603-1853B-06
Proposed Committee Substitute by the Committee on Health and Human Services Appropriations

1 A bill to be entitled
2 An act relating to medical services; amending
3 s. 409.906, F.S.; authorizing the Agency for
4 Health Care Administration to pay for full or
5 partial dentures for certain recipients and for
6 procedures relating to the seating and repair
7 of dentures; authorizing the provision of
8 hearing and visual services to recipients
9 younger than 21 years of age; amending s.
10 409.9122, F.S., relating to mandatory Medicaid
11 managed care enrollment; revising the
12 percentages for the agency to achieve in
13 enrolling certain Medicaid recipients in
14 managed care plans or in MediPass; amending s.
15 409.911, F.S.; revising the audited data used
16 by the agency to determine the amount
17 distributed to hospitals under the
18 disproportionate share program; revising the
19 number of Medicaid days used in the
20 calculation; deleting obsolete provisions;
21 amending s. 409.9113, F.S.; providing for the
22 distribution of funds to statutorily defined
23 teaching hospitals and family practice teaching
24 hospitals; providing an effective date.
25
26 Be It Enacted by the Legislature of the State of Florida:
27
28 Section 1. Paragraph (b) of subsection (1) and
29 subsections (12) and (23) of section 409.906, Florida
30 Statutes, are amended to read:
31 409.906 Optional Medicaid services.--Subject to

1 specific appropriations, the agency may make payments for
2 services which are optional to the state under Title XIX of
3 the Social Security Act and are furnished by Medicaid
4 providers to recipients who are determined to be eligible on
5 the dates on which the services were provided. Any optional
6 service that is provided shall be provided only when medically
7 necessary and in accordance with state and federal law.
8 Optional services rendered by providers in mobile units to
9 Medicaid recipients may be restricted or prohibited by the
10 agency. 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 or chapter 216.
16 If necessary to safeguard the state's systems of providing
17 services to elderly and disabled persons and subject to the
18 notice and review provisions of s. 216.177, the Governor may
19 direct the Agency for Health Care Administration to amend the
20 Medicaid state plan to delete the optional Medicaid service
21 known as "Intermediate Care Facilities for the Developmentally
22 Disabled." Optional services may include:
23 (1) ADULT DENTAL SERVICES.--
24 (b) Beginning July 1, 2006 ~~January 1, 2005~~, the agency
25 may pay for full and partial dentures, the procedures required
26 to seat full or partial dentures, and the repair and reline of
27 full or partial dentures, provided by or under the direction
28 of a licensed dentist, for a recipient who is 21 years of age
29 or older.
30 (12) ~~CHILDREN'S~~ HEARING SERVICES.--The agency may pay
31 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 2. Paragraphs (f) and (k) 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 35 ~~40~~ percent in MediPass and 65 ~~60~~ 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 35 ~~40~~ percent and 65 ~~60~~ 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

1 who are required to but have failed to make a choice of
2 managed care plan or MediPass, including children, and who are
3 to be assigned to the MediPass program to children's networks
4 as described in s. 409.912(4)(g), Children's Medical Services
5 Network as defined in s. 391.021, exclusive provider
6 organizations, provider service networks, minority physician
7 networks, and pediatric emergency department diversion
8 programs authorized by this chapter or the General
9 Appropriations Act, in such manner as the agency deems
10 appropriate, until the agency has determined that the networks
11 and programs have sufficient numbers to be economically
12 operated. For purposes of this paragraph, when referring to
13 assignment, the term "managed care plans" includes health
14 maintenance organizations, exclusive provider organizations,
15 provider service networks, minority physician networks,
16 Children's Medical Services Network, and pediatric emergency
17 department diversion programs authorized by this chapter or
18 the General Appropriations Act. When making assignments, the
19 agency shall take into account the following criteria:
20 1. A managed care plan has sufficient network capacity
21 to meet the need of members.
22 2. The managed care plan or MediPass has previously
23 enrolled the recipient as a member, or one of the managed care
24 plan's primary care providers or MediPass providers has
25 previously provided health care to the recipient.
26 3. The agency has knowledge that the member has
27 previously expressed a preference for a particular managed
28 care plan or MediPass provider as indicated by Medicaid
29 fee-for-service claims data, but has failed to make a choice.
30 4. The managed care plan's or MediPass primary care
31 providers are geographically accessible to the recipient's

1 residence.
2 (k) 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, except
5 in those counties in which there are fewer than two managed
6 care plans accepting Medicaid enrollees, in which case
7 assignment shall be to a managed care plan or a MediPass
8 provider. Medicaid recipients in counties with fewer than two
9 managed care plans accepting Medicaid enrollees who are
10 subject to mandatory assignment but who fail to make a choice
11 shall be assigned to managed care plans until an enrollment of
12 35 ~~40~~ percent in MediPass and 65 ~~60~~ percent in managed care
13 plans is achieved. Once that enrollment is achieved, the
14 assignments shall be divided in order to maintain an
15 enrollment in MediPass and managed care plans which is in a 35
16 ~~40~~ percent and 65 ~~60~~ percent proportion, respectively. In
17 service areas 1 and 6 of the Agency for Health Care
18 Administration where the agency is contracting for the
19 provision of comprehensive behavioral health services through
20 a capitated prepaid arrangement, recipients who fail to make a
21 choice shall be assigned equally to MediPass or a managed care
22 plan. For purposes of this paragraph, when referring to
23 assignment, the term "managed care plans" includes exclusive
24 provider organizations, provider service networks, Children's
25 Medical Services Network, minority physician networks, and
26 pediatric emergency department diversion programs authorized
27 by this chapter or the General Appropriations Act. When making
28 assignments, the agency shall take into account the following
29 criteria:
30 1. A managed care plan has sufficient network capacity
31 to meet the need of members.

1 2. The managed care plan or MediPass has previously
2 enrolled the recipient as a member, or one of the managed care
3 plan's primary care providers or MediPass providers has
4 previously provided health care to the recipient.
5 3. The agency has knowledge that the member has
6 previously expressed a preference for a particular managed
7 care plan or MediPass provider as indicated by Medicaid
8 fee-for-service claims data, but has failed to make a choice.
9 4. The managed care plan's or MediPass primary care
10 providers are geographically accessible to the recipient's
11 residence.
12 5. The agency has authority to make mandatory
13 assignments based on quality of service and performance of
14 managed care plans.
15 Section 3. Paragraph (a) of subsection (2), subsection
16 (3), and paragraphs (b) and (c) of subsection (4) of section
17 409.911, Florida Statutes, as amended by section 1 of chapter
18 2005-358, Laws of Florida, are amended to read:
19 409.911 Disproportionate share program.--Subject to
20 specific allocations established within the General
21 Appropriations Act and any limitations established pursuant to
22 chapter 216, the agency shall distribute, pursuant to this
23 section, moneys to hospitals providing a disproportionate
24 share of Medicaid or charity care services by making quarterly
25 Medicaid payments as required. Notwithstanding the provisions
26 of s. 409.915, counties are exempt from contributing toward
27 the cost of this special reimbursement for hospitals serving a
28 disproportionate share of low-income patients.
29 (2) The Agency for Health Care Administration shall
30 use the following actual audited data to determine the
31 Medicaid days and charity care to be used in calculating the

disproportionate share payment:

(a) The average of the 2000, 2001 ~~1998, 1999~~, and 2002 ~~2000~~ audited disproportionate share data to determine each hospital's Medicaid days and charity care for the 2006-2007 ~~2004-2005~~ state fiscal year ~~and the average of the 1999, 2000, and 2001 audited disproportionate share data to determine the Medicaid days and charity care for the 2005-2006 state fiscal year~~.

(3) 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/TMSD) x $1 million

Where:

DSHP = disproportionate share hospital payment.

HMD = hospital Medicaid days.

TSD = total state Medicaid days.

Any funds not allocated to hospitals qualifying under this section shall be redistributed to the non-state government owned or operated hospitals with greater than 3,100 ~~3,300~~ Medicaid days.

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

(b) For non-state government owned or operated hospitals with 3,100 ~~3,300~~ or more Medicaid days:

DSHP = [(.82 x HCCD/TCCD) + (.18 x HMD/TMD)]
x 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.

TCCD = total state charity care dollars for public non-state hospitals.

~~1. For the 2005-2006 state fiscal year only, the DSHP for the public nonstate hospitals shall be computed using a weighted average of the disproportionate share payments for the 2004-2005 state fiscal year which uses an average of the 1998, 1999, and 2000 audited disproportionate share data and the disproportionate share payments for the 2005-2006 state fiscal year as computed using the formula above and using the average of the 1999, 2000, and 2001 audited disproportionate share data. The final DSHP for the public nonstate hospitals shall be computed as an average using the calculated payments for the 2005-2006 state fiscal year weighted at 65 percent and the disproportionate share payments for the 2004-2005 state fiscal year weighted at 35 percent.~~

~~2.~~ The TAAPH shall be reduced by $6,365,257 before computing the DSHP for each public hospital. The $6,365,257 shall be distributed equally between the public hospitals that are also designated statutory teaching hospitals.

(c) For non-state government owned or operated hospitals with less than 3,100 ~~3,300~~ Medicaid days, a total of $750,000 shall be distributed equally among these hospitals.

1 Section 4. Section 409.9113, Florida Statutes, is
2 amended to read:
3 409.9113 Disproportionate share program for teaching
4 hospitals.--In addition to the payments made under ss. 409.911
5 and 409.9112, the Agency for Health Care Administration shall
6 make disproportionate share payments to statutorily defined
7 teaching hospitals for their increased costs associated with
8 medical education programs and for tertiary health care
9 services provided to the indigent. This system of payments
10 shall conform with federal requirements and shall distribute
11 funds in each fiscal year for which an appropriation is made
12 by making quarterly Medicaid payments. Notwithstanding s.
13 409.915, counties are exempt from contributing toward the cost
14 of this special reimbursement for hospitals serving a
15 disproportionate share of low-income patients. For the
16 2006-2007 state fiscal year ~~2005-2006~~, the agency shall ~~not~~
17 distribute moneys provided in the General Appropriations Act
18 to statutorily defined teaching hospitals and family practice
19 teaching hospitals under the teaching hospital
20 disproportionate share program. The funds provided for
21 statutorily defined teaching hospitals shall be distributed in
22 the same proportion as funds were distributed under the
23 teaching hospital disproportionate share program during the
24 2003-2004 fiscal year. The funds provided for family practice
25 teaching hospitals shall be distributed equally among the
26 family practice teaching hospitals.
27 (1) On or before September 15 of each year, the Agency
28 for Health Care Administration shall calculate an allocation
29 fraction to be used for distributing funds to state statutory
30 teaching hospitals. Subsequent to the end of each quarter of
31 the state fiscal year, the agency shall distribute to each

1 statutory teaching hospital, as defined in s. 408.07, an
2 amount determined by multiplying one-fourth of the funds
3 appropriated for this purpose by the Legislature times such
4 hospital's allocation fraction. The allocation fraction for
5 each such hospital shall be determined by the sum of three
6 primary factors, divided by three. The primary factors are:
7 (a) The number of nationally accredited graduate
8 medical education programs offered by the hospital, including
9 programs accredited by the Accreditation Council for Graduate
10 Medical Education and the combined Internal Medicine and
11 Pediatrics programs acceptable to both the American Board of
12 Internal Medicine and the American Board of Pediatrics at the
13 beginning of the state fiscal year preceding the date on which
14 the allocation fraction is calculated. The numerical value of
15 this factor is the fraction that the hospital represents of
16 the total number of programs, where the total is computed for
17 all state statutory teaching hospitals.
18 (b) The number of full-time equivalent trainees in the
19 hospital, which comprises two components:
20 1. The number of trainees enrolled in nationally
21 accredited graduate medical education programs, as defined in
22 paragraph (a). Full-time equivalents are computed using the
23 fraction of the year during which each trainee is primarily
24 assigned to the given institution, over the state fiscal year
25 preceding the date on which the allocation fraction is
26 calculated. The numerical value of this factor is the fraction
27 that the hospital represents of the total number of full-time
28 equivalent trainees enrolled in accredited graduate programs,
29 where the total is computed for all state statutory teaching
30 hospitals.
31 2. The number of medical students enrolled in

1 accredited colleges of medicine and engaged in clinical
2 activities, including required clinical clerkships and
3 clinical electives. Full-time equivalents are computed using
4 the fraction of the year during which each trainee is
5 primarily assigned to the given institution, over the course
6 of the state fiscal year preceding the date on which the
7 allocation fraction is calculated. The numerical value of this
8 factor is the fraction that the given hospital represents of
9 the total number of full-time equivalent students enrolled in
10 accredited colleges of medicine, where the total is computed
11 for all state statutory teaching hospitals.
12
13 The primary factor for full-time equivalent trainees is
14 computed as the sum of these two components, divided by two.
15 (c) A service index that comprises three components:
16 1. The Agency for Health Care Administration Service
17 Index, computed by applying the standard Service Inventory
18 Scores established by the Agency for Health Care
19 Administration to services offered by the given hospital, as
20 reported on Worksheet A-2 for the last fiscal year reported to
21 the agency before the date on which the allocation fraction is
22 calculated. The numerical value of this factor is the
23 fraction that the given hospital represents of the total
24 Agency for Health Care Administration Service Index values,
25 where the total is computed for all state statutory teaching
26 hospitals.
27 2. A volume-weighted service index, computed by
28 applying the standard Service Inventory Scores established by
29 the Agency for Health Care Administration to the volume of
30 each service, expressed in terms of the standard units of
31 measure reported on Worksheet A-2 for the last fiscal year

1 reported to the agency before the date on which the allocation
2 factor is calculated. The numerical value of this factor is
3 the fraction that the given hospital represents of the total
4 volume-weighted service index values, where the total is
5 computed for all state statutory teaching hospitals.
6 3. Total Medicaid payments to each hospital for direct
7 inpatient and outpatient services during the fiscal year
8 preceding the date on which the allocation factor is
9 calculated. This includes payments made to each hospital for
10 such services by Medicaid prepaid health plans, whether the
11 plan was administered by the hospital or not. The numerical
12 value of this factor is the fraction that each hospital
13 represents of the total of such Medicaid payments, where the
14 total is computed for all state statutory teaching hospitals.
15
16 The primary factor for the service index is computed as the
17 sum of these three components, divided by three.
18 (2) By October 1 of each year, the agency shall use
19 the following formula to calculate the maximum additional
20 disproportionate share payment for statutorily defined
21 teaching hospitals:
22
23 TAP = THAF x A
24
25 Where:
26 TAP = total additional payment.
27 THAF = teaching hospital allocation factor.
28 A = amount appropriated for a teaching hospital
29 disproportionate share program.
30 Section 5. This act shall take effect July 1, 2006.
31