be made in quarterly payments subsequent to~~
349 ~~each quarter during the fiscal year.~~
350 (3)~~(4)~~ Hospitals that qualify for a disproportionate share
351 payment solely under paragraph (2)(c) shall have their payment
352 calculated in accordance with the following formulas:
353
354 DSHP = (HMD/TSMD) x $1 million
355 ~~TAA = TA x (1/5.5)~~
356 ~~DSHP = (HMD/TSMD) x TAA~~
357
358 Where:
359 ~~TAA = total amount available.~~
360 ~~TA = total appropriation.~~
361 DSHP = disproportionate share hospital payment.
362 HMD = hospital Medicaid days.
363 TSMD = total state Medicaid days.
364
365 (4) The following formulas shall be used to pay
366 disproportionate share dollars to public hospitals:
367 (a) For state mental health hospitals:
368
369 DSHP = (HMD/TMDMH) x TAAMH
370

371 The total amount available for the state mental health hospitals
372 shall be the difference between the federal cap for Institutions
373 for Mental Diseases and the amounts paid under the mental health
374 disproportionate share program.
375
376 Where:
377 DSHP = disproportionate share hospital payment.
378 HMD = hospital Medicaid days.
379 TMDMH = total Medicaid days for state mental health
380 hospitals.
381 TAAMH = total amount available for mental health hospitals.
382
383 (b) For nonstate government owned or operated hospitals
384 with 3,200 or more Medicaid days:
385
386 DSHP = [(.82 x HCCD/TCCD) + (.18 x HMD/TMD)] x TAAPH
387 TAAPH = TAA - TAAMH - 1,400,000
388
389 Where:
390 DSHP = disproportionate share hospital payments.
391 HCCD = hospital charity care dollars.
392 TCCD = total charity care dollars for public nonstate
393 hospitals.
394 HMD = hospital Medicaid days.
395 TMD = total Medicaid days for public nonstate hospitals.
396 TAAPH = total amount available for public hospitals.
397 TAA = total available appropriation.
398 TAAMH = total amount available for mental health hospitals.
399

400 (c) For nonstate government owned or operated hospitals
401 with less than 3,200 Medicaid days, a total of $400,000 shall be
402 distributed equally among these hospitals.
403 ~~(5) The following formula shall be utilized by the agency~~
404 ~~to determine the maximum disproportionate share rate to be used~~
405 ~~to increase the Medicaid per diem rate for hospitals that~~
406 ~~qualify pursuant to paragraphs (2)(a) and (b):~~

~~DSR = CCD MD~~
407 ~~((----------) x 4.5) + (----------)~~
408 ~~APD APD~~

409
410 ~~Where:~~
411 ~~APD = adjusted patient days.~~
412 ~~CCD = charity care days.~~
413 ~~DSR = disproportionate share rate.~~
414 ~~MD = Medicaid days.~~
415
416 ~~(6)(a) To calculate the total amount earned by all~~
417 ~~hospitals under this section, hospitals with a disproportionate~~
418 ~~share rate less than 50 percent shall divide their Medicaid days~~
419 ~~by four, and hospitals with a disproportionate share rate~~
420 ~~greater than or equal to 50 percent and with greater than 40,000~~
421 ~~Medicaid days shall multiply their Medicaid days by 1.5, and the~~
422 ~~following formula shall be used by the agency to calculate the~~
423 ~~total amount earned by all hospitals under this section:~~
424
425 ~~TAE = BMPD x MD x DSP~~
426

427 ~~Where:~~

428 ~~TAE = total amount earned.~~

429 ~~BMPD = base Medicaid per diem.~~

430 ~~MD = Medicaid days.~~

431 ~~DSP = disproportionate share percentage.~~

432

433 (5)~~(b)~~ In no case shall total payments to a hospital under
434 this section, with the exception of public nonstate facilities
435 or state facilities, exceed the total amount of uncompensated
436 charity care of the hospital, as determined by the agency
437 according to the most recent calendar year audited data
438 available at the beginning of each state fiscal year.

439 ~~(7) The following criteria shall be used in determining~~
440 ~~the disproportionate share percentage:~~

441 ~~(a) If the disproportionate share rate is less than 10~~
442 ~~percent, the disproportionate share percentage is zero and there~~
443 ~~is no additional payment.~~

444 ~~(b) If the disproportionate share rate is greater than or~~
445 ~~equal to 10 percent, but less than 20 percent, then the~~
446 ~~disproportionate share percentage is 1.8478498.~~

447 ~~(c) If the disproportionate share rate is greater than or~~
448 ~~equal to 20 percent, but less than 30 percent, then the~~
449 ~~disproportionate share percentage is 3.4145488.~~

450 ~~(d) If the disproportionate share rate is greater than or~~
451 ~~equal to 30 percent, but less than 40 percent, then the~~
452 ~~disproportionate share percentage is 6.3095734.~~

453 ~~(e) If the disproportionate share rate is greater than or~~
454 ~~equal to 40 percent, but less than 50 percent, then the~~
455 ~~disproportionate share percentage is 11.6591440.~~

456 ~~(f) If the disproportionate share rate is greater than or~~
457 ~~equal to 50 percent, but less than 60 percent, then the~~
458 ~~disproportionate share percentage is 73.5642254.~~
459 ~~(g) If the disproportionate share rate is greater than or~~
460 ~~equal to 60 percent but less than 72.5 percent, then the~~
461 ~~disproportionate share percentage is 135.9356391.~~
462 ~~(h) If the disproportionate share rate is greater than or~~
463 ~~equal to 72.5 percent, then the disproportionate share~~
464 ~~percentage is 170.~~
465 ~~(8) The following formula shall be used by the agency to~~
466 ~~calculate the total amount earned by all hospitals under this~~
467 ~~section:~~
468
469 ~~TAE = BMPD x MD x DSP~~
470
471 ~~Where:~~
472 ~~TAE = total amount earned.~~
473 ~~BMPD = base Medicaid per diem.~~
474 ~~MD = Medicaid days.~~
475 ~~DSP = disproportionate share percentage.~~
476
477 (6)~~(9)~~ The agency is authorized to receive funds from
478 local governments and other local political subdivisions for the
479 purpose of making payments, including federal matching funds,
480 through the Medicaid disproportionate share program. Funds
481 received from local governments for this purpose shall be
482 separately accounted for and shall not be commingled with other
483 state or local funds in any manner.

484 <u>(7)</u>~~(10)~~ Payments made by the agency to hospitals eligible
485 to participate in this program shall be made in accordance with
486 federal rules and regulations.
487 (a) If the Federal Government prohibits, restricts, or
488 changes in any manner the methods by which funds are distributed
489 for this program, the agency shall not distribute any additional
490 funds and shall return all funds to the local government from
491 which the funds were received, except as provided in paragraph
492 (b).
493 (b) If the Federal Government imposes a restriction that
494 still permits a partial or different distribution, the agency
495 may continue to disburse funds to hospitals participating in the
496 disproportionate share program in a federally approved manner,
497 provided:
498 1. Each local government which contributes to the
499 disproportionate share program agrees to the new manner of
500 distribution as shown by a written document signed by the
501 governing authority of each local government; and
502 2. The Executive Office of the Governor, the Office of
503 Planning and Budgeting, the House of Representatives, and the
504 Senate are provided at least 7 days' prior notice of the
505 proposed change in the distribution, and do not disapprove such
506 change.
507 (c) No distribution shall be made under the alternative
508 method specified in paragraph (b) unless all parties agree or
509 unless all funds of those parties that disagree which are not
510 yet disbursed have been returned to those parties.
511 <u>(8)</u>~~(11)~~ Notwithstanding the provisions of chapter 216, the
512 Executive Office of the Governor is hereby authorized to

513 establish sufficient trust fund authority to implement the
514 disproportionate share program.
515 Section 9. Subsections (1) and (2) of section 409.9112,
516 Florida Statutes, are amended to read:
517 409.9112 Disproportionate share program for regional
518 perinatal intensive care centers.--In addition to the payments
519 made under s. 409.911, the Agency for Health Care Administration
520 shall design and implement a system of making disproportionate
521 share payments to those hospitals that participate in the
522 regional perinatal intensive care center program established
523 pursuant to chapter 383. This system of payments shall conform
524 with federal requirements and shall distribute funds in each
525 fiscal year for which an appropriation is made by making
526 quarterly Medicaid payments. Notwithstanding the provisions of
527 s. 409.915, counties are exempt from contributing toward the
528 cost of this special reimbursement for hospitals serving a
529 disproportionate share of low-income patients.
530 (1) The following formula shall be used by the agency to
531 calculate the total amount earned for hospitals that participate
532 in the regional perinatal intensive care center program:
533
534 TAE = HDSP/THDSP
535
536 Where:
537 TAE = total amount earned by a regional perinatal intensive
538 care center.
539 HDSP = the prior state fiscal year regional perinatal
540 intensive care center disproportionate share payment to the
541 individual hospital.

542 THDSP = the prior state fiscal year total regional
543 perinatal intensive care center disproportionate share payments
544 to all hospitals.
545 (2) The total additional payment for hospitals that
546 participate in the regional perinatal intensive care center
547 program shall be calculated by the agency as follows:
548
549 TAP = TAE x TA
550
551 Where:
552 TAP = total additional payment for a regional perinatal
553 intensive care center.
554 TAE = total amount earned by a regional perinatal intensive
555 care center.
556 TA = total appropriation for the regional perinatal
557 intensive care center disproportionate share program.
558
559 ~~TAE = DSR x BMPD x MD~~
560
561 ~~Where:~~
562 ~~TAE = total amount earned by a regional perinatal intensive~~
563 ~~care center.~~
564 ~~DSR = disproportionate share rate.~~
565 ~~BMPD = base Medicaid per diem.~~
566 ~~MD = Medicaid days.~~
567
568 ~~(2) The total additional payment for hospitals that~~
569 ~~participate in the regional perinatal intensive care center~~
570 ~~program shall be calculated by the agency as follows:~~

~~TAP =~~ ~~TAE x TA~~
571
~~(----------------)~~
572
~~STAE~~
573
574 ~~Where:~~
575 ~~TAP = total additional payment for a regional perinatal~~
576 ~~intensive care center.~~
577 ~~TAE = total amount earned by a regional perinatal intensive~~
578 ~~care center.~~
579 ~~STAE = sum of total amount earned by each hospital that~~
580 ~~participates in the regional perinatal intensive care center~~
581 ~~program.~~
582 ~~TA = total appropriation for the regional perinatal~~
583 ~~intensive care disproportionate share program.~~
584 Section 10. Section 409.9117, Florida Statutes, is amended
585 to read:
586 409.9117 Primary care disproportionate share program.--
587 (1) If federal funds are available for disproportionate
588 share programs in addition to those otherwise provided by law,
589 there shall be created a primary care disproportionate share
590 program.
591 (2) The following formula shall be used by the agency to
592 calculate the total amount earned for hospitals that participate
593 in the primary care disproportionate share program:
594
595 TAE = HDSP/THDSP
596
597 Where:

598 TAE = total amount earned by a hospital participating in
599 the primary care disproportionate share program.
600 HDSP = the prior state fiscal year primary care
601 disproportionate share payment to the individual hospital.
602 THDSP = the prior state fiscal year to primary care
603 disproportionate share payments to all hospitals.
604 (3) The total additional payment for hospitals that
605 participate in the primary care disproportionate share program
606 shall be calculated by the agency as follows:
607
608 TAP = TAE x TA
609
610 Where:
611 TAP = total additional payment for a primary care hospital.
612 TAE = total amount earned by a primary care hospital.
613 TA = total appropriation for the primary care
614 disproportionate share program.
615 (4)~~(2)~~ In the establishment and funding of this program,
616 the agency shall use the following criteria in addition to those
617 specified in s. 409.911.~~,~~ Payments may not be made to a hospital
618 unless the hospital agrees to:
619 (a) Cooperate with a Medicaid prepaid health plan, if one
620 exists in the community.
621 (b) Ensure the availability of primary and specialty care
622 physicians to Medicaid recipients who are not enrolled in a
623 prepaid capitated arrangement and who are in need of access to
624 such physicians.
625 (c) Coordinate and provide primary care services free of
626 charge, except copayments, to all persons with incomes up to 100

627 percent of the federal poverty level who are not otherwise
628 covered by Medicaid or another program administered by a
629 governmental entity, and to provide such services based on a
630 sliding fee scale to all persons with incomes up to 200 percent
631 of the federal poverty level who are not otherwise covered by
632 Medicaid or another program administered by a governmental
633 entity, except that eligibility may be limited to persons who
634 reside within a more limited area, as agreed to by the agency
635 and the hospital.
636 (d) Contract with any federally qualified health center,
637 if one exists within the agreed geopolitical boundaries,
638 concerning the provision of primary care services, in order to
639 guarantee delivery of services in a nonduplicative fashion, and
640 to provide for referral arrangements, privileges, and
641 admissions, as appropriate. The hospital shall agree to provide
642 at an onsite or offsite facility primary care services within 24
643 hours to which all Medicaid recipients and persons eligible
644 under this paragraph who do not require emergency room services
645 are referred during normal daylight hours.
646 (e) Cooperate with the agency, the county, and other
647 entities to ensure the provision of certain public health
648 services, case management, referral and acceptance of patients,
649 and sharing of epidemiological data, as the agency and the
650 hospital find mutually necessary and desirable to promote and
651 protect the public health within the agreed geopolitical
652 boundaries.
653 (f) In cooperation with the county in which the hospital
654 resides, develop a low-cost, outpatient, prepaid health care

655 program to persons who are not eligible for the Medicaid
656 program, and who reside within the area.
657 (g) Provide inpatient services to residents within the
658 area who are not eligible for Medicaid or Medicare, and who do
659 not have private health insurance, regardless of ability to pay,
660 on the basis of available space, except that nothing shall
661 prevent the hospital from establishing bill collection programs
662 based on ability to pay.
663 (h) Work with the ~~Florida Healthy Kids Corporation, the~~
664 Florida Health Care Purchasing Cooperative~~,~~ and business health
665 coalitions, as appropriate, to develop a feasibility study and
666 plan to provide a low-cost comprehensive health insurance plan
667 to persons who reside within the area and who do not have access
668 to such a plan.
669 (i) Work with public health officials and other experts to
670 provide community health education and prevention activities
671 designed to promote healthy lifestyles and appropriate use of
672 health services.
673 (j) Work with the local health council to develop a plan
674 for promoting access to affordable health care services for all
675 persons who reside within the area, including, but not limited
676 to, public health services, primary care services, inpatient
677 services, and affordable health insurance generally.
678
679 Any hospital that fails to comply with any of the provisions of
680 this subsection, or any other contractual condition, may not
681 receive payments under this section until full compliance is
682 achieved.

683 Section 11. Section 409.9119, Florida Statutes, is amended
684 to read:
685 409.9119 Disproportionate share program for specialty
686 hospitals for children.--In addition to the payments made under
687 s. 409.911, the Agency for Health Care Administration shall
688 develop and implement a system under which disproportionate
689 share payments are made to those hospitals that are licensed by
690 the state as specialty hospitals for children and were licensed
691 on January 1, 2000, as specialty hospitals for children. This
692 system of payments must conform to federal requirements and must
693 distribute funds in each fiscal year for which an appropriation
694 is made by making quarterly Medicaid payments. Notwithstanding
695 s. 409.915, counties are exempt from contributing toward the
696 cost of this special reimbursement for hospitals that serve a
697 disproportionate share of low-income patients. Payments are
698 subject to specific appropriations in the General Appropriations
699 Act.
700 (1) The agency shall use the following formula to
701 calculate the total amount earned for hospitals that participate
702 in the specialty hospital for children disproportionate share
703 program:
704
705 TAE = DSR x BMPD x MD
706
707 Where:
708 TAE = total amount earned by a specialty hospital for
709 children.
710 DSR = disproportionate share rate.
711 BMPD = base Medicaid per diem.

712 MD = Medicaid days.

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

716
717
718

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

719 Where:

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

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

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

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

729

730 (3) A hospital may not receive any payments under this
731 section until it achieves full compliance with the applicable
732 rules of the agency. A hospital that is not in compliance for
733 two or more consecutive quarters may not receive its share of
734 the funds. Any forfeited funds must be distributed to the
735 remaining participating specialty hospitals for children that
736 are in compliance.

737 Section 12. Paragraph (d) of subsection (3) of section
738 409.912, Florida Statutes, is amended, and subsection (41) is
739 added to said section, to read:
740 409.912 Cost-effective purchasing of health care.--The
741 agency shall purchase goods and services for Medicaid recipients
742 in the most cost-effective manner consistent with the delivery
743 of quality medical care. The agency shall maximize the use of
744 prepaid per capita and prepaid aggregate fixed-sum basis
745 services when appropriate and other alternative service delivery
746 and reimbursement methodologies, including competitive bidding
747 pursuant to s. 287.057, designed to facilitate the cost-
748 effective purchase of a case-managed continuum of care. The
749 agency shall also require providers to minimize the exposure of
750 recipients to the need for acute inpatient, custodial, and other
751 institutional care and the inappropriate or unnecessary use of
752 high-cost services. The agency may establish prior authorization
753 requirements for certain populations of Medicaid beneficiaries,
754 certain drug classes, or particular drugs to prevent fraud,
755 abuse, overuse, and possible dangerous drug interactions. The
756 Pharmaceutical and Therapeutics Committee shall make
757 recommendations to the agency on drugs for which prior
758 authorization is required. The agency shall inform the
759 Pharmaceutical and Therapeutics Committee of its decisions
760 regarding drugs subject to prior authorization.
761 (3) The agency may contract with:
762 (d) A provider network ~~No more than four provider service~~
763 ~~networks for demonstration projects to test Medicaid direct~~
764 ~~contracting. The demonstration projects~~ may be reimbursed on a
765 fee-for-service or prepaid basis. A provider service network

766 which is reimbursed by the agency on a prepaid basis shall be
767 exempt from parts I and III of chapter 641, but must meet
768 appropriate financial reserve, quality assurance, and patient
769 rights requirements as established by the agency. The agency
770 shall award contracts on a competitive bid basis and shall
771 select bidders based upon price and quality of care. ~~Medicaid~~
772 ~~recipients assigned to a demonstration project shall be chosen~~
773 ~~equally from those who would otherwise have been assigned to~~
774 ~~prepaid plans and MediPass.~~ The agency is authorized to seek
775 federal Medicaid waivers as necessary to implement the
776 provisions of this section. ~~A demonstration project awarded~~
777 ~~pursuant to this paragraph shall be for 4 years from the date of~~
778 ~~implementation.~~
779 (41) The agency may contract on a prepaid or fixed-sum
780 basis with an appropriately licensed prepaid dental health plan
781 to provide Medicaid covered dental services to child or adult
782 Medicaid recipients.
783 Section 13. Paragraphs (f) and (k) of subsection (2) of
784 section 409.9122, Florida Statutes, are amended to read:
785 409.9122 Mandatory Medicaid managed care enrollment;
786 programs and procedures.--
787 (2)
788 (f) When a Medicaid recipient does not choose a managed
789 care plan or MediPass provider, the agency shall assign the
790 Medicaid recipient to a managed care plan or MediPass provider.
791 Medicaid recipients who are subject to mandatory assignment but
792 who fail to make a choice shall be assigned to managed care
793 plans until an enrollment of 40 ~~45~~ percent in MediPass and 60 ~~55~~
794 percent in managed care plans is achieved. Once this enrollment

795 is achieved, the assignments shall be divided in order to
796 maintain an enrollment in MediPass and managed care plans which
797 is in a <u>40</u> ~~45~~ percent and <u>60</u> ~~55~~ percent proportion,
798 respectively. Thereafter, assignment of Medicaid recipients who
799 fail to make a choice shall be based proportionally on the
800 preferences of recipients who have made a choice in the previous
801 period. Such proportions shall be revised at least quarterly to
802 reflect an update of the preferences of Medicaid recipients. The
803 agency shall disproportionately assign Medicaid-eligible
804 recipients who are required to but have failed to make a choice
805 of managed care plan or MediPass, including children, and who
806 are to be assigned to the MediPass program to children's
807 networks as described in s. 409.912(3)(g), Children's Medical
808 Services network as defined in s. 391.021, exclusive provider
809 organizations, provider service networks, minority physician
810 networks, and pediatric emergency department diversion programs
811 authorized by this chapter or the General Appropriations Act, in
812 such manner as the agency deems appropriate, until the agency
813 has determined that the networks and programs have sufficient
814 numbers to be economically operated. For purposes of this
815 paragraph, when referring to assignment, the term "managed care
816 plans" includes health maintenance organizations, exclusive
817 provider organizations, provider service networks, minority
818 physician networks, Children's Medical Services network, and
819 pediatric emergency department diversion programs authorized by
820 this chapter or the General Appropriations Act. Beginning July
821 1, 2002, the agency shall assign all children in families who
822 have not made a choice of a managed care plan or MediPass in the
823 required timeframe to a pediatric emergency room diversion

824 program described in s. 409.912(3)(g) that, as of July 1, 2002,
825 has executed a contract with the agency, until such network or
826 program has reached an enrollment of 15,000 children. Once that
827 minimum enrollment level has been reached, the agency shall
828 assign children who have not chosen a managed care plan or
829 MediPass to the network or program in a manner that maintains
830 the minimum enrollment in the network or program at not less
831 than 15,000 children. To the extent practicable, the agency
832 shall also assign all eligible children in the same family to
833 such network or program. When making assignments, the agency
834 shall take into account the following criteria:

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

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

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

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

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

851 (k) When a Medicaid recipient does not choose a managed
852 care plan or MediPass provider, the agency shall assign the

853 Medicaid recipient to a managed care plan, except in those
854 counties in which there are fewer than two managed care plans
855 accepting Medicaid enrollees, in which case assignment shall be
856 to a managed care plan or a MediPass provider. Medicaid
857 recipients in counties with fewer than two managed care plans
858 accepting Medicaid enrollees who are subject to mandatory
859 assignment but who fail to make a choice shall be assigned to
860 managed care plans until an enrollment of 40 ~~45~~ percent in
861 MediPass and 60 ~~55~~ percent in managed care plans is achieved.
862 Once that enrollment is achieved, the assignments shall be
863 divided in order to maintain an enrollment in MediPass and
864 managed care plans which is in a 40 ~~45~~ percent and 60 ~~55~~ percent
865 proportion, respectively. In geographic areas where the agency
866 is contracting for the provision of comprehensive behavioral
867 health services through a capitated prepaid arrangement,
868 recipients who fail to make a choice shall be assigned equally
869 to MediPass or a managed care plan. For purposes of this
870 paragraph, when referring to assignment, the term "managed care
871 plans" includes exclusive provider organizations, provider
872 service networks, Children's Medical Services network, minority
873 physician networks, and pediatric emergency department diversion
874 programs authorized by this chapter or the General
875 Appropriations Act. When making assignments, the agency shall
876 take into account the following criteria:
877 1. A managed care plan has sufficient network capacity to
878 meet the need of members.
879 2. The managed care plan or MediPass has previously
880 enrolled the recipient as a member, or one of the managed care

881 plan's primary care providers or MediPass providers has
882 previously provided health care to the recipient.
883 3. The agency has knowledge that the member has previously
884 expressed a preference for a particular managed care plan or
885 MediPass provider as indicated by Medicaid fee-for-service
886 claims data, but has failed to make a choice.
887 4. The managed care plan's or MediPass primary care
888 providers are geographically accessible to the recipient's
889 residence.
890 5. The agency has authority to make mandatory assignments
891 based on quality of service and performance of managed care
892 plans.
893 Section 14. Subsections (8) and (28) of section 409.913,
894 Florida Statutes, are amended to read:
895 409.913 Oversight of the integrity of the Medicaid
896 program.--The agency shall operate a program to oversee the
897 activities of Florida Medicaid recipients, and providers and
898 their representatives, to ensure that fraudulent and abusive
899 behavior and neglect of recipients occur to the minimum extent
900 possible, and to recover overpayments and impose sanctions as
901 appropriate. Beginning January 1, 2003, and each year
902 thereafter, the agency and the Medicaid Fraud Control Unit of
903 the Department of Legal Affairs shall submit a joint report to
904 the Legislature documenting the effectiveness of the state's
905 efforts to control Medicaid fraud and abuse and to recover
906 Medicaid overpayments during the previous fiscal year. The
907 report must describe the number of cases opened and investigated
908 each year; the sources of the cases opened; the disposition of
909 the cases closed each year; the amount of overpayments alleged

910 in preliminary and final audit letters; the number and amount of
911 fines or penalties imposed; any reductions in overpayment
912 amounts negotiated in settlement agreements or by other means;
913 the amount of final agency determinations of overpayments; the
914 amount deducted from federal claiming as a result of
915 overpayments; the amount of overpayments recovered each year;
916 the amount of cost of investigation recovered each year; the
917 average length of time to collect from the time the case was
918 opened until the overpayment is paid in full; the amount
919 determined as uncollectible and the portion of the uncollectible
920 amount subsequently reclaimed from the Federal Government; the
921 number of providers, by type, that are terminated from
922 participation in the Medicaid program as a result of fraud and
923 abuse; and all costs associated with discovering and prosecuting
924 cases of Medicaid overpayments and making recoveries in such
925 cases. The report must also document actions taken to prevent
926 overpayments and the number of providers prevented from
927 enrolling in or reenrolling in the Medicaid program as a result
928 of documented Medicaid fraud and abuse and must recommend
929 changes necessary to prevent or recover overpayments. For the
930 2001-2002 fiscal year, the agency shall prepare a report that
931 contains as much of this information as is available to it.
932 (8) A Medicaid provider shall retain medical,
933 professional, financial, and business records pertaining to
934 services and goods furnished to a Medicaid recipient and billed
935 to Medicaid for a period of 5 years after the date of furnishing
936 such services or goods. The agency <u>and its duly authorized</u>
937 <u>agents</u> may investigate, review, or analyze such records, which
938 must be made available during normal business hours. However,

939 24-hour notice must be provided if patient treatment would be
940 disrupted. The provider is responsible for furnishing to the
941 agency and its duly authorized agents, and keeping the agency
942 and its duly authorized agents informed of the location of, the
943 provider's Medicaid-related records. The authority of the agency
944 and its duly authorized agents to obtain Medicaid-related
945 records from a provider is neither curtailed nor limited during
946 a period of litigation between the agency and the provider.
947 (28) Notwithstanding other provisions of law, the agency
948 and its duly authorized agents and the Medicaid Fraud Control
949 Unit of the Department of Legal Affairs may review a provider's
950 Medicaid-related records in order to determine the total output
951 of a provider's practice to reconcile quantities of goods or
952 services billed to Medicaid against quantities of goods or
953 services used in the provider's total practice.
954 Section 15. Subsections (7), (8), and (9) are added to
955 section 430.502, Florida Statutes, to read:
956 430.502 Alzheimer's disease; memory disorder clinics and
957 day care and respite care programs.--
958 (7) The Agency for Health Care Administration and the
959 department shall seek a federal waiver to implement a Medicaid
960 home and community-based waiver targeted to persons with
961 Alzheimer's disease to test the effectiveness of Alzheimer's
962 specific interventions to delay or to avoid institutional
963 placement.
964 (8) The department shall implement the waiver program
965 specified in subsection (7). The agency and the department shall
966 ensure that providers are selected that have a history of
967 successfully serving persons with Alzheimer's disease. The

968 department and the agency shall develop specialized standards
969 for providers and services tailored to persons in the early,
970 middle, and late stages of Alzheimer's disease and designate a
971 level of care determination process and standard that is most
972 appropriate to this population. The department and the agency
973 shall include in the waiver services designed to assist the
974 caregiver in continuing to provide in-home care. The department
975 shall implement this waiver program subject to a specific
976 appropriation or as provided in the General Appropriations Act.
977 The department and the agency shall submit their program design
978 to the President of the Senate and the Speaker of the House of
979 Representatives for consultation during the development process.
980 (9) Authority to continue the waiver program specified in
981 subsection (7) shall be automatically eliminated at the close of
982 the 2008 Regular Session of the Legislature unless further
983 legislative action is taken to continue it prior to such time.
984 Section 16. Paragraph (b) of subsection (4) and paragraph
985 (a) of subsection (5) of section 624.91, Florida Statutes, are
986 amended to read:
987 624.91 The Florida Healthy Kids Corporation Act.--
988 (4) CORPORATION AUTHORIZATION, DUTIES, POWERS.--
989 (b) The Florida Healthy Kids Corporation shall:
990 1. Organize school children groups to facilitate the
991 provision of comprehensive health insurance coverage to
992 children.÷
993 2. Arrange for the collection of any family, local
994 contributions, or employer payment or premium, in an amount to
995 be determined by the board of directors, to provide for payment

996 of premiums for comprehensive insurance coverage and for the
997 actual or estimated administrative expenses.;
998 3. Arrange for the collection of any voluntary
999 contributions to provide for payment of premiums for children
1000 who are not eligible for medical assistance under Title XXI of
1001 the Social Security Act. Each fiscal year, the corporation shall
1002 establish a local match policy for the enrollment of non-Title-
1003 XXI-eligible children in the Healthy Kids program. By May 1 of
1004 each year, the corporation shall provide written notification of
1005 the amount to be remitted to the corporation for the following
1006 fiscal year under that policy. Local match sources may include,
1007 but are not limited to, funds provided by municipalities,
1008 counties, school boards, hospitals, health care providers,
1009 charitable organizations, special taxing districts, and private
1010 organizations. The minimum local match cash contributions
1011 required each fiscal year and local match credits shall be
1012 determined by the General Appropriations Act. The corporation
1013 shall calculate a county's local match rate based upon that
1014 county's percentage of the state's total non-Title-XXI
1015 expenditures as reported in the corporation's most recently
1016 audited financial statement. In awarding the local match
1017 credits, the corporation may consider factors including, but not
1018 limited to, population density, per capita income, and existing
1019 child-health-related expenditures and services.;
1020 4. Accept voluntary supplemental local match contributions
1021 that comply with the requirements of Title XXI of the Social
1022 Security Act for the purpose of providing additional coverage in
1023 contributing counties under Title XXI.;

1024 5. Establish the administrative and accounting procedures
1025 for the operation of the corporation.;
1026 6. Establish, with consultation from appropriate
1027 professional organizations, standards for preventive health
1028 services and providers and comprehensive insurance benefits
1029 appropriate to children; provided that such standards for rural
1030 areas shall not limit primary care providers to board-certified
1031 pediatricians.;
1032 7. Establish eligibility criteria which children must meet
1033 in order to participate in the program.;
1034 8. Establish procedures under which providers of local
1035 match to, applicants to and participants in the program may have
1036 grievances reviewed by an impartial body and reported to the
1037 board of directors of the corporation.;
1038 9. Establish participation criteria and, if appropriate,
1039 contract with an authorized insurer, health maintenance
1040 organization, or insurance administrator to provide
1041 administrative services to the corporation.;
1042 10. Establish enrollment criteria which shall include
1043 penalties or waiting periods of not fewer than 60 days for
1044 reinstatement of coverage upon voluntary cancellation for
1045 nonpayment of family premiums.;
1046 11. If a space is available, establish a special open
1047 enrollment period of 30 days' duration for any child who is
1048 enrolled in Medicaid or Medikids if such child loses Medicaid or
1049 Medikids eligibility and becomes eligible for the Florida
1050 Healthy Kids program.;
1051 12. Contract with authorized insurers or any provider of
1052 health care services, meeting standards established by the

1053 corporation, for the provision of comprehensive insurance
1054 coverage to participants.
1055 a. Such standards shall include criteria under which the
1056 corporation may contract with more than one provider of health
1057 care services in program sites. Health plans shall be selected
1058 through a competitive bid process that utilizes as the maximum
1059 payable rate the current Medicaid reimbursement being paid by
1060 the Agency for Health Care Administration to its managed care
1061 plans for the same age population, risk-adjusted for the Healthy
1062 Kids population and adjusted for enrollee demographics, services
1063 covered by the proposed rate, utilization, and inflation.
1064 Healthy Kids shall neither enter a contract nor renew a contract
1065 that has administrative costs greater than 15 percent.
1066 b. Enrollees shall be enrolled with the selected health
1067 plan or plans in their county. If no qualified bidder submits a
1068 proposal utilizing the rate, then enrollees in the Healthy Kids
1069 program may receive services through the Medikids program. If
1070 the corporation delivers services through the Medikids option,
1071 the corporation shall establish an appropriate level of reserves
1072 in which to pay claims. The amount of the reserves shall be
1073 appropriate for the number of enrollees accessing services
1074 through this option and will be actuarially reviewed for
1075 soundness and approved by the Department of Financial Services.
1076 c. Implementation of the process described in sub-
1077 subparagraphs a. and b. shall begin on July 1, 2003, or at
1078 renewal of each insurer's current contract, but shall be
1079 completed statewide no later than September 30, 2004. The term
1080 "renewal" includes contract options and option years.

1081 d. Dental services shall be provided to Healthy Kids
1082 enrollees using the administrative structure and provider
1083 network of the Medicaid program ~~The selection of health plans~~
1084 ~~shall be based primarily on quality criteria established by the~~
1085 ~~board~~.
1086
1087 The health plan selection criteria and scoring system, and the
1088 scoring results, shall be available upon request for inspection
1089 after the bids have been awarded.~~;~~
1090 13. Establish disenrollment criteria in the event local
1091 matching funds are insufficient to cover enrollments.~~;~~
1092 14. Develop and implement a plan to publicize the Florida
1093 Healthy Kids Corporation, the eligibility requirements of the
1094 program, and the procedures for enrollment in the program and to
1095 maintain public awareness of the corporation and the program.~~;~~
1096 15. Secure staff necessary to properly administer the
1097 corporation. Staff costs shall be funded from state and local
1098 matching funds and such other private or public funds as become
1099 available. The board of directors shall determine the number of
1100 staff members necessary to administer the corporation.~~;~~
1101 16. As appropriate, enter into contracts with local school
1102 boards or other agencies to provide onsite information,
1103 enrollment, and other services necessary to the operation of the
1104 corporation.~~;~~
1105 17. Provide a report annually to the Governor, Chief
1106 Financial Officer, Commissioner of Education, Senate President,
1107 Speaker of the House of Representatives, and Minority Leaders of
1108 the Senate and the House of Representatives.~~;~~

1109 18. Each fiscal year, establish a maximum number of
1110 participants, on a statewide basis, who may enroll in the
1111 program.~~; and~~
1112 19. Establish eligibility criteria, premium and cost-
1113 sharing requirements, and benefit packages which conform to the
1114 provisions of the Florida Kidcare program, as created in ss.
1115 409.810-409.820.
1116 (5) BOARD OF DIRECTORS.--
1117 (a) The Florida Healthy Kids Corporation shall operate
1118 subject to the supervision and approval of a board of directors
1119 chaired by the Chief Financial Officer or her or his designee,
1120 and composed of 6 ~~14~~ other members selected for 3-year terms of
1121 office as follows:
1122 1. One member, appointed by the Chief Financial Officer,
1123 who represents the Office of Insurance Regulation. ~~Commissioner~~
1124 ~~of Education from among three persons nominated by the Florida~~
1125 ~~Association of School Administrators;~~
1126 ~~2. One member appointed by the Commissioner of Education~~
1127 ~~from among three persons nominated by the Florida Association of~~
1128 ~~School Boards;~~
1129 ~~3. One member appointed by the Commissioner of Education~~
1130 ~~from the Office of School Health Programs of the Florida~~
1131 ~~Department of Education;~~
1132 ~~4. One member appointed by the Governor from among three~~
1133 ~~members nominated by the Florida Pediatric Society;~~
1134 2.~~5.~~ One member, appointed by the Governor, who represents
1135 the Children's Medical Services Program and the Department of
1136 Health.~~;~~

1137 ~~6. One member appointed by the Chief Financial Officer~~
1138 ~~from among three members nominated by the Florida Hospital~~
1139 ~~Association;~~
1140 ~~7. Two members, appointed by the Chief Financial Officer,~~
1141 ~~who are representatives of authorized health care insurers or~~
1142 ~~health maintenance organizations;~~
1143 3.~~8.~~ One member, appointed by the Chief Financial Officer,
1144 who represents the Institute for Child Health Policy.~~;~~
1145 ~~9. One member, appointed by the Governor, from among three~~
1146 ~~members nominated by the Florida Academy of Family Physicians;~~
1147 4.~~10.~~ One member, appointed by the Governor, who
1148 represents the Agency for Health Care Administration.~~;~~
1149 5.~~11.~~ One member, appointed by the Chief Financial
1150 Officer, from among three members nominated by the Florida
1151 Association of Counties, representing rural counties.~~;~~
1152 6.~~12.~~ One member, appointed by the Governor, from among
1153 three members nominated by the Florida Association of Counties,
1154 representing urban counties.~~; and~~
1155 ~~13. The State Health Officer or her or his designee.~~
1156 Section 17. The provisions of this act which would require
1157 changes to the contracts in existence on June 30, 2003, between
1158 the Florida Healthy Kids Corporation and its contracted
1159 providers shall be applied to such contracts upon the renewal of
1160 the contracts, but no later than September 30, 2004. The term
1161 "renewal" includes contract options and option years.
1162 Section 18. Section 57 of chapter 98-288, Laws of Florida,
1163 is repealed.
1164 Section 19. If any law amended by this act was also
1165 amended by a law enacted at the 2003 Regular Session of the

1166 Legislature, such laws shall be construed as if they had been
1167 enacted at the same session of the Legislature, and full effect
1168 shall be given to each if possible.
1169 Section 20. Except as otherwise provided herein, this act
1170 shall take effect July 1, 2003.
1171
1172 ================ T I T L E A M E N D M E N T ================
1173 Remove the entire title, and insert:
1174 A bill to be entitled
1175 An act relating to health care; amending s. 400.179, F.S.;
1176 retaining a fee against leasehold licensees to meet
1177 bonding requirements to cover Medicaid underpayments and
1178 overpayments; amending s. 409.811, F.S.; defining "managed
1179 care plan" for purposes of the Florida Kidcare Act;
1180 amending s. 409.8132, F.S.; providing a cross reference;
1181 amending s. 409.901, F.S.; revising the definition of
1182 "third party"; amending s. 409.904, F.S.; revising
1183 eligibility requirements for certain optional payments for
1184 medical assistance and related services; amending s.
1185 409.906, F.S.; revising requirements for payment of
1186 optional Medicaid services; limiting provision of dental,
1187 hearing, and visual services; amending s. 409.9081, F.S.;
1188 providing coinsurance requirements for prescription drugs;
1189 providing copayment requirements for hospital outpatient
1190 emergency department services; amending s. 409.911, F.S.;
1191 revising formulas for payment under the disproportionate
1192 share program; revising definitions; providing for use of
1193 audited data; amending s. 409.9112, F.S.; revising
1194 formulas for payment under the disproportionate share

1195 program for regional perinatal intensive care centers;
1196 amending s. 409.9117, F.S.; revising formulas for payment
1197 under the primary care disproportionate share program;
1198 revising criteria for such payments; amending s. 409.9119,
1199 F.S.; revising criteria for payment under the
1200 disproportionate share program for specialty hospitals for
1201 children; amending s. 409.912, F.S.; providing for the
1202 Agency for Health Care Administration to contract with a
1203 service network; deleting provisions for service network
1204 demonstration projects; providing for contracting to
1205 provide Medicaid covered dental services; amending s.
1206 409.9122, F.S.; revising provisions for assignment to a
1207 managed care plan by the agency; amending s. 409.913,
1208 F.S.; providing for oversight of Medicaid by authorized
1209 agents of the Agency for Health Care Administration;
1210 amending s. 430.502, F.S.; requiring the Agency for Health
1211 Care Administration and the Department of Elderly Affairs
1212 to seek and implement a Medicaid home and community-based
1213 waiver for persons with Alzheimer's disease; requiring the
1214 development of waiver program standards; providing for
1215 consultation with the presiding officers of the
1216 Legislature; providing for a contingent future repeal of
1217 such waiver program; amending s. 624.91, F.S.; revising
1218 duties of the Florida Healthy Kids Corporation; revising
1219 membership of the board of directors of the corporation;
1220 providing for application of the act to existing contracts
1221 between the Florida Healthy Kids Corporation and its
1222 contracted providers; repealing s. 57, ch. 98-288, Laws of
1223 Florida, relating to future review and repeal of the

1224 "Florida Kidcare Act" based on specified changes in
1225 federal policy; providing for construction of the act in
1226 pari materia with laws enacted during the Regular Session
1227 of the Legislature; providing effective dates.