

1 A bill to be entitled
2 An act relating to health care; amending s.
3 400.179, F.S.; deleting a repeal of provisions
4 requiring payment of certain fees upon the
5 transfer of the leasehold license for a nursing
6 facility; amending s. 400.23, F.S.; delaying
7 the effective date of certain requirements
8 concerning hours of direct care per resident
9 for nursing home facilities; amending ss.
10 400.452 and 400.6211, F.S.; revising training
11 requirements for administrators and staff of
12 assisted living facilities and adult
13 family-care home providers; requiring a
14 competency test; providing rulemaking
15 authority; amending s. 408.909, F.S., relating
16 to health flex plans; revising eligibility for
17 the plan; extending the expiration date of the
18 program; amending s. 409.815, F.S., relating to
19 benefits coverage under the Medicaid program;
20 specifying a maximum annual benefit for
21 children's dental services; amending s.
22 409.901, F.S.; defining the term "third party"
23 to include a third-party administrator or
24 pharmacy benefits manager; amending s. 409.904,
25 F.S.; revising provisions governing the payment
26 of optional medical benefits for certain
27 Medicaid-eligible persons; amending s. 409.906,
28 F.S.; revising requirements for hearing and
29 visual services to limit such services to
30 persons younger than 21 years of age; amending
31 s. 409.9065, F.S.; revising the pharmaceutical

1 expense assistance program for low-income
2 elderly individuals; adding eligibility groups;
3 providing benefits; requiring the Agency for
4 Health Care Administration, in administering
5 the program, to collaborate with both the
6 Department of Elderly Affairs and the
7 Department of Children and Family Services;
8 requiring federal approval of benefits;
9 amending s. 409.908, F.S., relating to
10 reimbursement of Medicaid providers; providing
11 for a fee to be paid to providers returning
12 unused medications and credited to the Medicaid
13 program; amending s. 409.9081, F.S.; providing
14 a copayment under the Medicaid program for
15 certain nonemergency hospital visits; providing
16 coinsurance of a specified amount for the
17 Medicaid cost of prescription drugs; amending
18 ss. 409.911, 409.9112, 409.9116, and 409.9117,
19 F.S.; revising the disproportionate share
20 program; deleting definitions; requiring the
21 Agency for Health Care Administration to use
22 actual audited data to determine the Medicaid
23 days and charity care to be used to calculate
24 the disproportionate share payment; revising
25 formulas for calculating payments; revising the
26 formula for calculating payments under the
27 disproportionate share program for regional
28 perinatal intensive care centers; providing for
29 estimates of the payments under the rural
30 disproportionate share and financial assistance
31 programs; providing a formula for calculating

1 payments under the primary care
2 disproportionate share program; amending s.
3 409.9119, F.S., relating to disproportionate
4 share program for specialty hospitals for
5 children; providing that payments are subject
6 to appropriations; amending s. 409.912, F.S.;
7 providing for reimbursement of provider service
8 networks; authorizing the agency to implement a
9 utilization management program for certain
10 services and contract for certain dental
11 services; amending s. 409.9122, F.S.; revising
12 the percentage of Medicaid recipients required
13 to be enrolled in managed care; revising
14 requirements for the enrollment process;
15 creating s. 430.83, F.S.; providing a popular
16 name; providing definitions; providing
17 legislative findings and intent; creating the
18 Sunshine for Seniors Program to assist
19 low-income seniors with obtaining prescription
20 drugs from manufacturers' pharmaceutical
21 assistance programs; providing implementation
22 and oversight duties of the Department of
23 Elderly Affairs; providing for community
24 partnerships; providing for contracts;
25 requiring annual evaluation reports on the
26 program; specifying that the program is not an
27 entitlement; amending s. 624.91, F.S., relating
28 to the Florida Healthy Kids Corporation Act;
29 providing for funding to be subject to specific
30 appropriations; providing contract
31 requirements; revising membership of the board

1 of directors of the corporation; repealing s.
2 57 of chapter 98-288, Laws of Florida;
3 abrogating a repeal of the Florida Kidcare Act;
4 authorizing the Agency for Health Care
5 Administration to make additional payments to
6 certain hospitals; specifying the amounts and
7 providing for adjustments; providing for
8 construction of the act in pari materia with
9 laws enacted during the Regular Session of the
10 Legislature; providing an effective date.

11
12 Be It Enacted by the Legislature of the State of Florida:

13
14 Section 1. Effective upon this act becoming a law,
15 paragraph (d) of subsection (5) of section 400.179, Florida
16 Statutes, is amended to read:

17 400.179 Sale or transfer of ownership of a nursing
18 facility; liability for Medicaid underpayments and
19 overpayments.--

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

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

28 1. The transferee shall, as a condition to being
29 issued a license by the agency, acquire, maintain, and provide
30 proof to the agency of a bond with a term of 30 months,
31 renewable annually, in an amount not less than the total of 3

1 months Medicaid payments to the facility computed on the basis
2 of the preceding 12-month average Medicaid payments to the
3 facility.

4 2. A leasehold licensee may meet the requirements of
5 subparagraph 1. by payment of a nonrefundable fee, paid at
6 initial licensure, paid at the time of any subsequent change
7 of ownership, and paid at the time of any subsequent annual
8 license renewal, in the amount of 2 percent of the total of 3
9 months' Medicaid payments to the facility computed on the
10 basis of the preceding 12-month average Medicaid payments to
11 the facility. If a preceding 12-month average is not
12 available, projected Medicaid payments may be used. The fee
13 shall be deposited into the Health Care Trust Fund and shall
14 be accounted for separately as a Medicaid nursing home
15 overpayment account. These fees shall be used at the sole
16 discretion of the agency to repay nursing home Medicaid
17 overpayments. Payment of this fee shall not release the
18 licensee from any liability for any Medicaid overpayments, nor
19 shall payment bar the agency from seeking to recoup
20 overpayments from the licensee and any other liable party. As
21 a condition of exercising this lease bond alternative,
22 licensees paying this fee must maintain an existing lease bond
23 through the end of the 30-month term period of that bond. The
24 agency is herein granted specific authority to promulgate all
25 rules pertaining to the administration and management of this
26 account, including withdrawals from the account, subject to
27 federal review and approval. ~~This subparagraph is repealed on~~
28 ~~June 30, 2003.~~This provision shall take effect upon becoming
29 law and shall apply to any leasehold license application.

30 a. The financial viability of the Medicaid nursing
31 home overpayment account shall be determined by the agency

1 through annual review of the account balance and the amount of
2 total outstanding, unpaid Medicaid overpayments owing from
3 leasehold licensees to the agency as determined by final
4 agency audits.

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

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

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

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

29 6. Any failure of the nursing facility operator to
30 acquire, maintain, renew annually, or provide proof to the
31 agency shall be grounds for the agency to deny, cancel,

1 revoke, or suspend the facility license to operate such
2 facility and to take any further action, including, but not
3 limited to, enjoining the facility, asserting a moratorium, or
4 applying for a receiver, deemed necessary to ensure compliance
5 with this section and to safeguard and protect the health,
6 safety, and welfare of the facility's residents. A lease
7 agreement required as a condition of bond financing or
8 refinancing under s. 154.213 by a health facilities authority
9 or required under s. 159.30 by a county or municipality is not
10 a leasehold for purposes of this paragraph and is not subject
11 to the bond requirement of this paragraph.

12 Section 2. Paragraph (a) of subsection (3) of section
13 400.23, Florida Statutes, as amended by chapter 2003-1, Laws
14 of Florida, is amended to read:

15 400.23 Rules; evaluation and deficiencies; licensure
16 status.--

17 (3)(a) The agency shall adopt rules providing for the
18 minimum staffing requirements for nursing homes. These
19 requirements shall include, for each nursing home facility, a
20 minimum certified nursing assistant staffing of 2.3 hours of
21 direct care per resident per day beginning January 1, 2002,
22 increasing to 2.6 hours of direct care per resident per day
23 beginning January 1, 2003, and increasing to 2.9 hours of
24 direct care per resident per day beginning May ~~January~~ 1,
25 2004. Beginning January 1, 2002, no facility shall staff below
26 one certified nursing assistant per 20 residents, and a
27 minimum licensed nursing staffing of 1.0 hour of direct
28 resident care per resident per day but never below one
29 licensed nurse per 40 residents. Nursing assistants employed
30 under s. 400.211(2) may be included in computing the staffing
31 ratio for certified nursing assistants only if they provide

1 nursing assistance services to residents on a full-time basis.
2 Each nursing home must document compliance with staffing
3 standards as required under this paragraph and post daily the
4 names of staff on duty for the benefit of facility residents
5 and the public. The agency shall recognize the use of licensed
6 nurses for compliance with minimum staffing requirements for
7 certified nursing assistants, provided that the facility
8 otherwise meets the minimum staffing requirements for licensed
9 nurses and that the licensed nurses so recognized are
10 performing the duties of a certified nursing assistant. Unless
11 otherwise approved by the agency, licensed nurses counted
12 towards the minimum staffing requirements for certified
13 nursing assistants must exclusively perform the duties of a
14 certified nursing assistant for the entire shift and shall not
15 also be counted towards the minimum staffing requirements for
16 licensed nurses. If the agency approved a facility's request
17 to use a licensed nurse to perform both licensed nursing and
18 certified nursing assistant duties, the facility must allocate
19 the amount of staff time specifically spent on certified
20 nursing assistant duties for the purpose of documenting
21 compliance with minimum staffing requirements for certified
22 and licensed nursing staff. In no event may the hours of a
23 licensed nurse with dual job responsibilities be counted
24 twice.

25 Section 3. Section 400.452, Florida Statutes, is
26 amended to read:

27 400.452 Staff training and educational programs; core
28 educational requirement.--

29 ~~(1) The department shall provide, or cause to be~~
30 ~~provided, training and educational programs for the~~
31 Administrators and other assisted living facility staff must

1 meet minimum training and education requirements established
2 by the Department of Elderly Affairs by rule. This training
3 and education is intended to assist facilities to better
4 ~~enable them~~ to appropriately respond to the needs of
5 residents, to maintain resident care and facility standards,
6 and to meet licensure requirements.

7 (2) The department shall ~~also~~ establish a competency
8 test and a minimum required score to indicate successful
9 completion of the training and ~~core~~ educational requirements
10 ~~requirement to be used in these programs. The competency test~~
11 must be developed by the department in conjunction with the
12 agency and providers. Successful completion of the core
13 ~~educational requirement must include successful completion of~~
14 ~~a competency test. Programs must be provided by the department~~
15 ~~or by a provider approved by the department at least~~
16 ~~quarterly. The required training and education core~~
17 ~~educational requirement must cover at least the following~~
18 topics:

19 (a) State law and rules relating to assisted living
20 facilities.

21 (b) Resident rights and identifying and reporting
22 abuse, neglect, and exploitation.

23 (c) Special needs of elderly persons, persons with
24 mental illness, and persons with developmental disabilities
25 and how to meet those needs.

26 (d) Nutrition and food service, including acceptable
27 sanitation practices for preparing, storing, and serving food.

28 (e) Medication management, recordkeeping, and proper
29 techniques for assisting residents with self-administered
30 medication.

31

1 (f) Firesafety requirements, including fire evacuation
2 drill procedures and other emergency procedures.

3 (g) Care of persons with Alzheimer's disease and
4 related disorders.

5 (3) Effective January 1, 2004,~~Such a program must be~~
6 ~~available at least quarterly in each planning and service area~~
7 ~~of the department. The competency test must be developed by~~
8 ~~the department in conjunction with the agency and providers. a~~
9 ~~new facility administrator must complete the required training~~
10 ~~and education, core educational requirement including the~~
11 ~~competency test, within a reasonable time ~~3 months~~ after being~~
12 ~~employed as an administrator, as determined by the department.~~

13 Failure to do so ~~complete a core educational requirement~~
14 ~~specified in this subsection~~ is a violation of this part and
15 subjects the violator to an administrative fine as prescribed
16 in s. 400.419. Administrators licensed in accordance with
17 chapter 468, part II, are exempt from this requirement. Other
18 licensed professionals may be exempted, as determined by the
19 department by rule.

20 (4) Administrators are required to participate in
21 continuing education for a minimum of 12 contact hours every 2
22 years.

23 (5) Staff involved with the management of medications
24 and assisting with the self-administration of medications
25 under s. 400.4256 must complete a minimum of 4 additional
26 hours of training ~~pursuant to a curriculum developed by the~~
27 ~~department and provided by a registered nurse, licensed~~
28 ~~pharmacist, or department staff. The department shall~~
29 ~~establish by rule the minimum requirements of this additional~~
30 ~~training.~~

31

1 (6) Other facility staff shall participate in training
2 relevant to their job duties as specified by rule of the
3 department.

4 ~~(7) A facility that does not have any residents who
5 receive monthly optional supplementation payments must pay a
6 reasonable fee for such training and education programs. A
7 facility that has one or more such residents shall pay a
8 reduced fee that is proportional to the percentage of such
9 residents in the facility. Any facility more than 90 percent
10 of whose residents receive monthly optional state
11 supplementation payments is not required to pay for the
12 training and continuing education programs required under this
13 section.~~

14 (7)(8) If the department or the agency determines that
15 there are problems in a facility that could be reduced through
16 specific staff training or education beyond that already
17 required under this section, the department or the agency may
18 require, and provide, or cause to be provided, the training or
19 education of any personal care staff in the facility.

20 ~~(8)(9) The department shall adopt rules related to
21 these establish training programs, standards and curriculum
22 for training, staff training requirements, the competency
23 test, necessary procedures for approving training programs,
24 and competency test training fees.~~

25 Section 4. Section 400.6211, Florida Statutes, is
26 amended to read:

27 400.6211 Training and education programs.--

28 (1) Each adult family-care home provider shall
29 complete ~~The department must provide~~ training and education
30 programs for all adult family-care home providers.
31

1 (2) Training and education programs must include
2 information relating to:

3 (a) State law and rules governing adult family-care
4 homes, with emphasis on appropriateness of placement of
5 residents in an adult family-care home.

6 (b) Identifying and reporting abuse, neglect, and
7 exploitation.

8 (c) Identifying and meeting the special needs of
9 disabled adults and frail elders.

10 (d) Monitoring the health of residents, including
11 guidelines for prevention and care of pressure ulcers.

12 (3) Effective January 1, 2004, providers must complete
13 the training and education program within a reasonable time
14 determined by the department. Failure to complete the training
15 and education program within the time set by the department is
16 a violation of this part and subjects the provider to
17 revocation of the license.

18 (4) If the Department of Children and Family Services,
19 the agency, or the department determines that there are
20 problems in an adult family-care home which could be reduced
21 through specific training or education beyond that required
22 under this section, the agency may require the provider or
23 staff to complete such training or education.

24 (5) The department may adopt rules ~~shall specify by~~
25 ~~rule training and education programs, training requirements~~
26 ~~and the assignment of training responsibilities for staff,~~
27 ~~training procedures, and training fees~~ as necessary to
28 administer this section.

29 Section 5. Paragraph (e) of subsection (2) and
30 subsection (10) of section 408.909, Florida Statutes, are
31 amended to read:

1 408.909 Health flex plans.--

2 (2) DEFINITIONS.--As used in this section, the term:

3 (e) "Health flex plan" means a health plan approved
4 under subsection (3) which guarantees payment for specified
5 health care coverage provided to the enrollee who purchases
6 coverage directly from the plan or through a small business
7 purchasing arrangement sponsored by a local government.

8 (10) EXPIRATION.--This section expires July 1, 2008
9 ~~2004~~.

10 Section 6. Paragraph (q) of subsection (2) of section
11 409.815, Florida Statutes, as amended by chapter 2003-1, Laws
12 of Florida, is amended to read:

13 409.815 Health benefits coverage; limitations.--

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

20 (q) Dental services.--~~Subject to a specific~~
21 ~~appropriation for this benefit,~~Covered services include those
22 dental services provided to children by the Florida Medicaid
23 program under s. 409.906(5), up to a maximum benefit of \$750
24 per enrollee per year.

25 Section 7. Subsection (25) of section 409.901, Florida
26 Statutes, is amended to read:

27 409.901 Definitions; ss. 409.901-409.920.--As used in
28 ss. 409.901-409.920, except as otherwise specifically
29 provided, the term:

30 (25) "Third party" means an individual, entity, or
31 program, excluding Medicaid, that is, may be, could be, should

1 be, or has been liable for all or part of the cost of medical
 2 services related to any medical assistance covered by
 3 Medicaid. A third party includes a third-party administrator
 4 or a pharmacy benefits manager.

5 Section 8. Subsection (2) of section 409.904, Florida
 6 Statutes, as amended by section 1 of chapter 2003-9, Laws of
 7 Florida, is amended to read:

8 409.904 Optional payments for eligible persons.--The
 9 agency may make payments for medical assistance and related
 10 services on behalf of the following persons who are determined
 11 to be eligible subject to the income, assets, and categorical
 12 eligibility tests set forth in federal and state law. Payment
 13 on behalf of these Medicaid eligible persons is subject to the
 14 availability of moneys and any limitations established by the
 15 General Appropriations Act or chapter 216.

16 (2) A family caretaker relative or parent, a pregnant
 17 woman, a child under age 21 ~~19 who would otherwise qualify for~~
 18 ~~Florida Kidcare Medicaid, a child up to age 21 who would~~
 19 ~~otherwise qualify under s. 409.903(1)~~, a person age 65 or
 20 over, or a blind or disabled person, who would ~~otherwise~~ be
 21 eligible under any group listed in s. 409.903(1), (2), or (3)
 22 ~~for Florida Medicaid~~, except that the income or assets of such
 23 family or person exceed established limitations. For a family
 24 or person in one of these coverage groups, medical expenses
 25 are deductible from income in accordance with federal
 26 requirements in order to make a determination of eligibility.
 27 ~~Expenses used to meet spend-down liability are not~~
 28 ~~reimbursable by Medicaid. Effective July 1, 2003, when~~
 29 ~~determining the eligibility of a pregnant woman, a child, or~~
 30 ~~an aged, blind, or disabled individual, \$270 shall be deducted~~
 31 ~~from the countable income of the filing unit. When determining~~

1 ~~the eligibility of the parent or caretaker relative as defined~~
2 ~~by Title XIX of the Social Security Act, the additional income~~
3 ~~disregard of \$270 does not apply.~~A family or person eligible
4 under the coverage known as the "medically needy," is eligible
5 to receive the same services as other Medicaid recipients,
6 with the exception of services in skilled nursing facilities
7 and intermediate care facilities for the developmentally
8 disabled.

9 Section 9. Subsections (12) and (23) of section
10 409.906, Florida Statutes, are amended to read:

11 409.906 Optional Medicaid services.--Subject to
12 specific appropriations, the agency may make payments for
13 services which are optional to the state under Title XIX of
14 the Social Security Act and are furnished by Medicaid
15 providers to recipients who are determined to be eligible on
16 the dates on which the services were provided. Any optional
17 service that is provided shall be provided only when medically
18 necessary and in accordance with state and federal law.
19 Optional services rendered by providers in mobile units to
20 Medicaid recipients may be restricted or prohibited by the
21 agency. Nothing in this section shall be construed to prevent
22 or limit the agency from adjusting fees, reimbursement rates,
23 lengths of stay, number of visits, or number of services, or
24 making any other adjustments necessary to comply with the
25 availability of moneys and any limitations or directions
26 provided for in the General Appropriations Act or chapter 216.
27 If necessary to safeguard the state's systems of providing
28 services to elderly and disabled persons and subject to the
29 notice and review provisions of s. 216.177, the Governor may
30 direct the Agency for Health Care Administration to amend the
31 Medicaid state plan to delete the optional Medicaid service

1 known as "Intermediate Care Facilities for the Developmentally
2 Disabled." Optional services may include:

3 (12) CHILDREN'S HEARING SERVICES.--The agency may pay
4 for hearing and related services, including hearing
5 evaluations, hearing aid devices, dispensing of the hearing
6 aid, and related repairs, if provided to a recipient younger
7 than 21 years of age by a licensed hearing aid specialist,
8 otolaryngologist, otologist, audiologist, or physician.

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

14 Section 10. Section 409.9065, Florida Statutes, is
15 amended to read:

16 409.9065 Pharmaceutical expense assistance.--

17 (1) PROGRAM ESTABLISHED.--There is established a
18 program to provide pharmaceutical expense assistance to
19 eligible ~~certain~~ low-income elderly individuals, which shall
20 be known as the "Ron Silver Senior Drug Program" and may be
21 referred to as the "Lifesaver Rx Program."

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

29 (a) Are Florida residents age 65 and over;

30 (b) Have an income equal to or less than 200 percent
31 of the federal poverty level;±

- 1 1. ~~Between 88 and 120 percent of the federal poverty~~
 2 ~~level;~~
- 3 2. ~~Between 88 and 150 percent of the federal poverty~~
 4 ~~level if the Federal Government increases the federal Medicaid~~
 5 ~~match for persons between 100 and 150 percent of the federal~~
 6 ~~poverty level; or~~
- 7 3. ~~Between 88 percent of the federal poverty level and~~
 8 ~~a level that can be supported with funds provided in the~~
 9 ~~General Appropriations Act for the program offered under this~~
 10 ~~section along with federal matching funds approved by the~~
 11 ~~Federal Government under a s. 1115 waiver. The agency is~~
 12 ~~authorized to submit and implement a federal waiver pursuant~~
 13 ~~to this subparagraph. The agency shall design a pharmacy~~
 14 ~~benefit that includes annual per-member benefit limits and~~
 15 ~~cost-sharing provisions and limits enrollment to available~~
 16 ~~appropriations and matching federal funds. Prior to~~
 17 ~~implementing this program, the agency must submit a budget~~
 18 ~~amendment pursuant to chapter 216;~~
- 19 (c) ~~Are eligible for both Medicare and Medicaid;~~
- 20 (d) Have exhausted pharmacy benefits under Medicare,
 21 Medicaid, or any other insurance plan ~~Are not enrolled in a~~
 22 ~~Medicare health maintenance organization that provides a~~
 23 ~~pharmacy benefit; and~~
- 24 (e) Request to be enrolled in the program.
- 25 (3) BENEFITS.--Eligible individuals shall receive a
 26 discount for prescription drugs ~~Medications covered under the~~
 27 ~~pharmaceutical expense assistance program are those covered~~
 28 ~~under the Medicaid program in s. 409.906(20)(19). Monthly~~
 29 ~~benefit payments shall be limited to \$80 per program~~
 30 ~~participant. Participants are required to make a 10-percent~~
 31

1 ~~coinsurance payment for each prescription purchased through~~
2 ~~this program.~~

3 (a) Eligible individuals with incomes equal to or less
4 than 120 percent of the federal poverty level shall receive a
5 discount of 100 percent for the first \$160 worth of
6 prescription drugs they receive each month, subject to
7 copayments that the agency requires on these benefits. For all
8 other prescription drugs received each month, eligible
9 individuals shall receive a discount of 50 percent.

10 (b) Eligible individuals with incomes of more than 120
11 percent but not more than 150 percent of the federal poverty
12 level shall receive a discount of 50 percent.

13 (c) Eligible individuals with incomes of more than 150
14 percent but not more than 175 percent of the federal poverty
15 level shall receive a discount of 41 percent.

16 (d) Eligible individuals with incomes of more than 175
17 percent but not more than 200 percent of the federal poverty
18 level shall receive a discount of 37 percent.

19 (4) ADMINISTRATION.--The pharmaceutical expense
20 assistance program shall be administered by the agency for
21 ~~Health Care Administration~~, in collaboration ~~consultation~~ with
22 the Department of Elderly Affairs and the Department of
23 Children and Family Services.

24 ~~(a) The Agency for Health Care Administration and the~~
25 ~~Department of Elderly Affairs shall develop a single-page~~
26 ~~application for the pharmaceutical expense assistance program.~~

27 ~~(a)(b)~~ The agency for Health Care Administration
28 shall, by rule, establish for the pharmaceutical expense
29 assistance program eligibility requirements; limits on
30 participation; ~~benefit limitations,~~ including copayments;
31 a requirement for generic drug substitution; ~~and other program~~

1 parameters comparable to those of the Medicaid program.
2 Individuals eligible to participate in this program are not
3 subject to the limit of four brand name drugs per month per
4 recipient as specified in s. 409.912(38)(a). There shall be no
5 monetary limit on prescription drugs purchased with discounts
6 of less than 51 percent unless the agency determines there is
7 a risk of a funding shortfall in the program. If the agency
8 determines there is a risk of a funding shortfall, the agency
9 may establish monetary limits on prescription drugs which
10 shall not be less than \$160 worth of prescription drugs per
11 month.

12 (b)(c) By January 1 of each year, the agency for
13 ~~Health Care Administration~~ shall report to the Legislature on
14 the operation of the program. The report shall include
15 information on the number of individuals served, use rates,
16 and expenditures under the program. The report shall also
17 address the impact of the program on reducing unmet
18 pharmaceutical drug needs among the elderly and recommend
19 programmatic changes.

20 (5) NONENTITLEMENT.--The pharmaceutical expense
21 assistance program established by this section is not an
22 entitlement. Enrollment levels are limited to those authorized
23 by the Legislature in the annual General Appropriations Act.
24 If, after establishing monetary limits as required by
25 paragraph (4)(a), funds are insufficient to serve all eligible
26 individuals ~~eligible under subsection (2) and seeking~~
27 coverage, the agency may develop a waiting list based on
28 application dates to use in enrolling individuals in unfilled
29 enrollment slots.

30
31

1 (6) PHARMACEUTICAL MANUFACTURER PARTICIPATION.--In
2 order for a drug product to be covered under Medicaid or this
3 program, the product's manufacturer shall:

4 (a) Provide a rebate to the state equal to the rebate
5 required by the Medicaid program; and

6 (b) Make the drug product available to the program for
7 the best price that the manufacturer makes the drug product
8 available in the Medicaid program.

9 (7) REIMBURSEMENT.--Total reimbursements to pharmacies
10 participating in the pharmaceutical expense assistance program
11 established under this section shall be equivalent to
12 reimbursements under the Medicaid program.

13 (8) FEDERAL APPROVAL.--The benefits provided in this
14 section are limited to those approved by the Federal
15 Government pursuant to a Medicaid waiver or an amendment to
16 the state Medicaid plan.

17 Section 11. Subsection (14) of section 409.908,
18 Florida Statutes, is amended to read:

19 409.908 Reimbursement of Medicaid providers.--Subject
20 to specific appropriations, the agency shall reimburse
21 Medicaid providers, in accordance with state and federal law,
22 according to methodologies set forth in the rules of the
23 agency and in policy manuals and handbooks incorporated by
24 reference therein. These methodologies may include fee
25 schedules, reimbursement methods based on cost reporting,
26 negotiated fees, competitive bidding pursuant to s. 287.057,
27 and other mechanisms the agency considers efficient and
28 effective for purchasing services or goods on behalf of
29 recipients. If a provider is reimbursed based on cost
30 reporting and submits a cost report late and that cost report
31 would have been used to set a lower reimbursement rate for a

1 rate semester, then the provider's rate for that semester
2 shall be retroactively calculated using the new cost report,
3 and full payment at the recalculated rate shall be affected
4 retroactively. Medicare-granted extensions for filing cost
5 reports, if applicable, shall also apply to Medicaid cost
6 reports. Payment for Medicaid compensable services made on
7 behalf of Medicaid eligible persons is subject to the
8 availability of moneys and any limitations or directions
9 provided for in the General Appropriations Act or chapter 216.
10 Further, nothing in this section shall be construed to prevent
11 or limit the agency from adjusting fees, reimbursement rates,
12 lengths of stay, number of visits, or number of services, or
13 making any other adjustments necessary to comply with the
14 availability of moneys and any limitations or directions
15 provided for in the General Appropriations Act, provided the
16 adjustment is consistent with legislative intent.

17 (14) A provider of prescribed drugs shall be
18 reimbursed the least of the amount billed by the provider, the
19 provider's usual and customary charge, or the Medicaid maximum
20 allowable fee established by the agency, plus a dispensing
21 fee. The agency is directed to implement a variable dispensing
22 fee for payments for prescribed medicines while ensuring
23 continued access for Medicaid recipients. The variable
24 dispensing fee may be based upon, but not limited to, either
25 or both the volume of prescriptions dispensed by a specific
26 pharmacy provider, the volume of prescriptions dispensed to an
27 individual recipient, and dispensing of preferred-drug-list
28 products. The agency may ~~shall~~ increase the pharmacy
29 dispensing fee authorized by statute and in the annual General
30 Appropriations Act by \$0.50 for the dispensing of a Medicaid
31 preferred-drug-list product and reduce the pharmacy dispensing

1 fee by \$0.50 for the dispensing of a Medicaid product that is
2 not included on the preferred-drug list. The agency may
3 establish a supplemental pharmaceutical dispensing fee to be
4 paid to providers returning unused unit-dose packaged
5 medications to stock and crediting the Medicaid program for
6 the ingredient cost of those medications if the ingredient
7 costs to be credited exceed the value of the supplemental
8 dispensing fee.The agency is authorized to limit
9 reimbursement for prescribed medicine in order to comply with
10 any limitations or directions provided for in the General
11 Appropriations Act, which may include implementing a
12 prospective or concurrent utilization review program.

13 Section 12. Subsection (1) of section 409.9081,
14 Florida Statutes, is amended to read:

15 409.9081 Copayments.--

16 (1) The agency shall require, subject to federal
17 regulations and limitations, each Medicaid recipient to pay at
18 the time of service a nominal copayment for the following
19 Medicaid services:

20 (a) Hospital outpatient services: up to \$3 for each
21 hospital outpatient visit.

22 (b) Physician services: up to \$2 copayment for each
23 visit with a physician licensed under chapter 458, chapter
24 459, chapter 460, chapter 461, or chapter 463.

25 (c) Hospital emergency department visits for
26 nonemergency care: \$15 for each emergency department visit.

27 (d) Prescription drugs: a coinsurance equal to 2.5
28 percent of the Medicaid cost of the prescription drug at the
29 time of purchase. The maximum coinsurance shall be \$7.50 per
30 prescription drug purchased.

31

1 Section 13. Section 409.911, Florida Statutes, is
2 amended to read:

3 409.911 Disproportionate share program.--Subject to
4 specific allocations established within the General
5 Appropriations Act and any limitations established pursuant to
6 chapter 216, the agency shall distribute, pursuant to this
7 section, moneys to hospitals providing a disproportionate
8 share of Medicaid or charity care services by making quarterly
9 Medicaid payments as required. Notwithstanding the provisions
10 of s. 409.915, counties are exempt from contributing toward
11 the cost of this special reimbursement for hospitals serving a
12 disproportionate share of low-income patients.

13 (1) Definitions.--As used in this section, s.
14 409.9112, and the Florida Hospital Uniform Reporting System
15 manual:

16 (a) "Adjusted patient days" means the sum of acute
17 care patient days and intensive care patient days as reported
18 to the Agency for Health Care Administration, divided by the
19 ratio of inpatient revenues generated from acute, intensive,
20 ambulatory, and ancillary patient services to gross revenues.

21 (b) "Actual audited data" or "actual audited
22 experience" means data reported to the Agency for Health Care
23 Administration which has been audited in accordance with
24 generally accepted auditing standards by the agency or
25 representatives under contract with the agency.

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

1 ~~(c)(d)~~ "Charity care" or "uncompensated charity care"
 2 means that portion of hospital charges reported to the Agency
 3 for Health Care Administration for which there is no
 4 compensation, other than restricted or unrestricted revenues
 5 provided to a hospital by local governments or tax districts
 6 regardless of the method of payment, for care provided to a
 7 patient whose family income for the 12 months preceding the
 8 determination is less than or equal to 200 percent of the
 9 federal poverty level, unless the amount of hospital charges
 10 due from the patient exceeds 25 percent of the annual family
 11 income. However, in no case shall the hospital charges for a
 12 patient whose family income exceeds four times the federal
 13 poverty level for a family of four be considered charity.

14 ~~(d)(e)~~ "Charity care days" means the sum of the
 15 deductions from revenues for charity care minus 50 percent of
 16 restricted and unrestricted revenues provided to a hospital by
 17 local governments or tax districts, divided by gross revenues
 18 per adjusted patient day.

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

22 ~~(e)(g)~~ "Hospital" means a health care institution
 23 licensed as a hospital pursuant to chapter 395, but does not
 24 include ambulatory surgical centers.

25 ~~(f)(h)~~ "Medicaid days" means the number of actual days
 26 attributable to Medicaid patients as determined by the Agency
 27 for Health Care Administration.

28 (2) The Agency for Health Care Administration shall
 29 use ~~utilize~~ the following actual audited data criteria to
 30 determine the Medicaid days and charity care to be used in
 31

1 ~~calculating the if a hospital qualifies for a~~ disproportionate
 2 share payment:

3 (a) The average of the 1997, 1998, and 1999 audited
 4 data to determine each hospital's Medicaid days and charity
 5 care.

6 (b) The average of the audited disproportionate share
 7 data for the years available if the Agency for Health Care
 8 Administration does not have the prescribed 3 years of audited
 9 disproportionate share data for a hospital.

10 ~~(a) A hospital's total Medicaid days when combined~~
 11 ~~with its total charity care days must equal or exceed 7~~
 12 ~~percent of its total adjusted patient days.~~

13 ~~(b) A hospital's total charity care days weighted by a~~
 14 ~~factor of 4.5, plus its total Medicaid days weighted by a~~
 15 ~~factor of 1, shall be equal to or greater than 10 percent of~~
 16 ~~its total adjusted patient days.~~

17 ~~(c) Additionally, In accordance with s. 1923(b) of the~~
 18 ~~Social Security Act the seventh federal Omnibus Budget~~
 19 ~~Reconciliation Act, a hospital with a Medicaid inpatient~~
 20 ~~utilization rate greater than one standard deviation above the~~
 21 ~~statewide mean or a hospital with a low-income utilization~~
 22 ~~rate of 25 percent or greater shall qualify for reimbursement.~~

23 ~~(3) In computing the disproportionate share rate:~~

24 ~~(a) Per diem increases earned from disproportionate~~
 25 ~~share shall be applied to each hospital's base Medicaid per~~
 26 ~~diem rate and shall be capped at 170 percent.~~

27 ~~(b) The agency shall use 1994 audited financial data~~
 28 ~~for the calculation of disproportionate share payments under~~
 29 ~~this section.~~

30 ~~(c) If the total amount earned by all hospitals under~~
 31 ~~this section exceeds the amount appropriated, each hospital's~~

1 ~~share shall be reduced on a pro rata basis so that the total~~
 2 ~~dollars distributed from the trust fund do not exceed the~~
 3 ~~total amount appropriated.~~

4 ~~(d) The total amount calculated to be distributed~~
 5 ~~under this section shall be made in quarterly payments~~
 6 ~~subsequent to each quarter during the fiscal year.~~

7 (3)~~(4)~~ Hospitals that qualify for a disproportionate
 8 share payment solely under paragraph (2)(c) shall have their
 9 payment calculated in accordance with the following formulas:

$$10 \quad \underline{DSHP = (HMD/TMSD)*\$1 \text{ million}}$$

11
 12 Where:

13
 14 DSHP = disproportionate share hospital payment.

15 HMD = hospital Medicaid days.

16 TSD = total state Medicaid days.

$$17$$

$$18$$

$$19 \quad \text{TAA} = \text{TA} \times (1/5.5)$$

$$20 \quad \text{DSHP} = (\text{HMD}/\text{TSMD}) \times \text{TAA}$$

21
 22 ~~Where:~~

23 ~~TAA = total amount available.~~

24 ~~TA = total appropriation.~~

25 ~~DSHP = disproportionate share hospital payment.~~

26 ~~HMD = hospital Medicaid days.~~

27 ~~TSMD = total state Medicaid days.~~

28
 29 (4) The following formulas shall be used to pay
 30 disproportionate share dollars to public hospitals:

31 (a) For state mental health hospitals:

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31

DSHP = (HMD/TMDMH) * TAAMH

shall be the difference between the federal cap for Institutions for Mental Diseases and the amounts paid under the mental health disproportionate share program.

Where:

DSHP = disproportionate share hospital payment.

HMD = hospital Medicaid days.

TMDHH = total Medicaid days for state mental health hospitals.

TAAMH = total amount available for mental health hospitals.

(b) For non-state government owned or operated hospitals with 3,300 or more Medicaid days:

DSHP = [(0.82*HCCD/TCCD) + (.18*HMD/TMD)] * TAAPH

TAAPH = TAA - TAAMH

Where:

TAA = total available appropriation.

TAAPH = total amount available for public hospitals.

DSHP = disproportionate share hospital payments.

HMD = hospital Medicaid days.

TMD = total state Medicaid days for public hospitals.

HCCD = hospital charity care dollars.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31

~~Where:~~

~~TAE - total amount earned.~~

~~BMPD - base Medicaid per diem.~~

~~MD - Medicaid days.~~

~~DSP - disproportionate share percentage.~~

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

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

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

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

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

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

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

1 ~~(f) If the disproportionate share rate is greater than~~
 2 ~~or equal to 50 percent, but less than 60 percent, then the~~
 3 ~~disproportionate share percentage is 73.5642254.~~

4 ~~(g) If the disproportionate share rate is greater than~~
 5 ~~or equal to 60 percent but less than 72.5 percent, then the~~
 6 ~~disproportionate share percentage is 135.9356391.~~

7 ~~(h) If the disproportionate share rate is greater than~~
 8 ~~or equal to 72.5 percent, then the disproportionate share~~
 9 ~~percentage is 170.~~

10 ~~(8) The following formula shall be used by the agency~~
 11 ~~to calculate the total amount earned by all hospitals under~~
 12 ~~this section:~~

$$14 \quad \text{TAE} = \text{BMPD} \times \text{MD} \times \text{DSP}$$

16 Where:

17 ~~TAE = total amount earned.~~

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

19 ~~MD = Medicaid days.~~

20 ~~DSP = disproportionate share percentage.~~

22 (6)~~(9)~~ The agency is authorized to receive funds from
 23 local governments and other local political subdivisions for
 24 the purpose of making payments, including federal matching
 25 funds, through the Medicaid disproportionate share program.
 26 Funds received from local governments for this purpose shall
 27 be separately accounted for and shall not be commingled with
 28 other state or local funds in any manner.

29 (7)~~(10)~~ Payments made by the agency to hospitals
 30 eligible to participate in this program shall be made in
 31 accordance with federal rules and regulations.

1 (a) If the Federal Government prohibits, restricts, or
2 changes in any manner the methods by which funds are
3 distributed for this program, the agency shall not distribute
4 any additional funds and shall return all funds to the local
5 government from which the funds were received, except as
6 provided in paragraph (b).

7 (b) If the Federal Government imposes a restriction
8 that still permits a partial or different distribution, the
9 agency may continue to disburse funds to hospitals
10 participating in the disproportionate share program in a
11 federally approved manner, provided:

12 1. Each local government which contributes to the
13 disproportionate share program agrees to the new manner of
14 distribution as shown by a written document signed by the
15 governing authority of each local government; and

16 2. The Executive Office of the Governor, the Office of
17 Planning and Budgeting, the House of Representatives, and the
18 Senate are provided at least 7 days' prior notice of the
19 proposed change in the distribution, and do not disapprove
20 such change.

21 (c) No distribution shall be made under the
22 alternative method specified in paragraph (b) unless all
23 parties agree or unless all funds of those parties that
24 disagree which are not yet disbursed have been returned to
25 those parties.

26 (8)~~(11)~~ Notwithstanding the provisions of chapter 216,
27 the Executive Office of the Governor is hereby authorized to
28 establish sufficient trust fund authority to implement the
29 disproportionate share program.

30 Section 14. Section 409.9112, Florida Statutes, is
31 amended to read:

1 409.9112 Disproportionate share program for regional
2 perinatal intensive care centers.--In addition to the payments
3 made under s. 409.911, the Agency for Health Care
4 Administration shall design and implement a system of making
5 disproportionate share payments to those hospitals that
6 participate in the regional perinatal intensive care center
7 program established pursuant to chapter 383. This system of
8 payments shall conform with federal requirements and shall
9 distribute funds in each fiscal year for which an
10 appropriation is made by making quarterly Medicaid payments.
11 Notwithstanding the provisions of s. 409.915, counties are
12 exempt from contributing toward the cost of this special
13 reimbursement for hospitals serving a disproportionate share
14 of low-income patients.

15 (1) The following formula shall be used by the agency
16 to calculate the total amount earned for hospitals that
17 participate in the regional perinatal intensive care center
18 program:

$$20 \qquad \qquad \qquad \text{TAE} = \text{HDSP/THDSP}$$

21
22 Where:

23
24 TAE = total amount earned by a regional perinatal
25 intensive care center.

26 HDSP = the prior state fiscal year regional perinatal
27 intensive care center disproportionate share payment to the
28 individual hospital.

29 THDSP = the prior state fiscal year total regional
30 perinatal intensive care center disproportionate share
31 payments to all hospitals.

1
2 (2) The total additional payment for hospitals that
3 participate in the regional perinatal intensive care center
4 program shall be calculated by the agency as follows:

$$5 \qquad \qquad \qquad 6 \qquad \qquad \qquad 7 \qquad \qquad \qquad 8 \qquad \qquad \qquad 9 \qquad \qquad \qquad 10 \qquad \qquad \qquad 11 \qquad \qquad \qquad 12 \qquad \qquad \qquad 13 \qquad \qquad \qquad 14 \qquad \qquad \qquad 15 \qquad \qquad \qquad 16 \qquad \qquad \qquad 17 \qquad \qquad \qquad 18 \qquad \qquad \qquad 19 \qquad \qquad \qquad 20 \qquad \qquad \qquad 21 \qquad \qquad \qquad 22 \qquad \qquad \qquad 23 \qquad \qquad \qquad 24 \qquad \qquad \qquad 25 \qquad \qquad \qquad 26 \qquad \qquad \qquad 27 \qquad \qquad \qquad 28 \qquad \qquad \qquad 29 \qquad \qquad \qquad 30 \qquad \qquad \qquad 31 \qquad \qquad \qquad$$

$$\underline{TAP = TAE * TA}$$

8 Where:

10 TAP = total additional payment for a regional perinatal
11 intensive care center.

12 TAE = total amount earned by a regional perinatal
13 intensive care center.

14 TA = total appropriation for the regional perinatal
15 intensive care center disproportionate share program.

$$16 \qquad \qquad \qquad 17 \qquad \qquad \qquad 18 \qquad \qquad \qquad 19 \qquad \qquad \qquad 20 \qquad \qquad \qquad 21 \qquad \qquad \qquad 22 \qquad \qquad \qquad 23 \qquad \qquad \qquad 24 \qquad \qquad \qquad 25 \qquad \qquad \qquad 26 \qquad \qquad \qquad 27 \qquad \qquad \qquad 28 \qquad \qquad \qquad 29 \qquad \qquad \qquad 30 \qquad \qquad \qquad 31 \qquad \qquad \qquad$$

$$\del{TAE = DSR * BMPD * MD}$$

19 ~~Where:~~

20 ~~TAE = total amount earned by a regional perinatal~~
21 ~~intensive care center.~~

22 ~~DSR = disproportionate share rate.~~

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

24 ~~MD = Medicaid days.~~

26 ~~(2) The total additional payment for hospitals that~~
27 ~~participate in the regional perinatal intensive care center~~
28 ~~program shall be calculated by the agency as follows:~~

$$31 \qquad \qquad \qquad$$

$$\del{TAE * TA}$$

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31

~~TAP = (.....)~~
STAE

Where:

~~TAP = total additional payment for a regional perinatal intensive care center.~~

~~TAE = total amount earned by a regional perinatal intensive care center.~~

~~STAE = sum of total amount earned by each hospital that participates in the regional perinatal intensive care center program.~~

~~TA = total appropriation for the regional perinatal intensive care disproportionate share program.~~

(3) In order to receive payments under this section, a hospital must be participating in the regional perinatal intensive care center program pursuant to chapter 383 and must meet the following additional requirements:

(a) Agree to conform to all departmental and agency requirements to ensure high quality in the provision of services, including criteria adopted by departmental and agency rule concerning staffing ratios, medical records, standards of care, equipment, space, and such other standards and criteria as the department and agency deem appropriate as specified by rule.

(b) Agree to provide information to the department and agency, in a form and manner to be prescribed by rule of the department and agency, concerning the care provided to all patients in neonatal intensive care centers and high-risk maternity care.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

1 (c) Agree to accept all patients for neonatal
2 intensive care and high-risk maternity care, regardless of
3 ability to pay, on a functional space-available basis.

4 (d) Agree to develop arrangements with other maternity
5 and neonatal care providers in the hospital's region for the
6 appropriate receipt and transfer of patients in need of
7 specialized maternity and neonatal intensive care services.

8 (e) Agree to establish and provide a developmental
9 evaluation and services program for certain high-risk
10 neonates, as prescribed and defined by rule of the department.

11 (f) Agree to sponsor a program of continuing education
12 in perinatal care for health care professionals within the
13 region of the hospital, as specified by rule.

14 (g) Agree to provide backup and referral services to
15 the department's county health departments and other
16 low-income perinatal providers within the hospital's region,
17 including the development of written agreements between these
18 organizations and the hospital.

19 (h) Agree to arrange for transportation for high-risk
20 obstetrical patients and neonates in need of transfer from the
21 community to the hospital or from the hospital to another more
22 appropriate facility.

23 (4) Hospitals which fail to comply with any of the
24 conditions in subsection (3) or the applicable rules of the
25 department and agency shall not receive any payments under
26 this section until full compliance is achieved. A hospital
27 which is not in compliance in two or more consecutive quarters
28 shall not receive its share of the funds. Any forfeited funds
29 shall be distributed by the remaining participating regional
30 perinatal intensive care center program hospitals.

31

1 Section 15. Subsection (1) of section 409.9116,
2 Florida Statutes, is amended to read:

3 409.9116 Disproportionate share/financial assistance
4 program for rural hospitals.--In addition to the payments made
5 under s. 409.911, the Agency for Health Care Administration
6 shall administer a federally matched disproportionate share
7 program and a state-funded financial assistance program for
8 statutory rural hospitals. The agency shall make
9 disproportionate share payments to statutory rural hospitals
10 that qualify for such payments and financial assistance
11 payments to statutory rural hospitals that do not qualify for
12 disproportionate share payments. The disproportionate share
13 program payments shall be limited by and conform with federal
14 requirements. Funds shall be distributed quarterly in each
15 fiscal year for which an appropriation is made.

16 Notwithstanding the provisions of s. 409.915, counties are
17 exempt from contributing toward the cost of this special
18 reimbursement for hospitals serving a disproportionate share
19 of low-income patients.

20 (1) The following formula shall be used by the agency
21 to calculate the total amount earned for hospitals that
22 participate in the rural hospital disproportionate share
23 program or the financial assistance program:

$$24 \qquad \qquad \qquad \text{TAERH} = (\text{CCD} + \text{MDD})/\text{TPD}$$

25
26
27 Where:

28 CCD = total charity care-other, plus charity
29 care-Hill-Burton, minus 50 percent of unrestricted tax revenue
30 from local governments, and restricted funds for indigent
31 care, divided by gross revenue per adjusted patient day;

1 however, if CCD is less than zero, then zero shall be used for
2 CCD.

3 MDD = Medicaid inpatient days plus Medicaid HMO
4 inpatient days.

5 TPD = total inpatient days.

6 TAERH = total amount earned by each rural hospital.
7

8 In computing the total amount earned by each rural hospital,
9 the agency must use the average of the 3 most recent years of
10 actual data reported in accordance with s. 408.061(4)(a). The
11 agency shall provide a preliminary estimate of the payments
12 under the rural disproportionate share and financial
13 assistance programs to the rural hospitals by August 31 of
14 each state fiscal year for review. Each rural hospital shall
15 have 30 days to review the preliminary estimates of payments
16 and report any errors to the agency. The agency shall make any
17 corrections deemed necessary and compute the rural
18 disproportionate share and financial assistance program
19 payments.

20 Section 16. Section 409.9117, Florida Statutes, is
21 amended to read:

22 409.9117 Primary care disproportionate share
23 program.--

24 (1) If federal funds are available for
25 disproportionate share programs in addition to those otherwise
26 provided by law, there shall be created a primary care
27 disproportionate share program.

28 (2) The following formula shall be used by the agency
29 to calculate the total amount earned for hospitals that
30 participate in the primary care disproportionate share
31 program:

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31

$$\underline{TAE = HDSP/THDSP}$$

Where:

TAE = total amount earned by a hospital participating in the primary care disproportionate share program.

HDSP = the prior state fiscal year primary care disproportionate share payment to the individual hospital.

THDSP = the prior state fiscal year total primary care disproportionate share payments to all hospitals.

(3) The total additional payment for hospitals that participate in the primary care disproportionate share program shall be calculated by the agency as follows:

$$\underline{TAP = TAE * TA}$$

Where:

TAP = total additional payment for a primary care hospital.

TAE = total amount earned by a primary care hospital.

TA = total appropriation for the primary care disproportionate share program.

(4)(2) In the establishment and funding of this program, the agency shall use the following criteria in addition to those specified in s. 409.911, payments may not be made to a hospital unless the hospital agrees to:

(a) Cooperate with a Medicaid prepaid health plan, if one exists in the community.

1 (b) Ensure the availability of primary and specialty
2 care physicians to Medicaid recipients who are not enrolled in
3 a prepaid capitated arrangement and who are in need of access
4 to such physicians.

5 (c) Coordinate and provide primary care services free
6 of charge, except copayments, to all persons with incomes up
7 to 100 percent of the federal poverty level who are not
8 otherwise covered by Medicaid or another program administered
9 by a governmental entity, and to provide such services based
10 on a sliding fee scale to all persons with incomes up to 200
11 percent of the federal poverty level who are not otherwise
12 covered by Medicaid or another program administered by a
13 governmental entity, except that eligibility may be limited to
14 persons who reside within a more limited area, as agreed to by
15 the agency and the hospital.

16 (d) Contract with any federally qualified health
17 center, if one exists within the agreed geopolitical
18 boundaries, concerning the provision of primary care services,
19 in order to guarantee delivery of services in a nonduplicative
20 fashion, and to provide for referral arrangements, privileges,
21 and admissions, as appropriate. The hospital shall agree to
22 provide at an onsite or offsite facility primary care services
23 within 24 hours to which all Medicaid recipients and persons
24 eligible under this paragraph who do not require emergency
25 room services are referred during normal daylight hours.

26 (e) Cooperate with the agency, the county, and other
27 entities to ensure the provision of certain public health
28 services, case management, referral and acceptance of
29 patients, and sharing of epidemiological data, as the agency
30 and the hospital find mutually necessary and desirable to
31

1 promote and protect the public health within the agreed
2 geopolitical boundaries.

3 (f) In cooperation with the county in which the
4 hospital resides, develop a low-cost, outpatient, prepaid
5 health care program to persons who are not eligible for the
6 Medicaid program, and who reside within the area.

7 (g) Provide inpatient services to residents within the
8 area who are not eligible for Medicaid or Medicare, and who do
9 not have private health insurance, regardless of ability to
10 pay, on the basis of available space, except that nothing
11 shall prevent the hospital from establishing bill collection
12 programs based on ability to pay.

13 (h) Work with the Florida Healthy Kids Corporation,
14 the Florida Health Care Purchasing Cooperative, and business
15 health coalitions, as appropriate, to develop a feasibility
16 study and plan to provide a low-cost comprehensive health
17 insurance plan to persons who reside within the area and who
18 do not have access to such a plan.

19 (i) Work with public health officials and other
20 experts to provide community health education and prevention
21 activities designed to promote healthy lifestyles and
22 appropriate use of health services.

23 (j) Work with the local health council to develop a
24 plan for promoting access to affordable health care services
25 for all persons who reside within the area, including, but not
26 limited to, public health services, primary care services,
27 inpatient services, and affordable health insurance generally.

28
29 Any hospital that fails to comply with any of the provisions
30 of this subsection, or any other contractual condition, may
31

1 not receive payments under this section until full compliance
2 is achieved.

3 Section 17. Section 409.9119, Florida Statutes, is
4 amended to read:

5 409.9119 Disproportionate share program for specialty
6 hospitals for children.--In addition to the payments made
7 under s. 409.911, the Agency for Health Care Administration
8 shall develop and implement a system under which
9 disproportionate share payments are made to those hospitals
10 that are licensed by the state as specialty hospitals for
11 children and were licensed on January 1, 2000, as specialty
12 hospitals for children. This system of payments must conform
13 to federal requirements and must distribute funds in each
14 fiscal year for which an appropriation is made by making
15 quarterly Medicaid payments. Notwithstanding s. 409.915,
16 counties are exempt from contributing toward the cost of this
17 special reimbursement for hospitals that serve a
18 disproportionate share of low-income patients. Payments are
19 subject to specific appropriations in the General
20 Appropriations Act.

21 (1) The agency shall use the following formula to
22 calculate the total amount earned for hospitals that
23 participate in the specialty hospital for children
24 disproportionate share program:

25

$$26 \qquad \qquad \qquad \text{TAE} = \text{DSR} \times \text{BMPD} \times \text{MD}$$

27

28 Where:

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

31 DSR = disproportionate share rate.

1 BMPD = base Medicaid per diem.

2 MD = Medicaid days.

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

7

8

9

$$\begin{aligned}
 & \text{TAE} \times \text{TA} \\
 10 \quad & \text{TAP} = (\dots\dots\dots) \\
 11 \quad & \text{STAE}
 \end{aligned}$$

12 Where:

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

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

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

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

22

23 (3) A hospital may not receive any payments under this
24 section until it achieves full compliance with the applicable
25 rules of the agency. A hospital that is not in compliance for
26 two or more consecutive quarters may not receive its share of
27 the funds. Any forfeited funds must be distributed to the
28 remaining participating specialty hospitals for children that
29 are in compliance.

30 Section 18. Paragraph (d) of subsection (3) of section
31 409.912, Florida Statutes, as amended by chapter 2003-1, Laws

1 of Florida, is amended, and subsections (41) and (42) are
2 added to that section, to read:

3 409.912 Cost-effective purchasing of health care.--The
4 agency shall purchase goods and services for Medicaid
5 recipients in the most cost-effective manner consistent with
6 the delivery of quality medical care. The agency shall
7 maximize the use of prepaid per capita and prepaid aggregate
8 fixed-sum basis services when appropriate and other
9 alternative service delivery and reimbursement methodologies,
10 including competitive bidding pursuant to s. 287.057, designed
11 to facilitate the cost-effective purchase of a case-managed
12 continuum of care. The agency shall also require providers to
13 minimize the exposure of recipients to the need for acute
14 inpatient, custodial, and other institutional care and the
15 inappropriate or unnecessary use of high-cost services. The
16 agency may establish prior authorization requirements for
17 certain populations of Medicaid beneficiaries, certain drug
18 classes, or particular drugs to prevent fraud, abuse, overuse,
19 and possible dangerous drug interactions. The Pharmaceutical
20 and Therapeutics Committee shall make recommendations to the
21 agency on drugs for which prior authorization is required. The
22 agency shall inform the Pharmaceutical and Therapeutics
23 Committee of its decisions regarding drugs subject to prior
24 authorization.

25 (3) The agency may contract with:

26 (d) A provider service network ~~No more than four~~
27 ~~provider service networks for demonstration projects to test~~
28 ~~Medicaid direct contracting. The demonstration projects may be~~
29 reimbursed on a fee-for-service or prepaid basis. A provider
30 service network which is reimbursed by the agency on a prepaid
31 basis shall be exempt from parts I and III of chapter 641, but

1 must meet appropriate financial reserve, quality assurance,
2 and patient rights requirements as established by the agency.
3 The agency shall award contracts on a competitive bid basis
4 and shall select bidders based upon price and quality of care.
5 Medicaid recipients assigned to a demonstration project shall
6 be chosen equally from those who would otherwise have been
7 assigned to prepaid plans and MediPass. The agency is
8 authorized to seek federal Medicaid waivers as necessary to
9 implement the provisions of this section. ~~A demonstration~~
10 ~~project awarded pursuant to this paragraph shall be for 4~~
11 ~~years from the date of implementation.~~

12 (41) The agency shall develop and implement a
13 utilization management program for Medicaid-eligible
14 recipients for the management of occupational, physical,
15 respiratory, and speech therapies. The agency shall establish
16 a utilization program that may require prior authorization in
17 order to ensure medically necessary and cost-effective
18 treatments. The program shall be operated in accordance with a
19 federally approved waiver program or state plan amendment. The
20 agency may seek a federal waiver or state plan amendment to
21 implement this program. The agency may also competitively
22 procure these services from an outside vendor on a regional or
23 statewide basis.

24 (42) The agency may contract on a prepaid or fixed-sum
25 basis with appropriately licensed prepaid dental health plans
26 to provide dental services.

27 Section 19. Paragraphs (f) and (k) of subsection (2)
28 of section 409.9122, Florida Statutes, are amended, and
29 subsection (13) is added to that section, to read:

30 409.9122 Mandatory Medicaid managed care enrollment;
31 programs and procedures.--

1 (2)
2 (f) When a Medicaid recipient does not choose a
3 managed care plan or MediPass provider, the agency shall
4 assign the Medicaid recipient to a managed care plan or
5 MediPass provider. Medicaid recipients who are subject to
6 mandatory assignment but who fail to make a choice shall be
7 assigned to managed care plans until an enrollment of 40 ~~45~~
8 percent in MediPass and 60 ~~55~~ percent in managed care plans is
9 achieved. Once this enrollment is achieved, the assignments
10 shall be divided in order to maintain an enrollment in
11 MediPass and managed care plans which is in a 40 ~~45~~ percent
12 and 60 ~~55~~ percent proportion, respectively. Thereafter,
13 assignment of Medicaid recipients who fail to make a choice
14 shall be based proportionally on the preferences of recipients
15 who have made a choice in the previous period. Such
16 proportions shall be revised at least quarterly to reflect an
17 update of the preferences of Medicaid recipients. The agency
18 shall disproportionately assign Medicaid-eligible recipients
19 who are required to but have failed to make a choice of
20 managed care plan or MediPass, including children, and who are
21 to be assigned to the MediPass program to children's networks
22 as described in s. 409.912(3)(g), Children's Medical Services
23 network as defined in s. 391.021, exclusive provider
24 organizations, provider service networks, minority physician
25 networks, and pediatric emergency department diversion
26 programs authorized by this chapter or the General
27 Appropriations Act, in such manner as the agency deems
28 appropriate, until the agency has determined that the networks
29 and programs have sufficient numbers to be economically
30 operated. For purposes of this paragraph, when referring to
31 assignment, the term "managed care plans" includes health

1 maintenance organizations, exclusive provider organizations,
2 provider service networks, minority physician networks,
3 Children's Medical Services network, and pediatric emergency
4 department diversion programs authorized by this chapter or
5 the General Appropriations Act.

6 1. Beginning July 1, 2002, the agency shall assign all
7 children in families who have not made a choice of a managed
8 care plan or MediPass in the required timeframe to a pediatric
9 emergency room diversion program described in s. 409.912(3)(g)
10 that, as of July 1, 2002, has executed a contract with the
11 agency, until such network or program has reached an
12 enrollment of 15,000 children. Once that minimum enrollment
13 level has been reached, the agency shall assign children who
14 have not chosen a managed care plan or MediPass to the network
15 or program in a manner that maintains the minimum enrollment
16 in the network or program at not less than 15,000 children. To
17 the extent practicable, the agency shall also assign all
18 eligible children in the same family to such network or
19 program. This subparagraph expires January 1, 2004.

20 2. When making assignments, the agency shall take into
21 account the following criteria:

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

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

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

1 ~~d.4.~~ The managed care plan's or MediPass primary care
2 providers are geographically accessible to the recipient's
3 residence.

4 (k) When a Medicaid recipient does not choose a
5 managed care plan or MediPass provider, the agency shall
6 assign the Medicaid recipient to a managed care plan, except
7 in those counties in which there are fewer than two managed
8 care plans accepting Medicaid enrollees, in which case
9 assignment shall be to a managed care plan or a MediPass
10 provider. Medicaid recipients in counties with fewer than two
11 managed care plans accepting Medicaid enrollees who are
12 subject to mandatory assignment but who fail to make a choice
13 shall be assigned to managed care plans until an enrollment of
14 40 ~~45~~ percent in MediPass and 60 ~~55~~ percent in managed care
15 plans is achieved. Once that enrollment is achieved, the
16 assignments shall be divided in order to maintain an
17 enrollment in MediPass and managed care plans which is in a 40
18 ~~45~~ percent and 60 ~~55~~ percent proportion, respectively. In
19 geographic areas where the agency is contracting for the
20 provision of comprehensive behavioral health services through
21 a capitated prepaid arrangement, recipients who fail to make a
22 choice shall be assigned equally to MediPass or a managed care
23 plan. For purposes of this paragraph, when referring to
24 assignment, the term "managed care plans" includes exclusive
25 provider organizations, provider service networks, Children's
26 Medical Services network, minority physician networks, and
27 pediatric emergency department diversion programs authorized
28 by this chapter or the General Appropriations Act. When making
29 assignments, the agency shall take into account the following
30 criteria:

31

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

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

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

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

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

17 (13) Effective July 1, 2003, the agency shall adjust
18 the enrollee assignment process of Medicaid managed prepaid
19 health plans for those Medicaid managed prepaid plans
20 operating in Miami-Dade County which have executed a contract
21 with the agency for a minimum of 8 consecutive years in order
22 for the Medicaid managed prepaid plan to maintain a minimum
23 enrollment level of 15,000 members per month.

24 Section 20. Section 430.83, Florida Statutes, is
25 created to read:

26 430.83 Sunshine for Seniors Program.--

27 (1) POPULAR NAME.--This section shall be known by the
28 popular name "The Sunshine for Seniors Act."

29 (2) DEFINITIONS.--As used in this section, the term:

30 (a) "Application assistance organization" means any
31 private organization that assists individuals with obtaining

1 prescription drugs through manufacturers' pharmaceutical
2 assistance programs.

3 (b) "Eligible individual" means any individual who is
4 60 years of age or older who lacks adequate pharmaceutical
5 insurance coverage.

6 (c) "Manufacturers' pharmaceutical assistance program"
7 means any program offered by a pharmaceutical manufacturer
8 which provides low-income individuals with prescription drugs
9 free or at reduced prices, including, but not limited to,
10 senior discount card programs and patient assistance programs.

11 (3) LEGISLATIVE FINDINGS AND INTENT.--The Legislature
12 finds that the pharmaceutical manufacturers, seeing a need,
13 have created charitable programs to aid low-income seniors
14 with the cost of prescription drugs. The Legislature also
15 finds that many low-income seniors are unaware of such
16 programs or either do not know how to apply for or need
17 assistance in completing the applications for such programs.
18 Therefore, it is the intent of the Legislature that the
19 Department of Elderly Affairs, in consultation with the Agency
20 for Health Care Administration, implement and oversee the
21 Sunshine for Seniors Program to help seniors in accessing
22 manufacturers' pharmaceutical assistance programs.

23 (4) SUNSHINE FOR SENIORS PROGRAM.--There is
24 established a program to assist low-income seniors with
25 obtaining prescription drugs from manufacturers'
26 pharmaceutical assistance programs, which shall be known as
27 the "Sunshine for Seniors Program." Implementation of the
28 program is subject to the availability of funding and any
29 limitations or directions provided for by the General
30 Appropriations Act or chapter 216.

31

1 (5) IMPLEMENTATION AND OVERSIGHT DUTIES.--In
2 implementing and overseeing the Sunshine for Seniors Program,
3 the Department of Elderly Affairs:

4 (a) Shall promote the availability of manufacturers'
5 pharmaceutical assistance programs to eligible individuals
6 with various outreach initiatives.

7 (b) Shall, working cooperatively with pharmaceutical
8 manufacturers and consumer advocates, develop a uniform
9 application form to be completed by seniors who wish to
10 participate in the Sunshine for Seniors Program.

11 (c) May request proposals from application assistance
12 organizations to assist eligible individuals with obtaining
13 prescription drugs through manufacturers' pharmaceutical
14 assistance programs.

15 (d) Shall train volunteers to help eligible
16 individuals fill out applications for the manufacturers'
17 pharmaceutical assistance programs.

18 (e) Shall train volunteers to determine when
19 applicants may be eligible for other state programs and refer
20 them to the proper entity for eligibility determination for
21 such programs.

22 (f) Shall seek federal funds to help fund the Sunshine
23 for Seniors Program.

24 (g) May seek federal waivers to help fund the Sunshine
25 for Seniors Program.

26 (6) COMMUNITY PARTNERSHIPS.--The Department of Elderly
27 Affairs may build private-sector and public-sector
28 partnerships with corporations, hospitals, physicians,
29 pharmacists, foundations, volunteers, state agencies,
30 community groups, area agencies on aging, and any other
31 entities that will further the intent of this section. These

1 community partnerships may also be used to facilitate other
2 pro bono benefits for eligible individuals, including, but not
3 limited to, medical, dental, and prescription services.

4 (7) CONTRACTS.--The Department of Elderly Affairs may
5 select and contract with application assistance organizations
6 to assist eligible individuals in obtaining their prescription
7 drugs through the manufacturers' pharmaceutical assistance
8 programs. If the department contracts with an application
9 assistance organization, the department shall evaluate
10 quarterly the performance of the application assistance
11 organization to ensure compliance with the contract and the
12 quality of service provided to eligible individuals.

13 (8) REPORTS AND EVALUATIONS.--By January 1 of each
14 year, while the Sunshine for Seniors Program is operating, the
15 Department of Elderly Affairs shall report to the Legislature
16 regarding the implementation and operation of the Sunshine for
17 Seniors Program.

18 (9) NONENTITLEMENT.--The Sunshine for Seniors Program
19 established by this section is not an entitlement. If funds
20 are insufficient to assist all eligible individuals, the
21 Department of Elderly Affairs may develop a waiting list
22 prioritized by application date.

23 Section 21. Paragraph (b) of subsection (2), paragraph
24 (b) of subsection (4), and paragraph (a) of subsection (5) of
25 section 624.91, Florida Statutes, are amended to read:

26 624.91 The Florida Healthy Kids Corporation Act.--

27 (2) LEGISLATIVE INTENT.--

28 (b) It is the intent of the Legislature that the
29 Florida Healthy Kids Corporation serve as one of several
30 providers of services to children eligible for medical
31 assistance under Title XXI of the Social Security Act.

1 Although the corporation may serve other children, the
2 Legislature intends the primary recipients of services
3 provided through the corporation be school-age children with a
4 family income below 200 percent of the federal poverty level,
5 who do not qualify for Medicaid. It is also the intent of the
6 Legislature that state and local government Florida Healthy
7 Kids funds be used to continue and expand coverage, subject to
8 specific within available appropriations in the General
9 Appropriations Act, to children not eligible for federal
10 matching funds under Title XXI.

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

12 (b) The Florida Healthy Kids Corporation shall:

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

16 1.2. Arrange for the collection of any family, local
17 contributions, or employer payment or premium, in an amount to
18 be determined by the board of directors, to provide for
19 payment of premiums for comprehensive insurance coverage and
20 for the actual or estimated administrative expenses;

21 2.3. Arrange for the collection of any voluntary
22 contributions to provide for payment of premiums for children
23 who are not eligible for medical assistance under Title XXI of
24 the Social Security Act. Each fiscal year, the corporation
25 shall establish a local match policy for the enrollment of
26 non-Title-XXI-eligible children in the Healthy Kids program.
27 By May 1 of each year, the corporation shall provide written
28 notification of the amount to be remitted to the corporation
29 for the following fiscal year under that policy. Local match
30 sources may include, but are not limited to, funds provided by
31 municipalities, counties, school boards, hospitals, health

1 care providers, charitable organizations, special taxing
2 districts, and private organizations. The minimum local match
3 cash contributions required each fiscal year and local match
4 credits shall be determined by the General Appropriations Act.
5 The corporation shall calculate a county's local match rate
6 based upon that county's percentage of the state's total
7 non-Title-XXI expenditures as reported in the corporation's
8 most recently audited financial statement. In awarding the
9 local match credits, the corporation may consider factors
10 including, but not limited to, population density, per capita
11 income, and existing child-health-related expenditures and
12 services;

13 ~~3.4.~~ Accept voluntary supplemental local match
14 contributions that comply with the requirements of Title XXI
15 of the Social Security Act for the purpose of providing
16 additional coverage in contributing counties under Title XXI;

17 ~~4.5.~~ Establish the administrative and accounting
18 procedures for the operation of the corporation;

19 ~~5.6.~~ Establish, with consultation from appropriate
20 professional organizations, standards for preventive health
21 services and providers and comprehensive insurance benefits
22 appropriate to children; provided that such standards for
23 rural areas shall not limit primary care providers to
24 board-certified pediatricians;

25 ~~6.7.~~ Establish eligibility criteria which children
26 must meet in order to participate in the program;

27 ~~7.8.~~ Establish procedures under which providers of
28 local match to, applicants to and participants in the program
29 may have grievances reviewed by an impartial body and reported
30 to the board of directors of the corporation;

31

1 ~~8.9.~~ Establish participation criteria and, if
2 appropriate, contract with an authorized insurer, health
3 maintenance organization, or insurance administrator to
4 provide administrative services to the corporation;

5 ~~9.10.~~ Establish enrollment criteria which shall
6 include penalties or waiting periods of not fewer than 60 days
7 for reinstatement of coverage upon voluntary cancellation for
8 nonpayment of family premiums;

9 ~~10.11.~~ If a space is available, establish a special
10 open enrollment period of 30 days' duration for any child who
11 is enrolled in Medicaid or Medikids if such child loses
12 Medicaid or Medikids eligibility and becomes eligible for the
13 Florida Healthy Kids program;

14 ~~11.12.~~ Contract with authorized insurers or any
15 provider of health care services, meeting standards
16 established by the corporation, for the provision of
17 comprehensive insurance coverage to participants. Such
18 standards shall include criteria under which the corporation
19 may contract with more than one provider of health care
20 services in program sites. Health plans shall be selected
21 through a competitive bid process. The maximum administrative
22 cost for a Florida Healthy Kids Corporation contract shall be
23 15 percent. The minimum medical loss ratio for a Florida
24 Healthy Kids Corporation contract shall be 85 percent.The
25 selection of health plans shall be based primarily on quality
26 criteria established by the board. The health plan selection
27 criteria and scoring system, and the scoring results, shall be
28 available upon request for inspection after the bids have been
29 awarded;

30 ~~12.13.~~ Establish disenrollment criteria in the event
31 local matching funds are insufficient to cover enrollments;

1 ~~13.14.~~ Develop and implement a plan to publicize the
2 Florida Healthy Kids Corporation, the eligibility requirements
3 of the program, and the procedures for enrollment in the
4 program and to maintain public awareness of the corporation
5 and the program;

6 ~~14.15.~~ Secure staff necessary to properly administer
7 the corporation. Staff costs shall be funded from state and
8 local matching funds and such other private or public funds as
9 become available. The board of directors shall determine the
10 number of staff members necessary to administer the
11 corporation;

12 ~~15.16.~~ As appropriate, enter into contracts with local
13 school boards or other agencies to provide onsite information,
14 enrollment, and other services necessary to the operation of
15 the corporation;

16 ~~16.17.~~ Provide a report annually to the Governor,
17 Chief Financial Officer, Commissioner of Education, Senate
18 President, Speaker of the House of Representatives, and
19 Minority Leaders of the Senate and the House of
20 Representatives;

21 ~~17.18.~~ Each fiscal year, establish a maximum number of
22 participants, on a statewide basis, who may enroll in the
23 program; and

24 ~~18.19.~~ Establish eligibility criteria, premium and
25 cost-sharing requirements, and benefit packages which conform
26 to the provisions of the Florida Kidcare program, as created
27 in ss. 409.810-409.820.

28 (5) BOARD OF DIRECTORS.--

29 (a) The Florida Healthy Kids Corporation shall operate
30 subject to the supervision and approval of a board of
31 directors chaired by the Chief Financial Officer or her or his

1 designee, and composed of 10 ~~14~~ other members selected for
2 3-year terms of office as follows:

3 1. The Secretary of Health Care Administration, or his
4 or her designee;

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

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

11 2.3. One member appointed by the Commissioner of
12 Education from the Office of School Health Programs of the
13 Florida Department of Education;

14 ~~3.4.~~ One member appointed by the Chief Financial
15 Officer ~~Governor~~ from among three members nominated by the
16 Florida Pediatric Society;

17 ~~4.5.~~ One member, appointed by the Governor, who
18 represents the Children's Medical Services Program;

19 ~~5.6.~~ One member appointed by the Chief Financial
20 Officer from among three members nominated by the Florida
21 Hospital Association;

22 ~~7. Two members, appointed by the Chief Financial~~
23 ~~Officer, who are representatives of authorized health care~~
24 ~~insurers or health maintenance organizations;~~

25 ~~6.8.~~ One member, appointed by the Governor ~~Chief~~
26 ~~Financial Officer~~, who is an expert on ~~represents the~~
27 ~~Institute for child health policy;~~

28 7.9. One member, appointed by the Chief Financial
29 Officer ~~Governor~~, from among three members nominated by the
30 Florida Academy of Family Physicians;

31

1 ~~8.10.~~ One member, appointed by the Governor, who
2 represents the state Medicaid program ~~Agency for Health Care~~
3 ~~Administration;~~

4 ~~11.~~ One member, appointed by the Chief Financial
5 Officer, ~~from among three members nominated by the Florida~~
6 ~~Association of Counties, representing rural counties;~~

7 ~~9.12.~~ One member, appointed by the Chief Financial
8 Officer ~~Governor~~, from among three members nominated by the
9 Florida Association of Counties, ~~representing urban counties;~~
10 and

11 ~~10.13.~~ The State Health Officer or her or his
12 designee.

13 Section 22. Section 57 of chapter 98-288, Laws of
14 Florida, is repealed.

15 Section 23. Effective upon this act becoming a law,
16 for the 2002-2003 state fiscal year, the Agency for Health
17 Care Administration may make additional payment of up to
18 \$7,561,104 from the Grants and Donations Trust Fund and
19 \$10,849,182 from the Medical Care Trust Fund to hospitals as
20 special Medicaid payments in order to use the full amount of
21 the upper payment limit available in the public hospital
22 category.

23 (1) These funds shall be distributed as follows:

24 (a) Statutory teaching hospitals - \$1,355,991.

25 (b) Family practice teaching hospitals - \$181,291.

26 (c) Primary care hospitals - \$1,355,991.

27 (d) Trauma hospitals - \$1,290,000.

28 (e) Rural hospitals - \$931,500.

29 (f) Hospitals receiving specific special Medicaid
30 payments not included in a payment under paragraphs (a)-(e),
31 \$4,359,417.

1 (g) Hospitals providing enhanced services to
2 low-income individuals - \$8,884,298.

3 (2) The payments shall be distributed proportionately
4 to each hospital in the specific payment category based on the
5 hospital's actual payments for the 2002-2003 state fiscal
6 year. These payment amounts shall be adjusted downward in a
7 proportionate manner as to not exceed the available upper
8 payment limit in the public hospital category. Payment of
9 these amounts are contingent on the state share being provided
10 through grants and donations from state, county, or other
11 local funds and approval by the Centers of Medicare and
12 Medicaid Services.

13 Section 24. If any law that is amended by this act was
14 also amended by a law enacted at the 2003 Regular Session of
15 the Legislature, such laws shall be construed as if they had
16 been enacted during the same session of the Legislature, and
17 full effect should be given to each if that is possible.

18 Section 25. Except as otherwise expressly provided in
19 this act, this act shall take effect July 1, 2003.
20
21
22
23
24
25
26
27
28
29
30
31