An act relating to Medicaid; repealing s. 381.0403, F.S., relating to the Community Hospital Education Act; amending s. 395.602, F.S.; providing that certain rural hospitals remain rural hospitals under specified circumstances; amending s. 409.905, F.S.; requiring the Agency for Health Care Administration to implement a prospective payment system for inpatient hospital services using diagnosis-related groups (DRGs); deleting provisions directing the agency to develop a plan to convert hospital reimbursement for inpatient services to a prospective payment system; requiring hospital reimbursement for outpatient services to be based on allowable costs; providing that adjustments may not be made after a certain date; providing for the reconciliation of errors in source data or calculations; amending s. 409.908, F.S.; revising exceptions to limitations on hospital reimbursement for inpatient services; providing parameters for submission of letters of agreement by local governmental entities to the agency relating to funds for special payments; providing that base rate reimbursement under a diagnosis-related group methodology shall be established in the General Appropriations Act; creating s. 409.909, F.S.; establishing the Statewide Medicaid Residency Program; providing the purposes of the program; providing definitions; providing a formula and limitations for allocating funds to participating hospitals;

authorizing the agency to adopt rules; amending s. 409.910, F.S.; revising provisions relating to responsibility for Medicaid payments in settlement proceedings; providing procedures for a recipient to contest the amount payable to the agency; amending s. 409.911, F.S.; updating references to data used for calculations in the disproportionate share program; amending s. 409.9118, F.S.; amending parameters for the disproportionate share program for specialty hospitals; limiting reimbursement to tuberculosis services provided under contract with the Department of Health; amending s. 409.9122, F.S.; providing that certain mandatory managed care provisions that apply to a Medicaid recipient diagnosed with HIV/AIDS apply only to a recipient who failed to choose a managed care option; amending s. 409.915, F.S.; specifying the total contribution for certain years and specifying the method for determining the amount in the following years; revising the method for calculating each county's contribution; providing tables for calculating county contributions; requiring the Agency for Health Care Administration to annually report the status of county billings to the Legislature; authorizing the Department of Revenue to withhold county distributions for failure to remit Medicaid contributions; deleting provisions specifying the care and services that counties must participate in, obsolete bond provisions, and a process for refund requests; specifying the method for calculating each

county's contribution for the 2013-2014 fiscal year; requiring the agency to submit an annual report to the Governor, the Legislature, and the Florida Association of Counties which includes information necessary to comprehensively evaluate the cost and utilization of health services by Medicaid enrollees; providing for the repeal and replacement of specified proviso in the 2013-2014 General Appropriations Act; providing an effective date.

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

Section 1. Section 381.0403, Florida Statutes, is repealed.

Section 2. Paragraph (e) of subsection (2) of section 395.602, Florida Statutes, is amended to read:

395.602 Rural hospitals.—

(2) DEFINITIONS.—As used in this part:

(e) "Rural hospital" means an acute care hospital licensed under this chapter, having 100 or fewer licensed beds and an emergency room, which is:

1. The sole provider within a county with a population density of no greater than 100 persons per square mile;

2. An acute care hospital, in a county with a population density of no greater than 100 persons per square mile, which is at least 30 minutes of travel time, on normally traveled roads under normal traffic conditions, from any other acute care hospital within the same county;

3. A hospital supported by a tax district or subdistrict whose boundaries encompass a population of 100 persons or fewer

per square mile;

4. A hospital in a constitutional charter county with a population of over 1 million persons that has imposed a local option health service tax pursuant to law and in an area that was directly impacted by a catastrophic event on August 24, 1992, for which the Governor of Florida declared a state of emergency pursuant to chapter 125, and has 120 beds or less that serves an agricultural community with an emergency room utilization of no less than 20,000 visits and a Medicaid inpatient utilization rate greater than 15 percent;

5. A hospital with a service area that has a population of 100 persons or fewer per square mile. As used in this subparagraph, the term "service area" means the fewest number of zip codes that account for 75 percent of the hospital's discharges for the most recent 5-year period, based on information available from the hospital inpatient discharge database in the Florida Center for Health Information and Policy Analysis at the agency ~~for Health Care Administration~~; or

6. A hospital designated as a critical access hospital, as defined in s. 408.07~~(15)~~.

Population densities used in this paragraph must be based upon the most recently completed United States census. A hospital that received funds under s. 409.9116 for a quarter beginning no later than July 1, 2002, is deemed to have been and shall continue to be a rural hospital from that date through June 30, 2015, if the hospital continues to have 100 or fewer licensed beds and an emergency room, or meets the criteria of subparagraph 4. An acute care hospital that has not previously

been designated as a rural hospital and that meets the criteria of this paragraph shall be granted such designation upon application, including supporting documentation, to the agency ~~for Health Care Administration~~. A hospital that was licensed as a rural hospital during the 2010-2011 or 2011-2012 fiscal year shall continue to be a rural hospital from the date of designation through June 30, 2015, if the hospital continues to have 100 or fewer licensed beds and an emergency room.

Section 3. Paragraphs (c), (d), and (f) of subsection (5) and subsection (6) of section 409.905, Florida Statutes, are amended to read:

409.905 Mandatory Medicaid services.—The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law. Mandatory services rendered by providers in mobile units to Medicaid recipients may be restricted 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, number of services, or 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.

(5) HOSPITAL INPATIENT SERVICES.—The agency shall pay for all covered services provided for the medical care and treatment of a recipient who is admitted as an inpatient by a licensed

physician or dentist to a hospital licensed under part I of chapter 395. However, the agency shall limit the payment for inpatient hospital services for a Medicaid recipient 21 years of age or older to 45 days or the number of days necessary to comply with the General Appropriations Act. Effective August 1, 2012, the agency shall limit payment for hospital emergency department visits for a nonpregnant Medicaid recipient 21 years of age or older to six visits per fiscal year.

(c) The agency shall implement a prospective payment methodology for establishing ~~base~~ reimbursement rates for inpatient hospital services ~~each hospital based on allowable costs, as defined by the agency~~. Rates shall be calculated annually and take effect July 1 of each year ~~based on the most recent complete and accurate cost report submitted by each hospital~~. The methodology shall categorize each inpatient admission into a diagnosis-related group and assign a relative payment weight to the base rate according to the average relative amount of hospital resources used to treat a patient in a specific diagnosis-related group category. The agency may adopt the most recent relative weights calculated and made available by the Nationwide Inpatient Sample maintained by the Agency for Healthcare Research and Quality or may adopt alternative weights if the agency finds that Florida-specific weights deviate with statistical significance from national weights for high-volume diagnosis-related groups. The agency shall establish a single, uniform base rate for all hospitals unless specifically exempt pursuant to s. 409.908(1).

1. Adjustments may not be made to the rates after October 31 of the state fiscal year in which the rates take effect,

except for cases of insufficient collections of intergovernmental transfers authorized under s. 409.908(1) or the General Appropriations Act. In such cases, the agency shall submit a budget amendment or amendments under chapter 216 requesting approval of rate reductions by amounts necessary for the aggregate reduction to equal the dollar amount of intergovernmental transfers not collected and the corresponding federal match. Notwithstanding the $1 million limitation on increases to an approved operating budget contained in ss. 216.181(11) and 216.292(3), a budget amendment exceeding that dollar amount is subject to notice and objection procedures set forth in s. 216.177.

2. Errors in source data or calculations ~~cost reporting or calculation of rates~~ discovered after October 31 must be reconciled in a subsequent rate period. However, the agency may not make any adjustment to a hospital's reimbursement ~~rate~~ more than 5 years after a hospital is notified of an audited rate established by the agency. The prohibition against adjustments ~~requirement that the agency may not make any adjustment to a hospital's reimbursement rate~~ more than 5 years after notification ~~a hospital is notified of an audited rate established by the agency~~ is remedial and applies to actions by providers involving Medicaid claims for hospital services. Hospital reimbursement is ~~rates are~~ subject to such limits or ceilings as may be established in law or described in the agency's hospital reimbursement plan. Specific exemptions to the limits or ceilings may be provided in the General Appropriations Act.

(d) The agency shall implement a comprehensive utilization

management program for hospital neonatal intensive care stays in certain high-volume participating hospitals, select counties, or statewide, and replace existing hospital inpatient utilization management programs for neonatal intensive care admissions. The program shall be designed to manage appropriate admissions and discharges ~~the lengths of stay~~ for children being treated in neonatal intensive care units and must seek ~~the earliest~~ medically appropriate discharge to the child's home or other less costly treatment setting. The agency may competitively bid a contract for the selection of a qualified organization to provide neonatal intensive care utilization management services. The agency may seek federal waivers to implement this initiative.

~~(f) The agency shall develop a plan to convert Medicaid inpatient hospital rates to a prospective payment system that categorizes each case into diagnosis-related groups (DRG) and assigns a payment weight based on the average resources used to treat Medicaid patients in that DRG. To the extent possible, the agency shall propose an adaptation of an existing prospective payment system, such as the one used by Medicare, and shall propose such adjustments as are necessary for the Medicaid population and to maintain budget neutrality for inpatient hospital expenditures.~~

~~1. The plan must:~~

~~a. Define and describe DRGs for inpatient hospital care specific to Medicaid in this state;~~

~~b. Determine the use of resources needed for each DRG;~~

~~c. Apply current statewide levels of funding to DRGs based on the associated resource value of DRGs. Current statewide~~

~~funding levels shall be calculated both with and without the use of intergovernmental transfers;~~

~~d. Calculate the current number of services provided in the Medicaid program based on DRGs defined under this subparagraph;~~

~~e. Estimate the number of cases in each DRG for future years based on agency data and the official workload estimates of the Social Services Estimating Conference;~~

~~f. Calculate the expected total Medicaid payments in the current year for each hospital with a Medicaid provider agreement, based on the DRGs and estimated workload;~~

~~g. Propose supplemental DRG payments to augment hospital reimbursements based on patient acuity and individual hospital characteristics, including classification as a children's hospital, rural hospital, trauma center, burn unit, and other characteristics that could warrant higher reimbursements, while maintaining budget neutrality; and~~

~~h. Estimate potential funding for each hospital with a Medicaid provider agreement for DRGs defined pursuant to this subparagraph and supplemental DRG payments using current funding levels, calculated both with and without the use of intergovernmental transfers.~~

~~2. The agency shall engage a consultant with expertise and experience in the implementation of DRG systems for hospital reimbursement to develop the DRG plan under subparagraph 1.~~

~~3. The agency shall submit the DRG plan, identifying all steps necessary for the transition and any costs associated with plan implementation, to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than January 1, 2013. The plan shall include a timeline~~

~~necessary to complete full implementation by July 1, 2013. If, during implementation of this paragraph, the agency determines that these timeframes might not be achievable, the agency shall report to the Legislative Budget Commission the status of its implementation efforts, the reasons the timeframes might not be achievable, and proposals for new timeframes.~~

(6) HOSPITAL OUTPATIENT SERVICES.—

(a) The agency shall pay for preventive, diagnostic, therapeutic, or palliative care and other services provided to a recipient in the outpatient portion of a hospital licensed under part I of chapter 395, and provided under the direction of a licensed physician or licensed dentist, except that payment for such care and services is limited to $1,500 per state fiscal year per recipient, unless an exception has been made by the agency, and with the exception of a Medicaid recipient under age 21, in which case the only limitation is medical necessity.

(b) The agency shall implement a methodology for establishing base reimbursement rates for outpatient services for each hospital based on allowable costs, as defined by the agency. Rates shall be calculated annually and take effect July 1 of each year based on the most recent complete and accurate cost report submitted by each hospital.

1. Adjustments may not be made to the rates after October 31 of the state fiscal year in which the rates take effect, except for cases of insufficient collections of intergovernmental transfers authorized under s. 409.908(1) or the General Appropriations Act. In such cases, the agency shall submit a budget amendment or amendments under chapter 216 requesting approval of rate reductions by amounts necessary for

the aggregate reduction to equal the dollar amount of intergovernmental transfers not collected and the corresponding federal match. Notwithstanding the $1 million limitation on increases to an approved operating budget under ss. 216.181(11) and 216.292(3), a budget amendment exceeding that dollar amount is subject to notice and objection procedures set forth in s. 216.177.

2. Errors in source data or calculations discovered after October 31 must be reconciled in a subsequent rate period. However, the agency may not make any adjustment to a hospital's reimbursement more than 5 years after a hospital is notified of an audited rate established by the agency. The prohibition against adjustments more than 5 years after notification is remedial and applies to actions by providers involving Medicaid claims for hospital services. Hospital reimbursement is subject to such limits or ceilings as may be established in law or described in the agency's hospital reimbursement plan. Specific exemptions to the limits or ceilings may be provided in the General Appropriations Act.

Section 4. Paragraph (a) of subsection (1) and subsection (23) of section 409.908, Florida Statutes, are amended to read:

409.908 Reimbursement of Medicaid providers.—Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency

considers efficient and effective for purchasing services or goods on behalf of recipients. If a provider is reimbursed based on cost reporting and submits a cost report late and that cost report would have been used to set a lower reimbursement rate for a rate semester, then the provider's rate for that semester shall be retroactively calculated using the new cost report, and full payment at the recalculated rate shall be effected retroactively. Medicare-granted extensions for filing cost reports, if applicable, shall also apply to Medicaid cost reports. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, 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, provided the adjustment is consistent with legislative intent.

(1) Reimbursement to hospitals licensed under part I of chapter 395 must be made prospectively or on the basis of negotiation.

(a) Reimbursement for inpatient care is limited as provided ~~for~~ in s. 409.905(5), except as otherwise provided in this subsection. ~~for:~~

1. If authorized by the General Appropriations Act, the agency may modify reimbursement for specific types of services or diagnoses, recipient ages, and hospital provider types ~~The~~

~~raising of rate reimbursement caps, excluding rural hospitals~~.

2. The agency may establish an alternative methodology to the DRG-based prospective payment system to set reimbursement rates for:

a. State-owned psychiatric hospitals.

b. Newborn hearing screening services.

c. Transplant services for which the agency has established a global fee.

d. Recipients who have tuberculosis that is resistant to therapy who are in need of long-term, hospital-based treatment pursuant to s. 392.62 ~~Recognition of the costs of graduate medical education~~.

3. The agency shall modify reimbursement according to other methodologies recognized in the General Appropriations Act.

~~During the years funds are transferred from the Department of Health, any reimbursement supported by such funds shall be subject to certification by the Department of Health that the hospital has complied with s. 381.0403.~~ The agency may ~~is authorized to~~ receive funds from state entities, including, but not limited to, the Department of Health, local governments, and other local political subdivisions, for the purpose of making special exception payments, including federal matching funds, through the Medicaid inpatient reimbursement methodologies. Funds received ~~from state entities or local governments~~ for this purpose shall be separately accounted for and may ~~shall~~ not be commingled with other state or local funds in any manner. The agency may certify all local governmental funds used as state match under Title XIX of the Social Security Act, to the extent

and in the manner authorized under ~~that the identified local health care provider that is otherwise entitled to and is contracted to receive such local funds is the benefactor under the state's Medicaid program as determined under~~ the General Appropriations Act and pursuant to an agreement between the agency ~~for Health Care Administration~~ and the local governmental entity. In order for the agency to certify such local governmental funds, a local governmental entity must submit a final, executed letter of agreement to the agency, which must be received by October 1 of each fiscal year and provide the total amount of local governmental funds authorized by the entity for that fiscal year under this paragraph, paragraph (b), or the General Appropriations Act. The local governmental entity shall use a certification form prescribed by the agency. At a minimum, the certification form must ~~shall~~ identify the amount being certified and describe the relationship between the certifying local governmental entity and the local health care provider. The agency shall prepare an annual statement of impact which documents the specific activities undertaken during the previous fiscal year pursuant to this paragraph, to be submitted to the Legislature annually by ~~no later than~~ January 1~~, annually~~.

(23)(a) The agency shall establish rates at a level that ensures no increase in statewide expenditures resulting from a change in unit costs effective July 1, 2011. Reimbursement rates shall be as provided in the General Appropriations Act.

(b) Base rate reimbursement under a diagnosis-related group payment methodology shall be provided in the General Appropriations Act.

(c)~~(b)~~ This subsection applies to the following provider

types:

1. Inpatient hospitals.

2. Outpatient hospitals.

3. Nursing homes.

4. County health departments.

5. Community intermediate care facilities for the developmentally disabled.

6. Prepaid health plans.

(d) ~~(c)~~ The agency shall apply the effect of this subsection to the reimbursement rates for nursing home diversion programs.

Section 5. Section 409.909, Florida Statutes, is created to read:

409.909 Statewide Medicaid Residency Program.—

(1) The Statewide Medicaid Residency Program is established to improve the quality of care and access to care for Medicaid recipients, expand graduate medical education on an equitable basis, and increase the supply of highly trained physicians statewide. The agency shall make payments to hospitals licensed under part I of chapter 395 for graduate medical education associated with the Medicaid program. This system of payments is designed to generate federal matching funds under Medicaid and distribute the resulting funds to participating hospitals on a quarterly basis in each fiscal year for which an appropriation is made.

(2) On or before September 15 of each year, the agency shall calculate an allocation fraction to be used for distributing funds to participating hospitals. On or before the final business day of each quarter of a state fiscal year, the agency shall distribute to each participating hospital one-

fourth of that hospital's annual allocation calculated under subsection (4). The allocation fraction for each participating hospital is based on the hospital's number of full-time equivalent residents and the amount of its Medicaid payments. As used in this section, the term:

(a) "Full-time equivalent," or "FTE," means a resident who is in his or her initial residency period, which is defined as the minimum number of years of training required before the resident may become eligible for board certification by the American Osteopathic Association Bureau of Osteopathic Specialists or the American Board of Medical Specialties in the specialty in which he or she first began training, not to exceed 5 years. A resident training beyond the initial residency period is counted as 0.5 FTE, unless his or her chosen specialty is in general surgery or primary care, in which case the resident is counted as 1.0 FTE. For the purposes of this section, primary care specialties include:

1. Family medicine;
2. General internal medicine;
3. General pediatrics;
4. Preventive medicine;
5. Geriatric medicine;
6. Osteopathic general practice;
7. Obstetrics and gynecology; and
8. Emergency medicine.

(b) "Medicaid payments" means the estimated total payments for reimbursing a hospital for direct inpatient services for the fiscal year in which the allocation fraction is calculated based on the hospital inpatient appropriation and the parameters for

the inpatient diagnosis-related group base rate, including applicable intergovernmental transfers, specified in the General Appropriations Act, as determined by the agency.

(c) "Resident" means a medical intern, fellow, or resident enrolled in a program accredited by the Accreditation Council for Graduate Medical Education, the American Association of Colleges of Osteopathic Medicine, or the American Osteopathic Association at the beginning of the state fiscal year during which the allocation fraction is calculated, as reported by the hospital to the agency.

(3) The agency shall use the following formula to calculate a participating hospital's allocation fraction:

HAF=[0.9 x (HFTE/TFTE)] + [0.1 x (HMP/TMP)]

Where:

HAF=A hospital's allocation fraction.

HFTE=A hospital's total number of FTE residents.

TFTE=The total FTE residents for all participating hospitals.

HMP=A hospital's Medicaid payments.

TMP=The total Medicaid payments for all participating hospitals.

(4) A hospital's annual allocation shall be calculated by multiplying the funds appropriated for the Statewide Medicaid Residency Program in the General Appropriations Act by that hospital's allocation fraction. If the calculation results in an annual allocation that exceeds $50,000 per FTE resident, the

hospital's annual allocation shall be reduced to a sum equaling no more than $50,000 per FTE resident. The funds calculated for that hospital in excess of $50,000 per FTE resident shall be redistributed to participating hospitals whose annual allocation does not exceed $50,000 per FTE resident, using the same methodology and payment schedule specified in this section.

(5) The agency may adopt rules to administer this section.

Section 6. Subsection (17) of section 409.910, Florida Statutes, is amended to read:

409.910 Responsibility for payments on behalf of Medicaid-eligible persons when other parties are liable.—

(17) A recipient or his or her legal representative or any person representing, or acting as agent for, a recipient or the recipient's legal representative, who has notice, excluding notice charged solely by reason of the recording of the lien pursuant to paragraph (6)(c), or who has actual knowledge of the agency's rights to third-party benefits under this section, who receives any third-party benefit or proceeds ~~therefrom~~ for a covered illness or injury, must ~~is required either to pay the agency~~, within 60 days after receipt of settlement proceeds, pay the agency the full amount of the third-party benefits, but not more than ~~in excess of~~ the total medical assistance provided by Medicaid, or ~~to~~ place the full amount of the third-party benefits in an interest-bearing ~~a~~ trust account for the benefit of the agency pending an ~~judicial or~~ administrative determination of the agency's right to the benefits ~~thereto~~. Proof that ~~any~~ such person had notice or knowledge that the recipient had received medical assistance from Medicaid, and that third-party benefits or proceeds ~~therefrom~~ were in any way

related to a covered illness or injury for which Medicaid had provided medical assistance, and that ~~any~~ such person knowingly obtained possession or control of, or used, third-party benefits or proceeds and failed ~~either~~ to pay the agency the full amount required by this section or to hold the full amount of third-party benefits or proceeds in an interest-bearing trust account pending an ~~judicial or~~ administrative determination, unless adequately explained, gives rise to an inference that such person knowingly failed to credit the state or its agent for payments received from social security, insurance, or other sources, pursuant to s. 414.39(4)(b), and acted with the intent set forth in s. 812.014(1).

(a) A recipient may contest the amount designated as recovered medical expense damages payable to the agency pursuant to the formula specified in paragraph (11)(f) by filing a petition under chapter 120 within 21 days after the date of payment of funds to the agency or after the date of placing the full amount of the third-party benefits in the trust account for the benefit of the agency. The petition shall be filed with the Division of Administrative Hearings. For purposes of chapter 120, the payment of funds to the agency or the placement of the full amount of the third-party benefits in the trust account for the benefit of the agency constitutes final agency action and notice thereof. Final order authority for the proceedings specified in this subsection rests with the Division of Administrative Hearings. This procedure is the exclusive method for challenging the amount of third-party benefits payable to the agency.

1. In order to successfully challenge the amount payable to

the agency, the recipient must prove, by clear and convincing evidence, that a lesser portion of the total recovery should be allocated as reimbursement for past and future medical expenses than the amount calculated by the agency pursuant to the formula set forth in paragraph (11)(f) or that Medicaid provided a lesser amount of medical assistance than that asserted by the agency.

2. The agency's provider processing system reports are admissible as prima facie evidence in substantiating the agency's claim.

3. Venue for all administrative proceedings pursuant to this subsection lies in Leon County, at the discretion of the agency. Venue for all appellate proceedings arising from the administrative proceeding outlined in this subsection lie at the First District Court of Appeal in Leon County, at the discretion of the agency.

4. Each party shall bear its own attorney fees and costs for any administrative proceeding conducted pursuant to this paragraph.

(b) ~~(a)~~ In cases of suspected criminal violations or fraudulent activity, the agency may take any civil action permitted at law or equity to recover the greatest possible amount, including, without limitation, treble damages under ss. 772.11 and 812.035(7).

1. ~~(b)~~ The agency may ~~is authorized to~~ investigate and ~~to~~ request appropriate officers or agencies of the state to investigate suspected criminal violations or fraudulent activity related to third-party benefits, including, without limitation, ss. 414.39 and 812.014. Such requests may be directed, without

limitation, to the Medicaid Fraud Control Unit of the Office of the Attorney General, or to any state attorney. Pursuant to s. 409.913, the Attorney General has primary responsibility to investigate and control Medicaid fraud.

2.~~(c)~~ In carrying out duties and responsibilities related to Medicaid fraud control, the agency may subpoena witnesses or materials within or outside the state and, through any duly designated employee, administer oaths and affirmations and collect evidence for possible use in either civil or criminal judicial proceedings.

3.~~(d)~~ All information obtained and documents prepared pursuant to an investigation of a Medicaid recipient, the recipient's legal representative, or any other person relating to an allegation of recipient fraud or theft is confidential and exempt from s. 119.07(1):

a.~~1.~~ Until such time as the agency takes final agency action;

b.~~2.~~ Until such time as the Department of Legal Affairs refers the case for criminal prosecution;

c.~~3.~~ Until such time as an indictment or criminal information is filed by a state attorney in a criminal case; or

d.~~4.~~ At all times if otherwise protected by law.

Section 7. Paragraph (a) of subsection (2) and paragraph (d) of subsection (4) of section 409.911, Florida Statutes, 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 ~~2004,~~ 2005, ~~and~~ 2006, and 2007 audited disproportionate share data to determine each hospital's Medicaid days and charity care for the 2013-2014 ~~2012-2013~~ state fiscal year.

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

(d) Any nonstate government owned or operated hospital eligible for payments under this section on July 1, 2011, remains eligible for payments during the 2013-2014 ~~2012-2013~~ state fiscal year.

Section 8. Subsection (2) of section 409.9118, Florida Statutes, is amended to read:

409.9118 Disproportionate share program for specialty hospitals.— The Agency for Health Care Administration shall design and implement a system of making disproportionate share payments to those hospitals licensed in accordance with part I of chapter 395 as a specialty hospital which meet all requirements listed in subsection (2). Notwithstanding s. 409.915, counties are exempt from contributing toward the cost

of this special reimbursement for patients.

(2) In order to receive payments under this section, a hospital must be licensed in accordance with part I of chapter 395, to participate in the Florida Title XIX program, and meet the following requirements:

(a) Be certified or certifiable to be a provider of Title XVIII services.

(b) Receive ~~all of its~~ inpatient clients through referrals or admissions from county public health departments, as defined in chapter 154.

(c) Require a diagnosis for the control of active tuberculosis or a history of noncompliance with prescribed drug regimens for the treatment of tuberculosis ~~a communicable disease~~ for ~~all~~ admissions for inpatient treatment.

(d) Retain a contract with the Department of Health to accept clients for admission and inpatient treatment pursuant to s. 392.62.

Section 9. Paragraphs (b), (l), and (m) of subsection (2) of section 409.9122, Florida Statutes, are amended, subsections (3) through (21) of that section are renumbered as subsections (4) through (22), respectively, and a new subsection (3) is added to that section, to read:

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

(2)

(b) A Medicaid recipient may ~~shall~~ not be enrolled in or assigned to a managed care plan or MediPass unless the managed care plan or MediPass has complied with the quality-of-care standards specified in paragraphs (4)(a) ~~(3)(a)~~ and (b),

respectively.

~~(l) If the Medicaid recipient is diagnosed with HIV/AIDS, the agency shall assign the Medicaid recipient to a managed care plan that is a health maintenance organization authorized under chapter 641, is under contract with the agency on July 1, 2011, and which offers a delivery system through a university-based teaching and research-oriented organization that specializes in providing health care services and treatment for individuals diagnosed with HIV/AIDS.~~

(l) ~~(m)~~ 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.

This subsection expires October 1, 2014.

(3) Notwithstanding s. 409.961, if a Medicaid recipient is diagnosed with HIV/AIDS, the agency shall assign the recipient to a managed care plan that is a health maintenance organization authorized under chapter 641, that is under contract with the agency as an HIV/AIDS specialty plan as of January 1, 2013, and that offers a delivery system through a university-based teaching and research-oriented organization that specializes in providing health care services and treatment for individuals diagnosed with HIV/AIDS. This subsection applies to recipients who are subject to mandatory managed care enrollment and have failed to choose a managed care option.

Section 10. Section 409.915, Florida Statutes, is amended

to read:

409.915 County contributions to Medicaid.—Although the state is responsible for the full portion of the state share of the matching funds required for the Medicaid program, ~~in order to acquire a certain portion of these funds,~~ the state shall charge the counties an annual contribution in order to acquire a certain portion of these funds ~~for certain items of care and service as provided in this section~~.

(1) As used in this section, the term "state Medicaid expenditures" means those expenditures used as matching funds for the federal Medicaid program.

(2)(a) For the 2013-2014 state fiscal year, the total amount of the counties' annual contribution is $269.6 million.

(b) For the 2014-2015 state fiscal year, the total amount of the counties' annual contribution is $277 million.

(c) By March 15, 2015, and each year thereafter, the Social Services Estimating Conference shall determine the percentage change in state Medicaid expenditures by comparing expenditures for the 2 most recent completed state fiscal years.

(d) For the 2015-2016 state fiscal year through the 2019-2020 state fiscal year, the total amount of the counties' annual contribution shall be the total contribution for the prior fiscal year adjusted by 50 percent of the percentage change in the state Medicaid expenditures as determined by the Social Services Estimating Conference.

(e) For each fiscal year after the 2019-2020 state fiscal year, the total amount of the counties' annual contribution shall be the total contribution for the prior fiscal year adjusted by the percentage change in the state Medicaid

expenditures as determined by the Social Services Estimating Conference.

(3)(a)1. The amount of each county's annual contribution is equal to the product of the amount determined under subsection (2) multiplied by the sum of the percentages calculated in sub-subparagraphs a. and b.:

a. The enrollment weight provided in subparagraph 2. is multiplied by a fraction, the numerator of which is the number of the county's Medicaid enrollees as of March 1 of each year, and the denominator of which is the number of all counties' Medicaid enrollees as of March 1 of each year. The agency shall calculate this amount for each county and provide the information to the Department of Revenue by May 15 of each year.

b. The payment weight provided in subparagraph 2. is multiplied by the percentage share of payments provided in subparagraph 3. for each county.

2. The weights for each fiscal year are equal to:

WEIGHTS

FISCAL YEAR	ENROLLMENT	PAYMENT
2013-14	0%	100%
2014-15	0%	100%
2015-16	20%	80%
2016-17	40%	60%

2017-18	60%	40%
2018-19	80%	20%
2019-20+	100%	0%

3. The percentage share of payments for each county is:

COUNTY	SHARE OF PAYMENTS
Alachua	1.278%
Baker	0.116%
Bay	0.607%
Bradford	0.179%
Brevard	2.471%
Broward	9.228%
Calhoun	0.084%
Charlotte	0.578%
Citrus	0.663%

Clay	0.635%
Collier	1.161%
Columbia	0.557%
Dade (Miami-Dade)	18.853%
Desoto	0.167%
Dixie	0.098%
Duval	5.337%
Escambia	1.615%
Flagler	0.397%
Franklin	0.091%
Gadsden	0.239%
Gilchrist	0.078%
Glades	0.055%
Gulf	0.076%

Hamilton	0.075%
Hardee	0.110%
Hendry	0.163%
Hernando	0.862%
Highlands	0.468%
Hillsborough	6.953%
Holmes	0.101%
Indian River	0.397%
Jackson	0.219%
Jefferson	0.083%
Lafayette	0.014%
Lake	1.525%
Lee	2.512%
Leon	0.929%
Levy	0.256%

Liberty	0.050%
Madison	0.086%
Manatee	1.623%
Marion	1.630%
Martin	0.353%
Monroe	0.262%
Nassau	0.240%
Okaloosa	0.567%
Okeechobee	0.235%
Orange	6.682%
Osceola	1.613%
Palm Beach	5.899%
Pasco	2.392%
Pinellas	6.645%

Polk	3.643%
Putnam	0.417%
Saint Johns	0.459%
Saint Lucie	1.155%
Santa Rosa	0.462%
Sarasota	1.230%
Seminole	1.740%
Sumter	0.218%
Suwannee	0.252%
Taylor	0.103%
Union	0.075%
Volusia	2.298%
Wakulla	0.103%
Walton	0.229%
Washington	0.114%

(b)1. The Legislature intends to replace the county percentage share provided in subparagraph (a)3. with percentage shares based upon each county's proportion of the total statewide amount of county billings made under this section from April 1, 2012, through March 31, 2013, for which the state ultimately receives payment.

2. By February 1 of each year and continuing until a certification is made under sub-subparagraph b., the agency shall report to the President of the Senate and the Speaker of the House of Representatives the status of the county billings made under this section from April 1, 2012, through March 31, 2013, by county, including:

a. The amounts billed to each county which remain unpaid, if any; and

b. A certification from the agency of a final accounting of the amount of funds received by the state from such billings, by county, upon the expiration of all appeal rights that counties may have to contest such billings.

3. By March 15 of the state fiscal year in which the state receives the certification provided for in sub-subparagraph (b)2.b., the Social Services Estimating Conference shall calculate each county's percentage share of the total statewide amount of county billings made under this section from April 1, 2012, through March 31, 2013, for which the state ultimately receives payment.

4. Beginning in the state fiscal year following the receipt by the state of the certification provided in sub-subparagraph

(b)2.b., each county's percentage share under subparagraph (a)3. shall be replaced by the percentage calculated under subparagraph (b)3.

5. If the court invalidates the replacement of each county's share as provided in this paragraph, the county share set forth in subparagraph (a)3. shall continue to apply.

(4) By June 1 of each year, the Department of Revenue shall notify each county of its required annual contribution. Each county shall pay its contribution, by check or electronic transfer, in equal monthly installments to the department by the 5th day of each month. If a county fails to remit the payment by the 5th day of the month, the department shall reduce the monthly distribution of that county pursuant to s. 218.61 and, if necessary, by the amount of the monthly installment pursuant to s. 218.26. The payments and the amounts by which the distributions are reduced shall be transferred to the General Revenue Fund.

~~(1) Each county shall participate in the following items of care and service:~~

~~(a) For both health maintenance members and fee-for-service beneficiaries, payments for inpatient hospitalization in excess of 10 days, but not in excess of 45 days, with the exception of pregnant women and children whose income is in excess of the federal poverty level and who do not participate in the Medicaid medically needy program, and for adult lung transplant services.~~

~~(b) For both health maintenance members and fee-for-service beneficiaries, payments for nursing home or intermediate facilities care in excess of $170 per month, with the exception of skilled nursing care for children under age 21.~~

~~(2) A county's participation must be 35 percent of the total cost, or the applicable discounted cost paid by the state for Medicaid recipients enrolled in health maintenance organizations or prepaid health plans, of providing the items listed in subsection (1), except that the payments for items listed in paragraph (1)(b) may not exceed $55 per month per person.~~

~~(3) Each county shall set aside sufficient funds to pay for items of care and service provided to the county's eligible recipients for which county contributions are required, regardless of where in the state the care or service is rendered.~~

~~(4) Each county shall contribute its pro rata share of the total county participation based upon statements rendered by the agency. The agency shall render such statements monthly based on each county's eligible recipients. For purposes of this section, each county's eligible recipients shall be determined by the recipient's address information contained in the federally approved Medicaid eligibility system within the Department of Children and Family Services. A county may use the process developed under subsection (10) to request a refund if it determines that the statement rendered by the agency contains errors.~~

(5) In any county in which a special taxing district or authority is located which benefits ~~will benefit~~ from the Medicaid program ~~medical assistance programs covered by this section~~, the board of county commissioners may divide the county's financial responsibility for this purpose proportionately, and each such district or authority must

furnish its share to the board of county commissioners in time for the board to comply with subsection (4) ~~(3)~~. Any appeal of the proration made by the board of county commissioners must be made to the Department of Financial Services, which shall ~~then~~ set the proportionate share for ~~of~~ each party.

~~(6) Counties are exempt from contributing toward the cost of new exemptions on inpatient ceilings for statutory teaching hospitals, specialty hospitals, and community hospital education program hospitals that came into effect July 1, 2000, and for special Medicaid payments that came into effect on or after July 1, 2000.~~

(6) ~~(7)~~ (a) By August 1, 2012, the agency shall certify to each county the amount of such county's billings from November 1, 2001, through April 30, 2012, which remain unpaid. A county may contest the amount certified by filing a petition under the applicable provisions of chapter 120 on or before September 1, 2012. This procedure is the exclusive method to challenge the amount certified. In order to successfully challenge the amount certified, a county must show, by a preponderance of the evidence, that a recipient was not an eligible recipient of that county or that the amount certified was otherwise in error.

(b) By September 15, 2012, the agency shall certify to the Department of Revenue:

1. For each county that files a petition on or before September 1, 2012, the amount certified under paragraph (a); and

2. For each county that does not file a petition on or before September 1, 2012, an amount equal to 85 percent of the amount certified under paragraph (a).

(c) The filing of a petition under paragraph (a) does ~~shall~~

not stay or stop the Department of Revenue from reducing distributions in accordance with paragraph (b) and subsection (7) ~~(8)~~. If a county that files a petition under paragraph (a) is able to demonstrate that the amount certified should be reduced, the agency shall notify the Department of Revenue of the amount of the reduction. The Department of Revenue shall adjust all future monthly distribution reductions under subsection (7) ~~(8)~~ in a manner that results in the remaining total distribution reduction being applied in equal monthly amounts.

(7)~~(8)~~(a) Beginning with the October 2012 distribution, the Department of Revenue shall reduce each county's distributions pursuant to s. 218.26 by one thirty-sixth of the amount certified by the agency under subsection (6) ~~(7)~~ for that county, minus any amount required under paragraph (b). Beginning with the October 2013 distribution, the Department of Revenue shall reduce each county's distributions pursuant to s. 218.26 by one forty-eighth of two-thirds of the amount certified by the agency under subsection (6) ~~(7)~~ for that county, minus any amount required under paragraph (b). However, the amount of the reduction may not exceed 50 percent of each county's distribution. If, after 60 months, the reductions for any county do not equal the total amount initially certified by the agency, the Department of Revenue shall continue to reduce such county's distribution by up to 50 percent until the total amount certified is reached. The amounts by which the distributions are reduced shall be transferred to the General Revenue Fund.

(b) As an assurance to holders of bonds issued before the effective date of this act to which distributions made pursuant

to s. 218.26 are pledged, or bonds issued to refund such bonds which mature no later than the bonds they refunded and which result in a reduction of debt service payable in each fiscal year, the amount available for distribution to a county shall remain as provided by law and continue to be subject to any lien or claim on behalf of the bondholders. The Department of Revenue must ensure, based on information provided by an affected county, that any reduction in amounts distributed pursuant to paragraph (a) does not reduce the amount of distribution to a county below the amount necessary for the timely payment of principal and interest when due on the bonds and the amount necessary to comply with any covenant under the bond resolution or other documents relating to the issuance of the bonds. If a reduction to a county's monthly distribution must be decreased in order to comply with this paragraph, the Department of Revenue must notify the agency of the amount of the decrease and the agency must send a bill for payment of such amount to the affected county.

~~(9)(a) Beginning May 1, 2012, and each month thereafter, the agency shall certify to the Department of Revenue by the 7th day of each month the amount of the monthly statement rendered to each county pursuant to subsection (4). Beginning with the May 2012 distribution, the Department of Revenue shall reduce each county's monthly distribution pursuant to s. 218.61 by the amount certified by the agency minus any amount required under paragraph (b). The amounts by which the distributions are reduced shall be transferred to the General Revenue Fund.~~

~~(b) As an assurance to holders of bonds issued before the effective date of this act to which distributions made pursuant~~

~~to s. 218.61 are pledged, or bonds issued to refund such bonds which mature no later than the bonds they refunded and which result in a reduction of debt service payable in each fiscal year, the amount available for distribution to a county shall remain as provided by law and continue to be subject to any lien or claim on behalf of the bondholders. The Department of Revenue must ensure, based on information provided by an affected county, that any reduction in amounts distributed pursuant to paragraph (a) does not reduce the amount of distribution to a county below the amount necessary for the timely payment of principal and interest when due on the bonds and the amount necessary to comply with any covenant under the bond resolution or other documents relating to the issuance of the bonds. If a reduction to a county's monthly distribution must be decreased in order to comply with this paragraph, the Department of Revenue must notify the agency of the amount of the decrease and the agency must send a bill for payment of such amount to the affected county.~~

~~(10) The agency, in consultation with the Department of Revenue and the Florida Association of Counties, shall develop a process for refund requests which:~~

~~(a) Allows counties to submit to the agency written requests for refunds of any amounts by which the distributions were reduced as provided in subsection (9) and which set forth the reasons for the refund requests.~~

~~(b) Requires the agency to make a determination as to whether a refund request is appropriate and should be approved, in which case the agency shall certify the amount of the refund to the department.~~

~~(c) Requires the department to issue the refund for the certified amount to the county from the General Revenue Fund. The Department of Revenue may issue the refund in the form of a credit against reductions to be applied to subsequent monthly distributions.~~

(8) ~~(11)~~ Beginning in the 2013-2014 fiscal year and each year thereafter through the 2020-2021 fiscal year, the Chief Financial Officer shall transfer from the General Revenue Fund to the Lawton Chiles Endowment Fund an amount equal to the amounts transferred to the General Revenue Fund in the previous fiscal year pursuant to subsections (4) and (7) ~~subsections (8) and (9), reduced by the amount of refunds paid pursuant to subsection (10),~~ which are in excess of the official estimate for medical hospital fees for such previous fiscal year adopted by the Revenue Estimating Conference on January 12, 2012, as reflected in the conference's workpapers. By July 20 of each year, the Office of Economic and Demographic Research shall certify the amount to be transferred to the Chief Financial Officer. Such transfers must be made before July 31 of each year until the total transfers for all years equal $350 million. If ~~In the event that~~ such transfers do not total $350 million by July 1, 2021, the Legislature shall provide for the transfer of amounts necessary to total $350 million. The Office of Economic and Demographic Research shall publish the official estimates reflected in the conference's workpapers on its website.

(9) ~~(12)~~ The agency may adopt rules to administer this section.

Section 11. Notwithstanding s. 409.915(3) and (4), Florida Statutes, as amended by this act, the amount of each county's

contribution during the 2013-2014 state fiscal year shall be determined and provided to the Department of Revenue by the Agency for Health Care Administration by June 15, 2013. The Department of Revenue shall notify each county of its annual contribution by June 20, 2013.

Section 12. The Agency for Health Care Administration shall submit a data report by March 1 of each year to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the Florida Association of Counties which includes such information as may be necessary for comprehensively evaluating the cost and utilization of health services by Medicaid enrollees by service type in each county. This section is repealed December 31, 2015.

Section 13. The paragraph following Specific Appropriation 195 contained in SB 1500, if adopted during the 2013 Regular Session of the Florida Legislature, is repealed and replaced with the following upon SB 1500 becoming a law:

From the funds in Specific Appropriations 195, 197, 198, 201, 203, 215, 219, 222, and 223, $677,722,971 from the Medical Care Trust Fund is provided for increased reimbursement rates for primary care services provided to eligible Medicaid recipients.

Section 14. This act shall take effect July 1, 2013.