CHAMBER ACTION

Senate		House
Floor: 1/AD/2R 04/19/2006 10:36 AM	.	

Senator Saunders moved the following amendment:

Senate Amendment (with title amendment)

Delete everything after the enacting clause

and insert:

Section 1. Paragraph (b) of subsection (1) and subsections (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.--

(b) Beginning July 1, 2006 ~~January 1, 2005~~, the agency may pay for full and partial dentures, the procedures required to seat full or partial dentures, and the repair and reline of full or partial dentures, provided by or under the direction of a licensed dentist, for a recipient who is 21 years of age or older.

(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 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 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(4)(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

1 operated. For purposes of this paragraph, when referring to
2 assignment, the term "managed care plans" includes health
3 maintenance organizations, exclusive provider organizations,
4 provider service networks, minority physician networks,
5 Children's Medical Services Network, and pediatric emergency
6 department diversion programs authorized by this chapter or
7 the General Appropriations Act. When making assignments, the
8 agency shall take into account the following criteria:
9 1. A managed care plan has sufficient network capacity
10 to meet the need of members.
11 2. The managed care plan or MediPass has previously
12 enrolled the recipient as a member, or one of the managed care
13 plan's primary care providers or MediPass providers has
14 previously provided health care to the recipient.
15 3. The agency has knowledge that the member has
16 previously expressed a preference for a particular managed
17 care plan or MediPass provider as indicated by Medicaid
18 fee-for-service claims data, but has failed to make a choice.
19 4. The managed care plan's or MediPass primary care
20 providers are geographically accessible to the recipient's
21 residence.
22 (k) When a Medicaid recipient does not choose a
23 managed care plan or MediPass provider, the agency shall
24 assign the Medicaid recipient to a managed care plan, except
25 in those counties in which there are fewer than two managed
26 care plans accepting Medicaid enrollees, in which case
27 assignment shall be to a managed care plan or a MediPass
28 provider. Medicaid recipients in counties with fewer than two
29 managed care plans accepting Medicaid enrollees who are
30 subject to mandatory assignment but who fail to make a choice
31 shall be assigned to managed care plans until an enrollment of

1 35 ~~40~~ percent in MediPass and 65 ~~60~~ percent in managed care
2 plans is achieved. Once that enrollment is achieved, the
3 assignments shall be divided in order to maintain an
4 enrollment in MediPass and managed care plans which is in a 35
5 ~~40~~ percent and 65 ~~60~~ percent proportion, respectively. In
6 service areas 1 and 6 of the Agency for Health Care
7 Administration where the agency is contracting for the
8 provision of comprehensive behavioral health services through
9 a capitated prepaid arrangement, recipients who fail to make a
10 choice shall be assigned equally to MediPass or a managed care
11 plan. For purposes of this paragraph, when referring to
12 assignment, the term "managed care plans" includes exclusive
13 provider organizations, provider service networks, Children's
14 Medical Services Network, minority physician networks, and
15 pediatric emergency department diversion programs authorized
16 by this chapter or the General Appropriations Act. When making
17 assignments, the agency shall take into account the following
18 criteria:
19 1. A managed care plan has sufficient network capacity
20 to meet the need of members.
21 2. The managed care plan or MediPass has previously
22 enrolled the recipient as a member, or one of the managed care
23 plan's primary care providers or MediPass providers has
24 previously provided health care to the recipient.
25 3. The agency has knowledge that the member has
26 previously expressed a preference for a particular managed
27 care plan or MediPass provider as indicated by Medicaid
28 fee-for-service claims data, but has failed to make a choice.
29 4. The managed care plan's or MediPass primary care
30 providers are geographically accessible to the recipient's
31 residence.

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

Section 3. Paragraph (a) of subsection (2), subsection (3), and paragraphs (b) and (c) of subsection (4) of section 409.911, Florida Statutes, as amended by section 1 of chapter 2005-358, Laws of Florida, are 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.

(2) The Agency for Health Care Administration shall use the following actual audited data to determine the 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 ~~1. For the 2005-2006 state fiscal year only, the DSHP~~
2 ~~for the public nonstate hospitals shall be computed using a~~
3 ~~weighted average of the disproportionate share payments for~~
4 ~~the 2004-2005 state fiscal year which uses an average of the~~
5 ~~1998, 1999, and 2000 audited disproportionate share data and~~
6 ~~the disproportionate share payments for the 2005-2006 state~~
7 ~~fiscal year as computed using the formula above and using the~~
8 ~~average of the 1999, 2000, and 2001 audited disproportionate~~
9 ~~share data. The final DSHP for the public nonstate hospitals~~
10 ~~shall be computed as an average using the calculated payments~~
11 ~~for the 2005-2006 state fiscal year weighted at 65 percent and~~
12 ~~the disproportionate share payments for the 2004-2005 state~~
13 ~~fiscal year weighted at 35 percent.~~
14 ~~2.~~ The TAAPH shall be reduced by $6,365,257 before
15 computing the DSHP for each public hospital. The $6,365,257
16 shall be distributed equally between the public hospitals that
17 are also designated statutory teaching hospitals.
18 (c) For non-state government owned or operated
19 hospitals with less than 3,100 ~~3,300~~ Medicaid days, a total of
20 $750,000 shall be distributed equally among these hospitals.
21 Section 4. Section 409.9113, Florida Statutes, is
22 amended to read:
23 409.9113 Disproportionate share program for teaching
24 hospitals.--In addition to the payments made under ss. 409.911
25 and 409.9112, the Agency for Health Care Administration shall
26 make disproportionate share payments to statutorily defined
27 teaching hospitals for their increased costs associated with
28 medical education programs and for tertiary health care
29 services provided to the indigent. This system of payments
30 shall conform with federal requirements and shall distribute
31 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 serving a disproportionate share of low-income patients. For the 2006-2007 state fiscal year ~~2005-2006~~, the agency shall ~~not~~ distribute moneys provided in the General Appropriations Act to statutorily defined teaching hospitals and family practice teaching hospitals under the teaching hospital disproportionate share program. The funds provided for statutorily defined teaching hospitals shall be distributed in the same proportion as funds were distributed under the teaching hospital disproportionate share program during the 2003-2004 fiscal year. The funds provided for family practice teaching hospitals shall be distributed equally among the family practice teaching hospitals.

(1) On or before September 15 of each year, the Agency for Health Care Administration shall calculate an allocation fraction to be used for distributing funds to state statutory teaching hospitals. Subsequent to the end of each quarter of the state fiscal year, the agency shall distribute to each statutory teaching hospital, as defined in s. 408.07, an amount determined by multiplying one-fourth of the funds appropriated for this purpose by the Legislature times such hospital's allocation fraction. The allocation fraction for each such hospital shall be determined by the sum of three primary factors, divided by three. The primary factors are:

(a) The number of nationally accredited graduate medical education programs offered by the hospital, including programs accredited by the Accreditation Council for Graduate Medical Education and the combined Internal Medicine and Pediatrics programs acceptable to both the American Board of

1 Internal Medicine and the American Board of Pediatrics at the
2 beginning of the state fiscal year preceding the date on which
3 the allocation fraction is calculated. The numerical value of
4 this factor is the fraction that the hospital represents of
5 the total number of programs, where the total is computed for
6 all state statutory teaching hospitals.
7 (b) The number of full-time equivalent trainees in the
8 hospital, which comprises two components:
9 1. The number of trainees enrolled in nationally
10 accredited graduate medical education programs, as defined in
11 paragraph (a). Full-time equivalents are computed using the
12 fraction of the year during which each trainee is primarily
13 assigned to the given institution, over the state fiscal year
14 preceding the date on which the allocation fraction is
15 calculated. The numerical value of this factor is the fraction
16 that the hospital represents of the total number of full-time
17 equivalent trainees enrolled in accredited graduate programs,
18 where the total is computed for all state statutory teaching
19 hospitals.
20 2. The number of medical students enrolled in
21 accredited colleges of medicine and engaged in clinical
22 activities, including required clinical clerkships and
23 clinical electives. Full-time equivalents are computed using
24 the fraction of the year during which each trainee is
25 primarily assigned to the given institution, over the course
26 of the state fiscal year preceding the date on which the
27 allocation fraction is calculated. The numerical value of this
28 factor is the fraction that the given hospital represents of
29 the total number of full-time equivalent students enrolled in
30 accredited colleges of medicine, where the total is computed
31 for all state statutory teaching hospitals.

The primary factor for full-time equivalent trainees is computed as the sum of these two components, divided by two.

(c) A service index that comprises three components:

1. The Agency for Health Care Administration Service Index, computed by applying the standard Service Inventory Scores established by the Agency for Health Care Administration to services offered by the given hospital, as reported on Worksheet A-2 for the last fiscal year reported to the agency before the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the given hospital represents of the total Agency for Health Care Administration Service Index values, where the total is computed for all state statutory teaching hospitals.

2. A volume-weighted service index, computed by applying the standard Service Inventory Scores established by the Agency for Health Care Administration to the volume of each service, expressed in terms of the standard units of measure reported on Worksheet A-2 for the last fiscal year reported to the agency before the date on which the allocation factor is calculated. The numerical value of this factor is the fraction that the given hospital represents of the total volume-weighted service index values, where the total is computed for all state statutory teaching hospitals.

3. Total Medicaid payments to each hospital for direct inpatient and outpatient services during the fiscal year preceding the date on which the allocation factor is calculated. This includes payments made to each hospital for such services by Medicaid prepaid health plans, whether the plan was administered by the hospital or not. The numerical

1 value of this factor is the fraction that each hospital
2 represents of the total of such Medicaid payments, where the
3 total is computed for all state statutory teaching hospitals.
4
5 The primary factor for the service index is computed as the
6 sum of these three components, divided by three.
7 (2) By October 1 of each year, the agency shall use
8 the following formula to calculate the maximum additional
9 disproportionate share payment for statutorily defined
10 teaching hospitals:
11
12 TAP = THAF x A
13
14 Where:
15 TAP = total additional payment.
16 THAF = teaching hospital allocation factor.
17 A = amount appropriated for a teaching hospital
18 disproportionate share program.
19 Section 5. Paragraph (b) of subsection (5) of section
20 624.91, Florida Statutes, is amended to read:
21 624.91 The Florida Healthy Kids Corporation Act.--
22 (5) CORPORATION AUTHORIZATION, DUTIES, POWERS.--
23 (b) The Florida Healthy Kids Corporation shall:
24 1. Arrange for the collection of any family, local
25 contributions, or employer payment or premium, in an amount to
26 be determined by the board of directors, to provide for
27 payment of premiums for comprehensive insurance coverage and
28 for the actual or estimated administrative expenses.
29 2. Arrange for the collection of any voluntary
30 contributions to provide for payment of premiums for children
31 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.~~

3. Subject to the provisions of s. 409.8134, 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.

4. Establish the administrative and accounting procedures for the operation of the corporation.

5. 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

1 rural areas shall not limit primary care providers to
2 board-certified pediatricians.
3 6. Determine eligibility for children seeking to
4 participate in the Title XXI-funded components of the Florida
5 KidCare program consistent with the requirements specified in
6 s. 409.814, as well as the non-Title-XXI-eligible children as
7 provided in subsection (3).
8 7. Establish procedures under which providers of local
9 match to, applicants to and participants in the program may
10 have grievances reviewed by an impartial body and reported to
11 the board of directors of the corporation.
12 8. Establish participation criteria and, if
13 appropriate, contract with an authorized insurer, health
14 maintenance organization, or third-party administrator to
15 provide administrative services to the corporation.
16 9. Establish enrollment criteria which shall include
17 penalties or waiting periods of not fewer than 60 days for
18 reinstatement of coverage upon voluntary cancellation for
19 nonpayment of family premiums.
20 10. Contract with authorized insurers or any provider
21 of health care services, meeting standards established by the
22 corporation, for the provision of comprehensive insurance
23 coverage to participants. Such standards shall include
24 criteria under which the corporation may contract with more
25 than one provider of health care services in program sites.
26 Health plans shall be selected through a competitive bid
27 process. The Florida Healthy Kids Corporation shall purchase
28 goods and services in the most cost-effective manner
29 consistent with the delivery of quality medical care. The
30 maximum administrative cost for a Florida Healthy Kids
31 Corporation contract shall be 15 percent. For health care

1 contracts, the minimum medical loss ratio for a Florida
2 Healthy Kids Corporation contract shall be 85 percent. For
3 dental contracts, the remaining compensation to be paid to the
4 authorized insurer or provider under a Florida Healthy Kids
5 Corporation contract shall be no less than an amount which is
6 85 percent of premium; to the extent any contract provision
7 does not provide for this minimum compensation, this section
8 shall prevail. The health plan selection criteria and scoring
9 system, and the scoring results, shall be available upon
10 request for inspection after the bids have been awarded.
11 11. Establish disenrollment criteria in the event
12 local matching funds are insufficient to cover enrollments.
13 12. Develop and implement a plan to publicize the
14 Florida Healthy Kids Corporation, the eligibility requirements
15 of the program, and the procedures for enrollment in the
16 program and to maintain public awareness of the corporation
17 and the program.
18 13. Secure staff necessary to properly administer the
19 corporation. Staff costs shall be funded from state and local
20 matching funds and such other private or public funds as
21 become available. The board of directors shall determine the
22 number of staff members necessary to administer the
23 corporation.
24 14. Provide a report annually to the Governor, Chief
25 Financial Officer, Commissioner of Education, Senate
26 President, Speaker of the House of Representatives, and
27 Minority Leaders of the Senate and the House of
28 Representatives.
29 15. Establish benefit packages which conform to the
30 provisions of the Florida KidCare program, as created in ss.
31 409.810-409.820.

1 Section 6. The Office of Program Policy Analysis and
2 Government Accountability (OPPAGA) shall review the functions
3 currently performed by the Comprehensive Assessment and Review
4 for Long-Term Care Services (CARES) Program within the
5 Department of Elderly Affairs. OPPAGA shall identify the
6 factors affecting the time currently required for CARES staff
7 to assess an individual's eligibility for long-term care
8 services. As part of this study, OPPAGA shall also examine
9 circumstances that could delay an individual's placement into
10 the Long-Term Care Community Diversion pilot project. OPPAGA
11 shall report its findings to the President of the Senate and
12 the Speaker of the House of Representatives by February 1,
13 2007.
14 Section 7. This act shall take effect July 1, 2006.
15
16
17 =============== T I T L E A M E N D M E N T ==============
18 And the title is amended as follows:
19 Delete everything before the enacting clause
20
21 and insert:
22 A bill to be entitled
23 An act relating to medical services; amending
24 s. 409.906, F.S.; authorizing the Agency for
25 Health Care Administration to pay for full or
26 partial dentures for certain recipients and for
27 procedures relating to the seating and repair
28 of dentures; authorizing the provision of
29 hearing and visual services to Medicaid
30 recipients; amending s. 409.9122, F.S.,
31 relating to mandatory Medicaid managed care

1 enrollment; revising the percentages for the
2 agency to achieve in enrolling certain Medicaid
3 recipients in managed care plans or in
4 MediPass; amending s. 409.911, F.S.; revising
5 the audited data used by the agency to
6 determine the amount distributed to hospitals
7 under the disproportionate share program;
8 revising the number of Medicaid days used in
9 the calculation; deleting obsolete provisions;
10 amending s. 409.9113, F.S.; providing for the
11 distribution of funds to statutorily defined
12 teaching hospitals and family practice teaching
13 hospitals; amending s. 624.91, F.S.; deleting
14 provisions requiring that the Florida Healthy
15 Kids Corporation establish a local match policy
16 each fiscal year for enrolling certain children
17 in the Healthy Kids program; requiring the
18 Office of Program Policy Analysis and
19 Government Accountability to review the
20 Comprehensive Assessment and Review for
21 Long-Term Care Services (CARES) Program within
22 the Department of Elderly Affairs and report to
23 the President of the Senate and the Speaker of
24 the House of Representatives by a specified
25 date; providing an effective date.
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