Amendment No. (for drafter's use only)

CHAMBER ACTION

Senate	House
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Representative Green offered the following:

Amendment (with title amendment)

Remove lines 169-1460, and insert:

Section 2. Subsections (17), (18), (19), (20), (21), (22), (23), (24), (25), (26), and (27) of section 409.811, Florida Statutes, are renumbered as subsections (18), (19), (20), (21), (22), (23), (24), (25), (26), (27), and (28), respectively, and a new subsection (17) is added to said section to read:

409.811 Definitions relating to Florida Kidcare Act.--As used in ss. 409.810-409.820, the term:

(17) "Managed care plan" means a health maintenance organization authorized pursuant to chapter 641 or a prepaid health plan authorized pursuant to s. 409.912.

Section 3. Subsection (7) of section 409.8132, Florida Statutes, is amended to read:

409.8132 Medikids program component.--

(7) ENROLLMENT.--Enrollment in the Medikids program component may only occur during periodic open enrollment periods as specified by the agency. An applicant may apply for enrollment in the Medikids program component and proceed through the eligibility determination process at any time throughout the year. However, enrollment in Medikids shall not begin until the next open enrollment period; and a child may not receive services under the Medikids program until the child is enrolled in a managed care plan as defined in s. 409.811 or in MediPass. In addition, once determined eligible, an applicant may receive choice counseling and select a managed care plan or MediPass. The agency may initiate mandatory assignment for a Medikids applicant who has not chosen a managed care plan or MediPass provider after the applicant's voluntary choice period ends. An applicant may select MediPass under the Medikids program component only in counties that have fewer than two managed care plans available to serve Medicaid recipients and only if the federal Health Care Financing Administration determines that MediPass constitutes "health insurance coverage" as defined in Title XXI of the Social Security Act.

Section 4. Subsection (25) of section 409.901, Florida Statutes, is amended to read:

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

(25) "Third party" means an individual, entity, or program, excluding Medicaid, that is, may be, could be, should be, or has been liable for all or part of the cost of medical services related to any medical assistance provided ~~covered by~~

~~Medicaid~~. Third party includes a third-party administrator or TPA and a pharmacy benefits manager or PBM.

Section 5. Subsection (2) of section 409.904, Florida Statutes, is amended to read:

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

(2) A caretaker relative or parent, a pregnant woman, a child under age 19 who would otherwise qualify for Florida Kidcare Medicaid, a child up to age 21 who would otherwise qualify under s. 409.903(1), a person age 65 or over, or a blind or disabled person, who would otherwise be eligible for Florida Medicaid, except that the income or assets of such family or person exceed established limitations. For a family or person in one of these coverage groups, medical expenses are deductible from income in accordance with federal requirements in order to make a determination of eligibility. ~~Expenses used to meet spend-down liability are not reimbursable by Medicaid. Effective May 1, 2003, When determining the eligibility of a pregnant woman, a child, or an aged, blind, or disabled individual, $270 shall be deducted from the countable income of the filing unit. When determining the eligibility of the parent or caretaker relative as defined by Title XIX of the Social Security Act, the additional income disregard of $270 does not apply.~~ A family or

person eligible under the coverage known as the "medically needy," is eligible to receive the same services as other Medicaid recipients, with the exception of services in skilled nursing facilities and intermediate care facilities for the developmentally disabled.

Section 6. Subsections (1), (12), and (23) of section 409.906, Florida Statutes, are amended to read:

409.906 Optional Medicaid services.--Subject to specific appropriations, the agency may make payments for services which are optional to the state under Title XIX of the Social Security Act and are furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any optional service that is provided shall be provided only when medically necessary and in accordance with state and federal law. Optional services rendered by providers in mobile units to Medicaid recipients may be restricted or prohibited by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. If necessary to safeguard the state's systems of providing services to elderly and disabled persons and subject to the notice and review provisions of s. 216.177, the Governor may direct the Agency for Health Care Administration to amend the Medicaid state plan to delete the optional Medicaid service known as "Intermediate Care Facilities for the Developmentally Disabled." Optional services may include:

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

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

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

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

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

(12) CHILDREN'S HEARING SERVICES.--The agency may pay for hearing and related services, including hearing evaluations, hearing aid devices, dispensing of the hearing aid, and related

repairs, if provided to a recipient younger than 21 years of age by a licensed hearing aid specialist, otolaryngologist, otologist, audiologist, or physician.

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

Section 7. Paragraphs (c) and (d) are added to subsection (1) of section 409.9081, Florida Statutes, to read:

409.9081 Copayments.--

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

(c) Prescription drugs: a coinsurance equal to 5 percent of the Medicaid cost of the prescription drug at the time of purchase. The maximum coinsurance shall be $15 per prescription drug purchased.

(d) Hospital outpatient services, emergency department: up to $15 for each hospital outpatient emergency department encounter that is for nonemergency purposes.

Section 8. Section 409.911, Florida Statutes, is amended to read:

409.911 Disproportionate share program.--Subject to specific allocations established within the General Appropriations Act and any limitations established pursuant to chapter 216, the agency shall distribute, pursuant to this section, moneys to hospitals providing a disproportionate share

of Medicaid or charity care services by making quarterly Medicaid payments as required. Notwithstanding the provisions of s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients.

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

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

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

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

(c)~~(d)~~ "Charity care" or "uncompensated charity care" means that portion of hospital charges reported to the Agency for Health Care Administration for which there is no compensation, other than restricted or unrestricted revenues provided to a hospital by local governments or tax districts regardless of the method of payment, for care provided to a patient whose family income for the 12 months preceding the

determination is less than or equal to 200 percent of the federal poverty level, unless the amount of hospital charges due from the patient exceeds 25 percent of the annual family income. However, in no case shall the hospital charges for a patient whose family income exceeds four times the federal poverty level for a family of four be considered charity.

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

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

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

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

(2) The Agency for Health Care Administration shall utilize the following actual audited data ~~criteria~~ to determine the Medicaid days and charity care to be used in the calculation of the ~~if a hospital qualifies for a~~ disproportionate share payment:

(a) The Agency for Health Care Administration shall use the average of the 1997, 1998, and 1999 audited data to determine each hospital's Medicaid days and charity care ~~A hospital's total Medicaid days when combined with its total~~

~~charity care days must equal or exceed 7 percent of its total adjusted patient days~~.

(b) In the event the Agency for Health Care Administration does not have the prescribed 3 years of audited disproportionate share data for a hospital, the Agency for Health Care Administration shall use the average of the audited disproportionate share data for the years available ~~A hospital's total charity care days weighted by a factor of 4.5, plus its total Medicaid days weighted by a factor of 1, shall be equal to or greater than 10 percent of its total adjusted patient days~~.

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

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

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

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

~~(c) If the total amount earned by all hospitals under this section exceeds the amount appropriated, each hospital's share shall be reduced on a pro rata basis so that the total dollars distributed from the trust fund do not exceed the total amount appropriated.~~

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

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

DSHP = (HMD/TSMD) x $1 million

~~TAA = TA x (1/5.5)~~

~~DSHP = (HMD/TSMD) x TAA~~

Where:

~~TAA = total amount available.~~

~~TA = total appropriation.~~

DSHP = disproportionate share hospital payment.

HMD = hospital Medicaid days.

TSMD = total state Medicaid days.

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

(a) For state mental health hospitals:

DSHP = (HMD/TMDMH) x TAAMH

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

Where:

DSHP = disproportionate share hospital payment.

HMD = hospital Medicaid days.

TMDMH = total Medicaid days for state mental health hospitals.

TAAMH = total amount available for mental health hospitals.

(b) For nonstate government owned or operated hospitals with 3,200 or more Medicaid days:

$$DSHP = [(.82 \times HCCD/TCCD) + (.18 \times HMD/TMD)] \times TAAPH$$

$$TAAPH = TAA - TAAMH - 1,400,000$$

Where:

DSHP = disproportionate share hospital payments.

HCCD = hospital charity care dollars.

TCCD = total charity care dollars for public nonstate hospitals.

HMD = hospital Medicaid days.

TMD = total Medicaid days for public nonstate hospitals.

TAAPH = total amount available for public hospitals.

TAA = total available appropriation.

TAAMH = total amount available for mental health hospitals.

(c) For nonstate government owned or operated hospitals with less than 3,200 Medicaid days, a total of $400,000 shall be distributed equally among these hospitals.

~~(5) The following formula shall be utilized by the agency to determine the maximum disproportionate share rate to be used~~

~~to increase the Medicaid per diem rate for hospitals that qualify pursuant to paragraphs (2)(a) and (b):~~

$$DSR = \left(\frac{CCD}{APD} \times 4.5\right) + \frac{MD}{APD}$$

~~Where:~~

~~APD = adjusted patient days.~~

~~CCD = charity care days.~~

~~DSR = disproportionate share rate.~~

~~MD = Medicaid days.~~

~~(6)(a) To calculate the total amount earned by all hospitals under this section, hospitals with a disproportionate share rate less than 50 percent shall divide their Medicaid days by four, and hospitals with a disproportionate share rate greater than or equal to 50 percent and with greater than 40,000 Medicaid days shall multiply their Medicaid days by 1.5, and the following formula shall be used by the agency to calculate the total amount earned by all hospitals under this section:~~

$$TAE = BMPD \times MD \times DSP$$

~~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 nonstate 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.~~

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

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

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

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

~~TAE = BMPD x MD x DSP~~

~~Where:~~

~~TAE = total amount earned.~~

~~BMPD = base Medicaid per diem.~~

~~MD = Medicaid days.~~

~~DSP = disproportionate share percentage.~~

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

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

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

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

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

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

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

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

Section 9. Subsections (1) and (2) of section 409.9112, Florida Statutes, are amended to read:

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

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

TAE = HDSP/THDSP

Where:

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

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

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

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

TAP = TAE x TA

Where:

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

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

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

~~TAE = DSR x BMPD x MD~~

~~Where:~~

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

~~DSR = disproportionate share rate.~~

~~BMPD = base Medicaid per diem.~~

~~MD = Medicaid days.~~

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

~~TAP = TAE x TA / 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.~~

Section 10. Section 409.9117, Florida Statutes, is amended to read:

409.9117 Primary care disproportionate share program.--

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

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

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 to 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:

$$TAP = TAE \times TA$$

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.

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

(c) Coordinate and provide primary care services free of charge, except copayments, to all persons with incomes up to 100

percent of the federal poverty level who are not otherwise covered by Medicaid or another program administered by a governmental entity, and to provide such services based on a sliding fee scale to all persons with incomes up to 200 percent of the federal poverty level who are not otherwise covered by Medicaid or another program administered by a governmental entity, except that eligibility may be limited to persons who reside within a more limited area, as agreed to by the agency and the hospital.

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

(e) Cooperate with the agency, the county, and other entities to ensure the provision of certain public health services, case management, referral and acceptance of patients, and sharing of epidemiological data, as the agency and the hospital find mutually necessary and desirable to promote and protect the public health within the agreed geopolitical boundaries.

(f) In cooperation with the county in which the hospital resides, develop a low-cost, outpatient, prepaid health care

program to persons who are not eligible for the Medicaid program, and who reside within the area.

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

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

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

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

Any hospital that fails to comply with any of the provisions of this subsection, or any other contractual condition, may not receive payments under this section until full compliance is achieved.

Section 11. Section 409.9119, Florida Statutes, is amended to read:

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

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

TAE = DSR x BMPD x MD

Where:

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

DSR = disproportionate share rate.

BMPD = base Medicaid per diem.

MD = Medicaid days.

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

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

Where:

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

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

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

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

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

Section 12. Paragraph (d) of subsection (3) of section 409.912, Florida Statutes, is amended, and subsection (41) is added to said section, to read:

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

(3) The agency may contract with:

(d) A provider network ~~No more than four provider service networks for demonstration projects to test Medicaid direct contracting. The demonstration projects~~ may be reimbursed on a fee-for-service or prepaid basis. A provider service network

which is reimbursed by the agency on a prepaid basis shall be exempt from parts I and III of chapter 641, but must meet appropriate financial reserve, quality assurance, and patient rights requirements as established by the agency. The agency shall award contracts on a competitive bid basis and shall select bidders based upon price and quality of care. ~~Medicaid recipients assigned to a demonstration project shall be chosen equally from those who would otherwise have been assigned to prepaid plans and MediPass.~~ The agency is authorized to seek federal Medicaid waivers as necessary to implement the provisions of this section. ~~A demonstration project awarded pursuant to this paragraph shall be for 4 years from the date of implementation.~~

(41) The agency may contract on a prepaid or fixed-sum basis with an appropriately licensed prepaid dental health plan to provide Medicaid covered dental services to child or adult Medicaid recipients.

Section 13. Paragraphs (f), (k), and (l) of subsection (2) of section 409.9122, Florida Statutes, are amended to read:

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

(2)

(f) When a Medicaid recipient does not choose a managed care plan or MediPass provider, the agency shall assign the Medicaid recipient to a managed care plan or MediPass provider. Medicaid recipients who are subject to mandatory assignment but who fail to make a choice shall be assigned to managed care plans until an enrollment of 40 ~~45~~ percent in MediPass and 60 ~~55~~ percent in managed care plans is achieved. Once this enrollment

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

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

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

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

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

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

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

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

~~Medicaid recipient to a managed care plan, except in those counties in which there are fewer than two managed care plans accepting Medicaid enrollees, in which case assignment shall be to a managed care plan or a MediPass provider. Medicaid recipients in counties with fewer than two managed care plans accepting Medicaid enrollees who are subject to mandatory assignment but who fail to make a choice shall be assigned to managed care plans until an enrollment of 45 percent in MediPass and 55 percent in managed care plans is achieved. Once that enrollment is achieved, the assignments shall be divided in order to maintain an enrollment in MediPass and managed care plans which is in a 45 percent and 55 percent proportion, respectively. In geographic areas where the agency is contracting for the provision of comprehensive behavioral health services through a capitated prepaid arrangement, recipients who fail to make a choice shall be assigned equally to MediPass or a managed care plan. For purposes of this paragraph, when referring to assignment, the term "managed care plans" includes exclusive provider organizations, provider service networks, Children's Medical Services network, minority physician networks, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act. When making assignments, the agency shall take into account the following criteria:~~

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

~~2. The managed care plan or MediPass has previously enrolled the recipient as a member, or one of the managed care~~

~~plan's primary care providers or MediPass providers has previously provided health care to the recipient.~~

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

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

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

(k)~~(l)~~ Notwithstanding the provisions of chapter 287, the agency may, at its discretion, renew cost-effective contracts for choice counseling services once or more for such periods as the agency may decide. However, all such renewals may not combine to exceed a total period longer than the term of the original contract.

Section 14. Subsections (8) and (28) of section 409.913, Florida Statutes, are amended to read:

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

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

(8) A Medicaid provider shall retain medical, professional, financial, and business records pertaining to services and goods furnished to a Medicaid recipient and billed to Medicaid for a period of 5 years after the date of furnishing such services or goods. The agency and its duly authorized agents may investigate, review, or analyze such records, which must be made available during normal business hours. However, 24-hour notice must be provided if patient treatment would be disrupted. The provider is responsible for furnishing to the agency and its duly authorized agents, and keeping the agency and its duly authorized agents informed of the location of, the provider's Medicaid-related records. The authority of the agency and its duly authorized agents to obtain Medicaid-related records from a provider is neither curtailed nor limited during a period of litigation between the agency and the provider.

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

Section 15. Subsections (7), (8), and (9) are added to section 430.502, Florida Statutes, to read:

430.502 Alzheimer's disease; memory disorder clinics and day care and respite care programs.--

(7) The Agency for Health Care Administration and the department shall seek a federal waiver to implement a Medicaid home and community-based waiver targeted to persons with

Alzheimer's disease to test the effectiveness of Alzheimer's specific interventions to delay or to avoid institutional placement.

(8) The department shall implement the waiver program specified in subsection (7). The agency and the department shall ensure that providers are selected that have a history of successfully serving persons with Alzheimer's disease. The department and the agency shall develop specialized standards for providers and services tailored to persons in the early, middle, and late stages of Alzheimer's disease and designate a level of care determination process and standard that is most appropriate to this population. The department and the agency shall include in the waiver services designed to assist the caregiver in continuing to provide in-home care. The department shall implement this waiver program subject to a specific appropriation or as provided in the General Appropriations Act. The department and the agency shall submit their program design to the President of the Senate and the Speaker of the House of Representatives for consultation during the development process.

(9) Authority to continue the waiver program specified in subsection (7) shall be automatically eliminated at the close of the 2008 Regular Session of the Legislature unless further legislative action is taken to continue it prior to such time.

Section 16. Paragraph (b) of subsection (4) and paragraph (a) of subsection (5) of section 624.91, Florida Statutes, are amended to read:

624.91 The Florida Healthy Kids Corporation Act.--

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

(b) The Florida Healthy Kids Corporation shall:

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

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

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

limited to, population density, per capita income, and existing child-health-related expenditures and services.~~;~~

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

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

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

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

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

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

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

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

12. Contract with authorized insurers or any provider of health care services, meeting standards established by the corporation, for the provision of comprehensive insurance coverage to participants.

a. Such standards shall include criteria under which the corporation may contract with more than one provider of health care services in program sites. Health plans shall be selected through a competitive bid process that utilizes as the maximum payable rate the current Medicaid reimbursement being paid by the Agency for Health Care Administration to its managed care plans for the same age population, risk-adjusted for the Healthy Kids population and adjusted for enrollee demographics, services covered by the proposed rate, utilization, and inflation. Healthy Kids shall neither enter a contract nor renew a contract that has administrative costs greater than 15 percent.

b. Enrollees shall be enrolled with the selected health plan or plans in their county. If no qualified bidder submits a proposal utilizing the rate, then enrollees in the Healthy Kids program may receive services through the Medikids program. If the corporation delivers services through the Medikids option, the corporation shall establish an appropriate level of reserves in which to pay claims. The amount of the reserves shall be appropriate for the number of enrollees accessing services

through this option and will be actuarially reviewed for soundness and approved by the Department of Financial Services.

c. Implementation of the process described in sub-subparagraphs a. and b. shall begin on July 1, 2003, or at renewal of each insurer's current contract, but shall be completed statewide no later than September 30, 2004. The term "renewal" includes contract options and option years.

d. Dental services shall be provided to Healthy Kids enrollees using the administrative structure and provider network of the Medicaid program ~~The selection of health plans shall be based primarily on quality criteria established by the board~~.

The health plan selection criteria and scoring system, and the scoring results, shall be available upon request for inspection after the bids have been awarded.~~;~~

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

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

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

16. As appropriate, enter into contracts with local school boards or other agencies to provide onsite information,

enrollment, and other services necessary to the operation of the corporation.~~;~~

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

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

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

(5) BOARD OF DIRECTORS.--

(a) The Florida Healthy Kids Corporation shall operate subject to the supervision and approval of a board of directors chaired by the Chief Financial Officer or her or his designee, and composed of 6 ~~14~~ other members selected for 3-year terms of office as follows:

1. One member, appointed by the Chief Financial Officer, who represents the Office of Insurance Regulation. ~~Commissioner of Education from among three persons nominated by the Florida Association of School Administrators;~~

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

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

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

2.~~5.~~ One member, appointed by the Governor, who represents the Children's Medical Services Program and the Department of Health.~~;~~

~~6. One member appointed by the Chief Financial Officer from among three members nominated by the Florida Hospital Association;~~

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

3.~~8.~~ One member, appointed by the Chief Financial Officer, who represents the Institute for Child Health Policy.~~;~~

~~9. One member, appointed by the Governor, from among three members nominated by the Florida Academy of Family Physicians;~~

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

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

6.~~12.~~ One member, appointed by the Governor, from among three members nominated by the Florida Association of Counties, representing urban counties.~~; and~~

~~13. The State Health Officer or her or his designee.~~

Section 17. The provisions of this act which would require changes to the contracts in existence on June 30, 2003, between the Florida Healthy Kids Corporation and its contracted providers shall be applied to such contracts upon the renewal of

the contracts, but no later than September 30, 2004. The term "renewal" includes contract options and option years.

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

Remove lines 14-72, and insert:

overpayments; amending s. 409.811, F.S.; defining "managed care plan" for purposes of the Florida Kidcare Act; amending s. 409.8132, F.S.; providing a cross reference; amending s. 409.901, F.S.; revising the definition of "third party"; amending s. 409.904, F.S.; revising eligibility requirements for certain optional payments for medical assistance and related services; amending s. 409.906, F.S.; revising requirements for payment of optional Medicaid services; limiting provision of dental, hearing, and visual services; amending s. 409.9081, F.S.; providing coinsurance requirements for prescription drugs; providing copayment requirements for hospital outpatient emergency department services; amending s. 409.911, F.S.; revising formulas for payment under the disproportionate share program; revising definitions; providing for use of audited data; amending s. 409.9112, F.S.; revising formulas for payment under the disproportionate share program for regional perinatal intensive care centers; amending s. 409.9117, F.S.; revising formulas for payment under the primary care disproportionate share program; revising criteria for such payments; amending s. 409.9119, F.S.; revising criteria for payment under the disproportionate share program for specialty hospitals for children; amending s. 409.912, F.S.; providing for the

Agency for Health Care Administration to contract with a service network; deleting provisions for service network demonstration projects; providing for contracting to provide Medicaid covered dental services; amending s. 409.9122, F.S.; revising provisions for assignment to a managed care plan by the agency; amending s. 409.913, F.S.; providing for oversight of Medicaid by authorized agents of the Agency for Health Care Administration; amending s. 430.502, F.S.; requiring the Agency for Health Care Administration and the Department of Health to seek and implement a Medicaid home and community-based waiver for persons with Alzheimer's disease; requiring the development of waiver program standards; providing for consultation with the presiding officers of the Legislature; providing for a contingent future repeal of such waiver program; amending s. 624.91, F.S.; revising duties of the Florida Healthy Kids Corporation; revising membership of the board of directors of the corporation; providing for application of the act to existing contracts between the Florida Healthy Kids Corporation and its contracted providers;