

CS/SB 360 by **HP, Garcia**; (Similar to CS/H 0281) Surgical Assistants and Surgical Technologists

895788 A S AHS, Garcia Delete L.34 - 40: 04/16 12:52 PM

CS/SB 896 by **HP, Garcia (CO-INTRODUCERS) Flores**; (Similar to CS/H 0793) Prepaid Dental Plans

331734 A S AHS, Garcia Delete L.78 - 83: 04/16 12:53 PM

CS/SB 844 by **HP, Grimsley**; (Compare to CS/CS/H 0939) Medicaid Fraud

531582 D S AHS, Grimsley Delete everything after 04/16 12:55 PM

CS/SB 1748 by **CF, Evers**; Medicaid Eligibility**SB 1816** by **AP**; Health Care

306188 A S AHS, Grimsley btw L.1345 - 1346: 04/16 12:56 PM

337632 A S L AHS, Gibson Delete L.1254 - 1255: 04/16 05:38 PM

201016 A S L AHS, Sobel Delete L.1006 - 1045: 04/16 08:07 PM

SB 1844 by **HP**; Health Choice Plus Program

393192 A S AHS, Bean Delete L.318: 04/16 12:57 PM

496256 A S AHS, Bean btw L.359 - 360: 04/16 12:58 PM

806166 D S L AHS, Bean Delete everything after 04/16 09:06 PM

The Florida Senate
COMMITTEE MEETING EXPANDED AGENDA
APPROPRIATIONS SUBCOMMITTEE ON HEALTH AND
HUMAN SERVICES
Senator Grimsley, Chair
Senator Flores, Vice Chair

MEETING DATE: Wednesday, April 17, 2013
TIME: 11:00 a.m.—1:00 p.m.
PLACE: *Pat Thomas Committee Room, 412 Knott Building*

MEMBERS: Senator Grimsley, Chair; Senator Flores, Vice Chair; Senators Bean, Benacquisto, Galvano, Garcia, Gibson, Lee, Montford, Richter, Smith, Sobel, and Thrasher

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	CS/SB 360 Health Policy / Garcia (Similar CS/H 281)	Surgical Assistants and Surgical Technologists; Providing requirements for health care facilities that employ or contract with surgical assistants and surgical technologists; providing exceptions to these requirements, etc.	HP 03/20/2013 Not Considered HP 04/02/2013 Fav/CS BI 04/09/2013 Favorable AHS 04/17/2013 AP
2	CS/SB 896 Health Policy / Garcia (Similar CS/H 793)	Prepaid Dental Plans; Postponing the scheduled repeal of a provision requiring the Agency for Health Care Administration to contract with dental plans for dental services on a prepaid or fixed-sum basis; authorizing the agency to provide a prepaid dental health program in Miami-Dade County on a permanent basis, etc.	HP 03/14/2013 Fav/CS AHS 04/17/2013 AP RC
3	CS/SB 844 Health Policy / Grimsley (Compare CS/CS/H 939)	Medicaid Fraud; Adding an additional provision relating to a change in principal that must be included in a Medicaid provider agreement with the Agency for Health Care Administration; revising provisions specifying grounds for terminating a provider from the program, for seeking certain remedies for violations, and for imposing certain sanctions; deleting the requirement that the agency place payments withheld from a provider in a suspended account and revising when a provider must reimburse overpayments, etc.	HP 03/07/2013 Fav/CS BI 04/09/2013 Favorable AHS 04/17/2013 AP

COMMITTEE MEETING EXPANDED AGENDA

Appropriations Subcommittee on Health and Human Services
Wednesday, April 17, 2013, 11:00 a.m.—1:00 p.m.

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
4	CS/SB 1748 Children, Families, and Elder Affairs / Evers	Medicaid Eligibility; Requiring the Department of Children and Families to review financial transactions affecting eligibility; exempting the value of a Medicaid applicant's life insurance policy, annuity, or group certificate from the determination of the applicant's Medicaid eligibility under certain circumstances; authorizing a state agency to delay implementation of certain provisions if a federal waiver or authorization is required; specifying limitations, etc.	
		CF 04/15/2013 Fav/CS AHS 04/17/2013 AP	
5	SB 1816 Appropriations	Health Care; Revising the components of the Florida Kidcare program; revising the eligibility of the Medikids program component; revising the minimum health benefits coverage under the Florida Kidcare Act; repealing provisions relating to the approval of health benefits coverage, financial assistance, and delivery of services in rural counties; creating the Healthy Florida program; authorizing the Florida Healthy Kids Corporation to contract with certain insurers; requiring the corporation to oversee the Healthy Florida program and to establish a grievance process and integrity process, etc.	
		AHS 04/17/2013 AP	
6	SB 1844 Health Policy	Health Choice Plus Program; Authorizing the Florida Health Choices, Inc., to accept funds from various sources to deposit into health benefits accounts, subsidize the costs of coverage, and administer and support the program; requiring the corporation to manage the health benefits accounts and provide the marketplace of options that an enrollee in the program may use; providing for payment for achieving health living performance goals, etc.	
		AHS 04/17/2013 AP	

Other Related Meeting Documents



895788

LEGISLATIVE ACTION

Senate

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House

Appropriations Subcommittee on Health and Human Services
(Garcia) recommended the following:

Senate Amendment

Delete lines 34 - 40
and insert:

4. "Surgical assistant" means a person who provides aid in exposure, hemostasis, closures, and other intraoperative technical functions and assists the surgeon in performing a safe operation with optimal results for the patient.

5. "Surgical technologist" means a person who assists and practices to ensure that the

The Florida Senate
BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Appropriations Subcommittee on Health and Human Services

BILL: CS/SB 360

INTRODUCER: Health Policy Committee and Senator Garica

SUBJECT: Surgical Assistants and Surgical Technologists

DATE: April 15, 2013 **REVISED:** _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	<u>Davlantes</u>	<u>Stovall</u>	<u>HP</u>	Fav/CS
2.	<u>Matiyow</u>	<u>Burgess</u>	<u>BI</u>	Favorable
3.	<u>Brown</u>	<u>Pigott</u>	<u>AHS</u>	Pre-meeting
4.	_____	_____	<u>AP</u>	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____

Please see Section VIII. for Additional Information:

A. COMMITTEE SUBSTITUTE..... Statement of Substantial Changes

B. AMENDMENTS..... Technical amendments were recommended

Amendments were recommended

Significant amendments were recommended

I. Summary:

CS/SB 360 amends s. 395.0191, F.S., to add a new subsection concerning surgical technologists and surgical assistants. The CS provides various definitions. The CS prohibits a health care facility from employing or contracting with any person to perform the duties of a surgical assistant or surgical technologist unless that person is a certified surgical assistant or surgical technologist and provides exceptions to these prohibitions.

The bill has no fiscal impact.

The bill has an effective date of July 1, 2013.

The bill substantially amends section 395.0191 of the Florida Statutes.

II. Present Situation:

Role of Surgical Technologists

Surgical technologists, also called scrubs or operating room technicians,¹ work under the supervision of surgeons to ensure that the operating room environment is safe, that equipment functions properly, and that the operative procedure is conducted under conditions that maximize patient safety. Surgical technologists are trained in aseptic technique and combine the knowledge of human anatomy, surgical procedures, and implementation tools and technologies, to facilitate a physician's performance of invasive therapeutic and diagnostic procedures.² Currently, no statutes or rules are in place to regulate the practice of surgical technology in Florida.

The Association of Surgical Technology (AST) is the oldest professional organization for surgical technologists and surgical assistants. The AST was established in 1969 by members of the American College of Surgeons, the American Hospital Association, and the Association of Perioperative Registered Nurses to ensure that surgical technologists and surgical assistants have the knowledge and skills to administer patient care of the highest quality. Some of the AST's duties include creating and administering national certification procedures for surgical technologists, providing continuing education for such certification, working with national accrediting committees to establish standards for training programs, and advocating the interests of surgical technologists to government entities.³

The AST has published national guidelines for the scope of practice of surgical technologists.⁴ It designates three different categories of technologist, each with different functions. A scrub technologist maintains sterility and handles necessary instruments, supplies, and equipment during a surgical procedure. A circulating technologist assists the circulating nurse in obtaining additional instruments, supplies, and equipment during the procedure. A second assisting technologist maintains sterility and assists the surgeon and the surgeon's first assistant during the procedure. More detailed duties are:

Scrub Technologist

- Check supplies and equipment needed for the surgical procedure;
- Scrub, gown, and glove;
- Set up the sterile table with instruments, supplies, equipment, and medications needed for the procedure;
- Perform appropriate counts with the circulator prior to the operation and before the incision is closed;
- Gown and glove the surgeon and assistants;
- Help in draping the sterile field;
- Pass instruments to the surgeon during the procedure;
- Prepare sterile dressings;
- Clean and prepare instruments for terminal sterilization;
- Assist other members of the surgical team with terminal cleaning of the operating room; and

¹ United States Department of Labor, Bureau of Labor Statistics, *Occupational Outlook Handbook, 2012-13 Edition: Surgical Technologists*, available at: <http://www.bls.gov/oco/ocos106.htm> (last visited on April 6, 2013).

² AST, *Job Description: Surgical Technologist*, available at: http://www.ast.org/professionals/documents/2009_Surgical_Technologist_Job_Description_10.6_Final.pdf (last visited on April 6, 2013).

³ AST, *About Us*, available at : http://www.ast.org/aboutus/about_ast.aspx (last visited on April 6, 2013).

⁴ *Supra* fn. 2.

- Assist in preparing the operating room for the next patient.

Circulating Technologist

- Obtain appropriate sterile and unsterile items needed for the procedure;
- Open sterile supplies;
- Check the patient's chart, identify the patient, verify the surgery to be performed with consent forms, and bring the patient to the assigned operating room;
- Transfer the patient to the operating table;
- Assess the patient's comfort and safety and provide verbal and tactile reassurance;
- Assist anesthesia personnel;
- Position the patient, using appropriate equipment;
- Apply electrosurgical grounding pads, tourniquets, monitors, etc., before the procedure begins;
- Prepare the patient's skin prior to draping by the surgical team;
- Perform appropriate counts with the scrub nurse or technologist prior to the operation and before the incision is closed;
- Anticipate additional supplies needed during the procedure;
- Keep accurate records throughout the procedure;
- Properly care for specimens;
- Secure dressings after incision closure;
- Help transport the patient to the recovery room; and
- Assist in cleaning the operating room and in preparing for the next patient.

Second Assisting Technologist

- Hold retractors or instruments as directed by the surgeon;
- Sponge or suction the operative site;
- Apply electrocautery to clamps on bleeding blood vessels;
- Cut suture material as directed by the surgeon;
- Connect drains to suction apparatus; and
- Apply dressings to the closed wound.

Education and Certification

Surgical technologists must have a high school diploma or equivalent and must complete a training program accredited by the Commission on Accreditation of Allied Health Education Programs or the Accrediting Bureau of Health Education Schools. The training program includes classroom education in anatomy, microbiology, pharmacology, ethics, medical terminology, and other topics, as well as supervised clinical experience. Surgical technologist training lasts from 9 to 24 months and culminates in a certificate, diploma, or associate's degree.

Professional certification is not required for employment as a surgical technologist, although most employers prefer to hire only certified individuals.⁵ Professional certification is available through the AST as a Certified Surgical Technologist (CST).⁶ Requirements for CST designation

⁵ *Supra* fn. 1.

⁶ *Id.*

include graduation from an accredited surgical technology program (with special exceptions for military-trained technologists), payment of fees, and passage of an examination offered by the National Board of Surgical Technology and Surgical Assisting (NBSTSA).⁷ The CST certification is valid for four years. To renew, an individual must either retake and pass the NBSTSA examination required for initial certification or complete 60 hours of continuing education. A renewal fee is also required.⁸

National certification may also be obtained from the National Center for Competency Testing (NCCT),⁹ which awards the “Tech in Surgery-Certified (NCCT)” designation. Applicants must graduate from an NCCT-approved surgical technology program, complete required practical experience, and pass the organization’s certification exam. Applicants who have not graduated from an approved surgical technology program may also qualify for certification if they have accrued some amount of practical experience, which varies depending on the situation. Passage of the examination and payment of fees is still required.¹⁰ The NCCT certification must be renewed annually by completing 14 hours of continuing education and paying a recertification fee.¹¹

Currently, there are approximately 4,800 surgical technologists employed in Florida. Of these, more than 3,400 are CSTs, and a few dozen hold the Tech in Surgery-Certified (NCCT) designation.¹²

Role of Surgical First Assistants

Surgical assistants provide aid in exposure, hemostasis, closure, and other intraoperative technical functions under the direct supervision of surgeons to help carry out safe operations with optimal results for patients. In addition to intraoperative duties, surgical assistants also perform preoperative and postoperative duties to better facilitate proper patient care.¹³ Surgical first assistants provide primary assistance to the primary surgeon, must be listed on the operative record as first assistants, and cannot be involved in any other role during the procedure.¹⁴

The primary professional organizations for surgical assistants are the Association of Surgical Technology (AST) and the National Surgical Assistant Association (NSAA). The NSAA was

⁷ NBSTSA, *CST Examinations*, available at: <http://nbstsa.org/examinations-cst.html> (last visited on April 6, 2013).

⁸ NBSTSA, *Renewal Options*, available at: <http://nbstsa.org/renewal/index.html> (last visited on April 6, 2013).

⁹ The NCCT is an independent entity which provides competency examinations and certifications for a variety of allied health professions, including medical assistants, phlebotomy technicians, patient care technicians, surgical technologists, and medical office assistants. It is not a professional organization. (Source: NCCT, *National Center for Competency Testing (NCCT)*, <http://www.ncctinc.com/General/>, last visited on April 6, 2013).

¹⁰ NCCT, *Certification Information*, available at: <http://www.ncctinc.com/Certifications/> (last visited on April 6, 2013).

¹¹ NCCT, *Recertification/CE*, available at: <http://www.ncctinc.com/CE/> (last visited on April 6, 2013).

¹² Email correspondence with the Florida State Assembly of the Association of Surgical Technologists. A copy of this correspondence is on file with the Senate Health Policy Committee.

¹³ Association of Surgical Technologists, *Job Description: Surgical Assistant*, available at: http://www.ast.org/professionals/documents/2011_%20Surgical%20Assistant_Job_Description_4.5.pdf (last visited on April 6, 2013).

¹⁴ American Board of Surgical Assistants, *Definitions*, available at: <http://www.absa.net/definitions.php> (last visited on April 6, 2013).

formed by surgical assistants in 1983 and was the nation's first organization to provide standards for competency, professionalism, and scope of practice in the field.¹⁵

Duties within the scope of practice of a surgical assistant include positioning the patient; providing visualization of the operative site, including appropriate placement of retractors, suctioning and sponging, and manipulation of suture materials; assisting with hemostasis; participating in volume replacement or autotransfusion techniques, as appropriate; assisting with wound closure, including administration of sutures and subcutaneous injection of local anesthetics; selecting and applying wound dressings; and providing assistance in securing drainage systems to tissue.¹⁶ Surgical assistants must be familiar with operating room procedures and able to anticipate the needs of the surgeon.¹⁷

Surgical First Assistants in Statute

Registered nurses licensed under ch. 464, F.S., may serve as surgical first assistants if they are certified in perioperative nursing through a year-long training program fulfilling certain conditions. Such nurses may be reimbursed by insurance companies for their first assistant services at a rate not less than 80 percent of what a physician would be paid for the same services.¹⁸

Physician assistants may also be reimbursed by insurance companies for surgical first assistant services if they act as substitutes for physicians who would have performed the same services.¹⁹

National Certification of Surgical First Assistants

AST: Certified Surgical First Assistant

An applicant for the Certified Surgical First Assistant (CSFA) designation must fulfill at least one of the following:

- Be a graduate of a surgical assistant program accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP);
- Hold current certification as a Certified Surgical Technologist from the AST, have participated in at least 350 cases within the last four years, and have completed at least two full years of surgical first assistant experience; or
- Hold current surgical assistant certification from the NSAA or the American Board of Surgical Assistants (ABSA), have completed 50 hours of AST-approved continuing education within the last two years, show proof of operative case experience, and have at least an associate's degree.

Eligible applicants may register to take the CSFA exam offered by the National Board of Surgical Technology and Surgical Assisting (NBSTSA).²⁰ The NBSTSA was previously known

¹⁵ NSAA, *Welcome*, available at: <http://www.nsaa.net/index.php> (last visited on April 6, 2013).

¹⁶ *Supra* fn. 12.

¹⁷ NSAA, *Scope of Practice*, available at: http://www.nsaa.net/scope_of_practice.php (last visited on April 6, 2013).

¹⁸ Sections 464.027 and 409.906(21), F.S.

¹⁹ Section 627.419(6), F.S.

as the Liaison Council on Certification for the Surgical Technologist (LCCST). After passage of the exam and payment of \$290 in fees, an applicant may be certified.²¹

The CSFA certification must be renewed every four years, either by retaking and passing the initial certification examination or completing 75 hours of continuing education approved by the AST. Recertification by examination costs \$499.²² Recertification by continuing education costs \$6 per credit hour for AST members and \$400 for non-members.²³

More than 2,100 people currently hold CSFA certification.²⁴

NSAA: Certified Surgical Assistant

Applicants for the Certified Surgical Assistant (CSA) designation must be graduates of approved surgical assistant training programs or provide documentation of 2,250 hours of assisting experience, along with several letters of reference from supervising surgeons. Applicants must also pass a multiple-choice examination offered by the NSAA which covers subjects such as anatomy, medical terminology, technical surgical skills, sterile technique, and anesthesia, and pay \$400 in fees. Discounts apply for recent graduates and military personnel, and certification by endorsement is available to nurses, physician assistants, and other practitioners under certain conditions.

The CSAs must be recertified every two years by completing 50 hours of approved continuing education or retaking and passing the initial certification exam. Recertification fees for NSAA non-members are \$700 if via continuing education and \$900 if via reexamination. Fees for NSAA members are \$100 if via continuing education or reexamination.^{25,26}

More than 1,300 people currently hold CSA certification nationally.²⁷

ABSA: Surgical Assistant-Certified

To be eligible to for ABSA certification, an applicant must hold at least an associate's degree with a "C" grade or higher in specified college-level courses, have completed an ABSA- or CAAHEP-approved surgical assistant training program, and have passed the ABSA Surgical Assistant-Certified (SA-C) examination. The examination consists of both multiple-choice and practical components and is offered four times per year in Miami, Chicago, New Jersey, and Houston. Payment of a \$710 fee is also required.

The SA-C certification must be renewed biennially by retaking and passing the initial certification exam or by completing certain professional development activities. Such activities include reading professional journals, presenting at a hospital seminar, publishing clinical

²⁰ Edu-Search, *Surgical Technology Certification*, available at: <http://www.surgicaltechnologists.net/education/certification> (last visited on April 6, 2013).

²¹ NBSTSA, *CSFA Examination*, available at: <http://nbstsa.org/examinations-csfa.html> (last visited on April 6, 2013).

²² NBSTSA, *Renewal Options*, available at: <http://nbstsa.org/renewal/index.html> (last visited on April 6, 2013).

²³ AST, *Certification*, available at: <http://www.ast.org/membership/certification.aspx> (last visited on April 6, 2013).

²⁴ Telephone conversation with NBSTSA staff.

²⁵ NSAA, *FAQs*, available at: <http://nsaa.net/faq.php> (last visited on April 6, 2013).

²⁶ NSAA, *Certification*, available at: <http://www.nsaa.net/requirements.php> (last visited on April 6, 2013).

²⁷ Telephone conversation with NSAA staff.

research, and attending medical conferences. Each certified individual must also document participation as a surgical first assistant in either 400 surgical cases or 1,500 procedure hours and hold current certification in cardiopulmonary resuscitation (CPR), advanced cardiac life support (ACLS), or pediatric advanced life support (PALS). Recertification via examination costs \$180 while recertification via professional development costs \$100.²⁸

More than 1,400 people currently hold active SA-C certification.²⁹

III. Effect of Proposed Changes:

Section 1 of the bill amends s. 395.0191, F.S., to add a new subsection concerning surgical technologists and surgical assistants. The bill provides definitions for “certified surgical assistant,” “certified surgical technologist,” “surgeon,” “surgical assistant,” and “surgical technologist.”

The bill states that a facility may not employ or contract with any person to perform the duties of a surgical assistant or surgical technologist unless that person is a certified surgical assistant or certified surgical technologist. These employment prohibitions do not apply to:

- A person employed or contracted to perform the duties of a surgical technologist or surgical assistant at any time between January 1, 2013, and July 1, 2013;
- Any health care practitioner as defined in ch. 456, F.S., or any student, if the duties performed fall within the scope of the practitioner’s or the student’s training and practice; or
- Any person enrolled in a surgical technology or surgical assisting training program accredited by CAAHEP, the Accrediting Bureau of Health Education Schools (ABHES), or another accrediting body recognized by the United States Department of Education. Such a person may practice for one year after completion of a training program before he or she is required to be certified.

Section 2 of the bill provides an effective date of July 1, 2013.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

²⁸ ABSA, *Candidate Information Booklet and Certification Examination Review Guide 2011-2012*, available at: http://www.absa.net/pdf/ABSA_Guide_2011-2012.pdf (last visited on April 6, 2013).

²⁹ ABSA, *History and Statistics*, available at: <http://www.absa.net/statistics.php> (last visited on April 6, 2013).

V. Fiscal Impact Statement:**A. Tax/Fee Issues:**

People wishing to practice as surgical technologists or surgical first assistants in Florida would be required to pay several hundred dollars in fees required to maintain national certification, unless they fall under one of the bill's exceptions.

B. Private Sector Impact:

Surgical technologists and surgical first assistants who do not meet any of the eligibility requirements in the bill will be unable to practice these occupations at Florida health care facilities. Businesses that offer continuing education courses and examination preparatory courses to surgical technologists and surgical first assistants are likely to receive more business as a result of the bill.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:**A. Committee Substitute – Statement of Substantial Changes:**

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Health Policy on April 2, 2013:

The CS redesignates section 1 of the bill as an amendment to ch. 395, F.S., instead of as a non-statutory provision of law. It also amends the definitions of “surgical assistant” and “surgical technologist” and adds definitions for “certified surgical first assistant,” “certified surgical technologist,” and “surgeon.” The CS amends the employment limitations in the bill to state that health care facilities may not employ or contract with any person *to perform the duties of a surgical assistant or a surgical technologist* unless that person is appropriately certified. The CS also clarifies exceptions to these employment limitations, including for health care practitioners and students for whom surgical technology or surgical assisting services are already within their scope of training and practice and students at surgical technology or surgical assisting training programs accredited by ABHES, CAAHEP, or another accrediting agency recognized by the United States Department of Education.

The CS deletes redundant provisions concerning inspections of health care facilities and rulemaking authority and removes provisions relating to insurance reimbursement of surgical assistant services.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

By the Committee on Health Policy; and Senator Garcia

588-03416-13

2013360c1

A bill to be entitled

An act relating to surgical assistants and surgical technologists; amending s. 395.0191, F.S.; providing definitions; providing requirements for health care facilities that employ or contract with surgical assistants and surgical technologists; providing exceptions to these requirements; providing an effective date.

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

Section 1. Subsection (11) is added to section 395.0191, Florida Statutes, to read:

395.0191 Staff membership and clinical privileges.—

(11) SURGICAL ASSISTANTS AND SURGICAL TECHNOLOGISTS.—

(a) Definitions.—As used in this subsection, the term:

1. "Certified surgical assistant" means a surgical assistant who maintains valid and active one of the following certifications:

a. Certified Surgical First Assistant from the National Board of Surgical Technology and Surgical Assisting.

b. Certified Surgical Assistant from the National Surgical Assistant Association.

c. Surgical Assistant-Certified from the American Board of Surgical Assistants.

2. "Certified surgical technologist" means a surgical technologist who maintains valid and active certification as a Certified Surgical Technologist from the National Board of Surgical Technology and Surgical Assisting.

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

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3. "Surgeon" means any health care practitioner as defined in chapter 456 whose scope of practice includes performing surgery and who is listed as the primary surgeon in the operative record.

4. "Surgical assistant" means a person who provides aid under the supervision of a surgeon in exposure, hemostasis, closures, and other intraoperative technical functions and assists the surgeon in performing a safe operation with optimal results for the patient.

5. "Surgical technologist" means a person who assists and practices under the supervision of a surgeon to ensure that the operating room environment is safe, that proper equipment is available, and that the operative procedure is conducted efficiently. Surgical technologist duties include, but are not limited to, maintaining sterility during a surgical procedure, handling and ensuring the availability of necessary equipment and supplies, and maintaining visibility of the operative site.

(b) Employment limitations.—

1. A facility may not employ or contract with any person to perform the duties of a surgical assistant unless the person is a certified surgical assistant.

2. A facility may not employ or contract with any person to perform the duties of a surgical technologist unless the person is a certified surgical technologist.

3. Subparagraphs 1. and 2. do not apply to:

a. A person who was employed or contracted to perform the duties of a surgical technologist or a surgical assistant at any time between January 1, 2013, and July 1, 2013.

b. A health care practitioner as defined in chapter 456 or

Page 2 of 3

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

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59 a student if the duties he or she performs fall within the scope
60 of the practitioner's or the student's training and practice.

61 c. A person enrolled in a surgical technology or surgical
62 assisting training program accredited by the Commission on
63 Accreditation of Allied Health Education Programs, the
64 Accrediting Bureau of Health Education Schools, or another
65 accrediting body recognized by the United States Department of
66 Education on July 1, 2013. A person may practice as a surgical
67 technologist or a surgical assistant for 1 year after completion
68 of such a training program before he or she is required to meet
69 the criteria in subparagraphs 1. or 2.

70 Section 2. This act shall take effect July 1, 2013.



331734

LEGISLATIVE ACTION

Senate

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House

Appropriations Subcommittee on Health and Human Services
(Garcia) recommended the following:

Senate Amendment

Delete lines 78 - 83
and insert:

(41) (a) Notwithstanding s. 409.961, the agency shall contract on a prepaid or fixed-sum basis with appropriately licensed prepaid dental health plans to provide dental services. This paragraph expires October 1, 2017 ~~2014~~.

(b) Notwithstanding paragraph (a) ~~and for the 2012-2013 fiscal year only~~, the agency is authorized to provide a

The Florida Senate
BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Appropriations Subcommittee on Health and Human Services

BILL: CS/SB 896

INTRODUCER: Health Policy Committee; and Senators Garica and Flores

SUBJECT: Prepaid Dental Plans

DATE: April 15, 2013 **REVISED:** _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Stovall	HP	Fav/CS
2.	Brown	Pigott	AHS	Pre-meeting
3.	_____	_____	AP	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____

Please see Section VIII. for Additional Information:

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|------------------------------|-------------------------------------|---|
| A. COMMITTEE SUBSTITUTE..... | <input checked="" type="checkbox"/> | Statement of Substantial Changes |
| B. AMENDMENTS..... | <input type="checkbox"/> | Technical amendments were recommended |
| | <input type="checkbox"/> | Amendments were recommended |
| | <input type="checkbox"/> | Significant amendments were recommended |

I. Summary:

CS/SB 896 postpones the scheduled repeal of a provision that requires the Agency for Health Care Administration (AHCA) to contract separately with prepaid dental health plans on a prepaid or fixed-sum basis for Medicaid recipients. The bill also authorizes the AHCA to provide a Medicaid prepaid dental program in Miami-Dade County on a permanent basis. Provisions requiring the AHCA to allow other qualified dental providers to participate in the Medicaid dental program on a fee-for-service basis are deleted.

The bill also requires the AHCA to provide an annual report to the governor and Legislature that compares utilization, benefit, and cost data from Medicaid dental contractors, as well as reports on compliance and access to care for the state's overall Medicaid dental population.

The bill has an indeterminate fiscal impact.

The bill has an effective date of June 30, 2013.

This bill substantially amends section 409.912 of the Florida Statutes.

II. Present Situation:

Medicaid is a joint federal and state funded program that provides health care for low income Floridians. The program is administered by the AHCA and financed with federal and state funds. Over 3.3 million Floridians are currently enrolled in Medicaid and the program is expected to have more than \$22 billion in expenditures for Fiscal Year 2012-2013.¹ The statutory authority for the Medicaid program is contained in ch. 409, F.S.

Federal law establishes the minimum benefit levels to be covered in order to receive federal matching funds. Benefit requirements can vary by eligibility category. For example, more benefits are required for children than for the adult population. Florida's mandatory and optional benefits are prescribed in state law under ss. 409.905, and 409.906 F.S., respectively.

Florida Medicaid recipients receive their benefits through a number of different delivery systems. Florida has at least 15 different managed care models,² including the model being used for the delivery of dental services, licensed, prepaid dental health plans (PDHP). The PDHPs are classified as prepaid ambulatory health plans by 42 CFR Part 438.³

Prepaid Dental Health Plans and Florida Medicaid

Proviso language in the 2001-2002 General Appropriations Act (GAA) authorized the AHCA to initiate a PDHP pilot program in Miami-Dade County.⁴ The 2003 Legislature authorized the AHCA to contract on prepaid or fixed sum basis for dental services for Medicaid-eligible recipients using PDHPs.⁵ Through a competitive process, the AHCA executed its first PDHP contract in 2004 to serve children under age 21 in Miami-Dade County.⁶ Comprehensive dental benefit coverage is a mandatory Medicaid service only for children in Florida. The PDHPs are paid on a capitated basis for all covered dental services, meaning that the plans receive a single rate per individual member for all dental costs associated with that member. Currently, two PDHPs serve Medicaid members in Miami-Dade County.⁷

The Legislature included proviso in the 2010-2011 GAA authorizing the AHCA to contract by competitive procurement with one or more prepaid dental plans on a regional or statewide basis for a period not to exceed two years, in all counties except Miami-Dade, under a fee-for-service or managed care delivery system.⁸ The AHCA did not procure contracts under the 2010-2011

¹ Agency for Health Care Administration, *Statewide Medicaid Managed Care Overview, Presentation to House Health Care Subcommittee*, (Jan. 15, 2013), http://ahca.myflorida.com/Medicaid/recent_presentations/SMMC_Overview_House_HHS_Approps.pdf (last visited Mar. 8, 2013).

² Comm. on Health Regulation, Fla. Senate, *Overview of Medicaid Managed Care Programs in Florida*, p.1, (Issue Brief 2011-221) (November 2010).

³ See Agency for Health Care Administration, *Model Statewide Prepaid Dental Health Plan (SPDHP) Contract, Attachment II-Core Contract Provisions*, p. 17, http://ahca.myflorida.com/medicaid/pdhp/docs/120120_Attachment_II_Core.pdf (last visited Mar. 8, 2013).

⁴ See Specific Proviso 135A, General Appropriations Act 2001-2002 (Conference Report on CS/SB 2C).

⁵ Chapter 2003-405, L.O.F.

⁶ Agency for Health Care Administration, *Senate Bill 896 Bill Analysis and Economic Impact Statement*, (Mar. 11, 2013) (on file with the Senate Health Policy Committee).

⁷ *Ibid.*

⁸ See Specific Proviso 204, General Appropriations Act 2010-2011 (Conference Report on HB 5001).

proviso. In the 2011-2012 GAA, similar proviso language was included to require such a competitive procurement.

The Legislature passed proviso in the 2012-2013 GAA requiring that, for all counties other than Miami-Dade, the AHCA could not limit Medicaid dental services to prepaid plans and must allow qualified dental providers to provide dental services on a fee-for-service basis. Language to that effect was also passed in the 2012-2013 appropriations implementing bill, which included additional language directing the AHCA to terminate existing contracts as needed. The implementing bill provisions have a sunset date of July 1, 2013.

According to the AHCA website, two vendors were selected for the statewide program and it has been implemented statewide⁹ as of December 1, 2012. Under the statewide program, Medicaid recipients may select one of the two PDHPs in their county or opt-out and receive their dental care through Medicaid fee-for-service providers.¹⁰

Statewide Medicaid Managed Care

In 2011, the Legislature also passed HB 7107¹¹ creating the Statewide Medicaid Managed Care (SMMC) program as part IV of ch. 409, F.S. SMMC requires the AHCA to create an integrated managed care program for Medicaid enrollees that incorporates all of the minimum benefits, for the delivery of primary and acute care, including dental.¹² Instead of being delivered as a separate benefit under a separate contract, dental services are to be incorporated by and be the responsibility of a managed care organization. Medicaid recipients who are enrolled in the SMMC program will receive their dental services through the fully integrated managed care plans as the program is implemented.¹³

The AHCA began implementing the SMMC in January 2012 and recently released an Invitation to Negotiate (ITN) to competitively procure managed care plans on a statewide basis. Plans can supplement the minimum benefits in their bids and offer enhanced options.¹⁴ Statewide implementation of SMMC is expected to be completed by October 1, 2014. Final approval of the necessary Medicaid waiver by the federal government has not yet been received; however on February 20, 2013, the AHCA and the federal Centers for Medicare and Medicaid Services reached an “Agreement in Principle” on the proposed plan.¹⁵ The integrated Medicaid plans

⁹ Six counties were excluded from the statewide roll-out. Miami-Dade was excluded because of the prepaid dental program that has been in place there since 2004. Baker, Broward, Clay, Duval, and Nassau counties were excluded because the Medicaid Reform Pilot Project has been implemented in those counties since 2006, which requires most Medicaid recipients to enroll in managed care plans that provide dental care as a covered service.

¹⁰ Agency for Health Care Administration, *Statewide Prepaid Dental Program*, <http://ahca.myflorida.com/Medicaid/index.shtml#mc> (last visited: Mar. 7, 2013).

¹¹ See ch. 2011-134, L.O.F.

¹² Health and Human Services Committee, Fla. House of Representatives, *PCB HHSC 11-01 Staff Analysis*, p.25, (Mar. 25, 2011).

¹³ AHCA, *supra* note 6, at 2.

¹⁴ *Ibid.*

¹⁵ See Correspondence between Agency for Health Care Administration and the Centers for Medicare and Medicaid Services, http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/Letter_from_CMS_re_Agreement_in_Principal_2013-02-20.pdf (last visited Mar. 11, 2013).

would cover both children and adults. The current dental plan contracts held by the AHCA cover only Medicaid recipients under age 21.

III. Effect of Proposed Changes:

Section 1 amends s. 409.912, F.S., relating to the cost effective purchasing of health care under the Medicaid program. The bill postpones the scheduled repeal of the provision that currently requires the AHCA to contract on a fixed-sum or prepaid basis with licensed prepaid dental health plans to provide dental services to Medicaid recipients. The modification extends the repeal date from October 1, 2014, to October 1, 2017.

Extending the requirement that the AHCA contract on a fixed-sum or pre-paid basis for dental services to October 1, 2017, may result in the overlap of stand-alone prepaid dental service contracts and those procured under SMMC. Dental benefits are required under the SMMC program.

The bill also deletes the current-law provision authorizing the AHCA to provide a Medicaid prepaid dental program in Miami-Dade County only during the 2012-2013 fiscal year, meaning that the AHCA will be authorized to provide the current program in Miami-Dade County in perpetuity.

The provision requiring a fee-for-service option for dental benefits – scheduled to sunset on July 1, 2013 – is deleted.

The AHCA is directed to provide the governor, president of the Senate, and speaker of the House of Representatives with a report that compares benefits, utilization, and costs of the contracted dental plans and the extent to which the prepaid plans are in compliance with their contract terms, including statistical trends with indicators of good oral health, in comparison to the overall Medicaid dental population. The report is due by January 15 each year.

Section 2 provides an effective date of June 30, 2013.

Other Potential Implications:

The AHCA analysis of the bill indicates that if the sunset provision is removed or postponed and results in changes to dental service delivery under SMMC, there is the possibility of a protest under the Managed Medical Assistance ITN procurement that is currently underway. Dental services are currently incorporated in that ITN.

The AHCA also identifies a potential conflict between the modifications proposed in the bill and the provisions of ss. 409.961 through 409.977, F.S., relating to managed medical assistance and the requirement that managed care plans provide comprehensive Medicaid services, including all Medicaid covered dental services, to their enrollees.¹⁶

¹⁶ AHCA, *supra* note 6, at 1 and 3.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill has limited private sector impact. The bill deletes a provision that will sunset July 1, 2013, relating to the fee-for-service reimbursement and extends the authorization of separate PDHP contracts to from October 1, 2014, to October 1, 2017. These contracts cover the same benefits that will be incorporated through those being procured now under the SMMC program. The proposed contract extension period overlaps with those SMMC contracts.

C. Government Sector Impact:

The bill's fiscal impact is indeterminate because it is impossible to know whether directing the AHCA to continue with the statewide prepaid dental program until October 1, 2017, and authorizing the continuation of prepaid dental in Miami-Dade County in perpetuity, might result in more or less cost to the state than the costs that will be incurred for dental services under the SMMC program.

VI. Technical Deficiencies:

None.

VII. Related Issues:

The AHCA has released an ITN covering all Medicaid services as part of the SMMC. This ITN includes dental services as part of those comprehensive medical services and requires the managed care organizations to cover all benefits. Extending the time frame for the existing prepaid dental health plan contracts for Medicaid enrollees under the age of 21 would overlap with the dental services proposed under that procurement document and other statutory direction.

Section 409.961, F.S., provides that if any conflict exists between provisions contained in the Medicaid Managed Care part (part IV) and in other parts of the chapter, the provisions of part IV would control.

VIII. Additional Information:

- A. **Committee Substitute – Statement of Substantial Changes:**
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Health Policy on March 14, 2013:

CS for SB 896 adds a requirement directing AHCA to provide the Governor, President of the Senate and Speaker of the House of Representatives with a report that compares benefits, utilization and costs of the contracted dental plans and the extent to which the prepaid plans are in compliance with their contract terms, including statistical trends with indicators of good oral health, in comparison to the overall Medicaid dental population. The report is due by January 15, each year. (WITH TITLE AMENDMENT)

- B. **Amendments:**

None.

By the Committee on Health Policy; and Senators Garcia and Flores

588-02413-13

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1 A bill to be entitled
 2 An act relating to prepaid dental plans; amending s.
 3 409.912, F.S.; postponing the scheduled repeal of a
 4 provision requiring the Agency for Health Care
 5 Administration to contract with dental plans for
 6 dental services on a prepaid or fixed-sum basis;
 7 authorizing the agency to provide a prepaid dental
 8 health program in Miami-Dade County on a permanent
 9 basis; requiring an annual report to the Governor and
 10 Legislature; providing an effective date.
 11
 12 Be It Enacted by the Legislature of the State of Florida:
 13
 14 Section 1. Subsection (41) of section 409.912, Florida
 15 Statutes, is amended to read:
 16 409.912 Cost-effective purchasing of health care.—The
 17 agency shall purchase goods and services for Medicaid recipients
 18 in the most cost-effective manner consistent with the delivery
 19 of quality medical care. To ensure that medical services are
 20 effectively utilized, the agency may, in any case, require a
 21 confirmation or second physician's opinion of the correct
 22 diagnosis for purposes of authorizing future services under the
 23 Medicaid program. This section does not restrict access to
 24 emergency services or poststabilization care services as defined
 25 in 42 C.F.R. part 438.114. Such confirmation or second opinion
 26 shall be rendered in a manner approved by the agency. The agency
 27 shall maximize the use of prepaid per capita and prepaid
 28 aggregate fixed-sum basis services when appropriate and other
 29 alternative service delivery and reimbursement methodologies,

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30 including competitive bidding pursuant to s. 287.057, designed
 31 to facilitate the cost-effective purchase of a case-managed
 32 continuum of care. The agency shall also require providers to
 33 minimize the exposure of recipients to the need for acute
 34 inpatient, custodial, and other institutional care and the
 35 inappropriate or unnecessary use of high-cost services. The
 36 agency shall contract with a vendor to monitor and evaluate the
 37 clinical practice patterns of providers in order to identify
 38 trends that are outside the normal practice patterns of a
 39 provider's professional peers or the national guidelines of a
 40 provider's professional association. The vendor must be able to
 41 provide information and counseling to a provider whose practice
 42 patterns are outside the norms, in consultation with the agency,
 43 to improve patient care and reduce inappropriate utilization.
 44 The agency may mandate prior authorization, drug therapy
 45 management, or disease management participation for certain
 46 populations of Medicaid beneficiaries, certain drug classes, or
 47 particular drugs to prevent fraud, abuse, overuse, and possible
 48 dangerous drug interactions. The Pharmaceutical and Therapeutics
 49 Committee shall make recommendations to the agency on drugs for
 50 which prior authorization is required. The agency shall inform
 51 the Pharmaceutical and Therapeutics Committee of its decisions
 52 regarding drugs subject to prior authorization. The agency is
 53 authorized to limit the entities it contracts with or enrolls as
 54 Medicaid providers by developing a provider network through
 55 provider credentialing. The agency may competitively bid single-
 56 source-provider contracts if procurement of goods or services
 57 results in demonstrated cost savings to the state without
 58 limiting access to care. The agency may limit its network based

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59 on the assessment of beneficiary access to care, provider
60 availability, provider quality standards, time and distance
61 standards for access to care, the cultural competence of the
62 provider network, demographic characteristics of Medicaid
63 beneficiaries, practice and provider-to-beneficiary standards,
64 appointment wait times, beneficiary use of services, provider
65 turnover, provider profiling, provider licensure history,
66 previous program integrity investigations and findings, peer
67 review, provider Medicaid policy and billing compliance records,
68 clinical and medical record audits, and other factors. Providers
69 are not entitled to enrollment in the Medicaid provider network.
70 The agency shall determine instances in which allowing Medicaid
71 beneficiaries to purchase durable medical equipment and other
72 goods is less expensive to the Medicaid program than long-term
73 rental of the equipment or goods. The agency may establish rules
74 to facilitate purchases in lieu of long-term rentals in order to
75 protect against fraud and abuse in the Medicaid program as
76 defined in s. 409.913. The agency may seek federal waivers
77 necessary to administer these policies.

78 (41) (a) The agency shall contract on a prepaid or fixed-sum
79 basis with appropriately licensed prepaid dental health plans to
80 provide dental services. This paragraph expires October 1, 2017
81 2014.

82 (b) Notwithstanding paragraph (a) ~~and for the 2012-2013~~
83 ~~fiscal year only~~, the agency may ~~is authorized to~~ provide a
84 Medicaid prepaid dental health program in Miami-Dade County. The
85 agency shall provide an annual report by January 15 to the
86 Governor, the President of the Senate, and the Speaker of the
87 House of Representatives which compares the combined reported

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88 annual benefits utilization and encounter data from all
89 contractors, along with the agency's findings as to projected
90 and budgeted annual program costs, the extent to which each
91 contracting entity is complying with all contract terms and
92 conditions, the effect that each entity's operation is having on
93 access to care for Medicaid recipients in the contractor's
94 service area, and the statistical trends associated with
95 indicators of good oral health among all recipients served in
96 comparison with the state's population as a whole. For all other
97 counties, the agency may not limit dental services to prepaid
98 plans and must allow qualified dental providers to provide
99 dental services under Medicaid on a fee for service
100 reimbursement methodology. The agency may seek any necessary
101 revisions or amendments to the state plan or federal waivers in
102 order to implement this paragraph. The agency shall terminate
103 existing contracts as needed to implement this paragraph. This
104 paragraph expires July 1, 2013.

105 Section 2. This act shall take effect June 30, 2013.



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LEGISLATIVE ACTION

Senate	.	House
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Appropriations Subcommittee on Health and Human Services
(Grimsley) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause
and insert:

Section 1. Paragraph (c) of subsection (3) of section
409.907, Florida Statutes, is amended, paragraph (k) is added to
that subsection, and subsections (6) through (9) of that section
are amended, to read:

409.907 Medicaid provider agreements.—The agency may make
payments for medical assistance and related services rendered to
Medicaid recipients only to an individual or entity who has a
provider agreement in effect with the agency, who is performing



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13 services or supplying goods in accordance with federal, state,
14 And local law, and who agrees that no person shall, on the
15 grounds of handicap, race, color, or national origin, or for any
16 other reason, be subjected to discrimination under any program
17 or activity for which the provider receives payment from the
18 agency.

19 (3) The provider agreement developed by the agency, in
20 addition to the requirements specified in subsections (1) and
21 (2), shall require the provider to:

22 (c) Retain all medical and Medicaid-related records for 6 a
23 ~~period of 5~~ years to satisfy all necessary inquiries by the
24 agency.

25 (k) Report a change in any principal of the provider,
26 including any officer, director, agent, managing employee, or
27 affiliated person, or any partner or shareholder who has an
28 ownership interest equal to 5 percent or more in the provider,
29 to the agency in writing within 30 days after the change occurs.
30 For a hospital licensed under chapter 395 or a nursing home
31 licensed under part II of chapter 400, a principal of the
32 provider is one who meets the definition of a controlling
33 interest under s. 408.803.

34 (6) A Medicaid provider agreement may be revoked, at the
35 option of the agency, due to ~~as the result of~~ a change of
36 ownership of any facility, association, partnership, or other
37 entity named as the provider in the provider agreement.

38 (a) If there is ~~In the event of~~ a change of ownership, the
39 transferor remains liable for all outstanding overpayments,
40 administrative fines, and any other moneys owed to the agency
41 before the effective date of the change ~~of ownership~~. ~~In~~



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42 ~~addition to the continuing liability of the transferor,~~ The
43 transferee is also liable to the agency for all outstanding
44 overpayments identified by the agency on or before the effective
45 date of the change of ownership. ~~For purposes of this~~
46 ~~subsection, the term "outstanding overpayment" includes any~~
47 ~~amount identified in a preliminary audit report issued to the~~
48 ~~transferor by the agency on or before the effective date of the~~
49 ~~change of ownership.~~ In the event of a change of ownership for a
50 skilled nursing facility or intermediate care facility, the
51 Medicaid provider agreement shall be assigned to the transferee
52 if the transferee meets all other Medicaid provider
53 qualifications. In the event of a change of ownership involving
54 a skilled nursing facility licensed under part II of chapter
55 400, liability for all outstanding overpayments, administrative
56 fines, and any moneys owed to the agency before the effective
57 date of the change of ownership shall be determined in
58 accordance with s. 400.179.

59 (b) At least 60 days before the anticipated date of the
60 change of ownership, the transferor must ~~shall~~ notify the agency
61 of the intended change ~~of ownership~~ and the transferee must
62 ~~shall~~ submit to the agency a Medicaid provider enrollment
63 application. If a change of ownership occurs without compliance
64 with the notice requirements of this subsection, the transferor
65 and transferee are ~~shall be~~ jointly and severally liable for all
66 overpayments, administrative fines, and other moneys due to the
67 agency, regardless of whether the agency identified the
68 overpayments, administrative fines, or other moneys before or
69 after the effective date of the change ~~of ownership~~. The agency
70 may not approve a transferee's Medicaid provider enrollment



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71 application if the transferee or transferor has not paid or
72 agreed in writing to a payment plan for all outstanding
73 overpayments, administrative fines, and other moneys due to the
74 agency. This subsection does not preclude the agency from
75 seeking any other legal or equitable remedies available to the
76 agency for the recovery of moneys owed to the Medicaid program.
77 In the event of a change of ownership involving a skilled
78 nursing facility licensed under part II of chapter 400,
79 liability for all outstanding overpayments, administrative
80 fines, and any moneys owed to the agency before the effective
81 date of the change of ownership shall be determined in
82 accordance with s. 400.179 if the Medicaid provider enrollment
83 application for change of ownership is submitted before the
84 change of ownership.

85 (c) As used in this subsection, the term:

86 1. "Administrative fines" includes any amount identified in
87 a notice of a monetary penalty or fine which has been issued by
88 the agency or other regulatory or licensing agency that governs
89 the provider.

90 2. "Outstanding overpayment" includes any amount identified
91 in a preliminary audit report issued to the transferor by the
92 agency on or before the effective date of a change of ownership.

93 ~~(7) The agency may require,~~ As a condition of participating
94 in the Medicaid program and before entering into the provider
95 agreement, the agency may require ~~that~~ the provider to submit
96 information, in an initial and any required renewal
97 applications, concerning the professional, business, and
98 personal background of the provider and permit an onsite
99 inspection of the provider's service location by agency staff or



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100 other personnel designated by the agency to perform this
101 function. Before entering into a provider agreement, the agency
102 ~~may shall~~ perform an a random onsite inspection, ~~within 60 days~~
103 ~~after receipt of a fully complete new provider's application,~~ of
104 the provider's service location ~~prior to making its first~~
105 ~~payment to the provider for Medicaid services~~ to determine the
106 applicant's ability to provide the services in compliance with
107 the Medicaid program and professional regulations ~~that the~~
108 ~~applicant is proposing to provide for Medicaid reimbursement.~~
109 ~~The agency is not required to perform an onsite inspection of a~~
110 ~~provider or program that is licensed by the agency, that~~
111 ~~provides services under waiver programs for home and community-~~
112 ~~based services, or that is licensed as a medical foster home by~~
113 ~~the Department of Children and Family Services.~~ As a continuing
114 condition of participation in the Medicaid program, a provider
115 must shall immediately notify the agency of any current or
116 pending bankruptcy filing. Before entering into the provider
117 agreement, or as a condition of continuing participation in the
118 Medicaid program, the agency may also require ~~that~~ Medicaid
119 providers that are reimbursed on a fee-for-services basis or fee
120 schedule basis that which is not cost-based to, post a surety
121 bond not to exceed \$50,000 or the total amount billed by the
122 provider to the program during the current or most recent
123 calendar year, whichever is greater. For new providers, the
124 amount of the surety bond shall be determined by the agency
125 based on the provider's estimate of its first year's billing. If
126 the provider's billing during the first year exceeds the bond
127 amount, the agency may require the provider to acquire an
128 additional bond equal to the actual billing level of the



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129 provider. A provider's bond need ~~shall~~ not exceed \$50,000 if a
130 physician or group of physicians licensed under chapter 458,
131 chapter 459, or chapter 460 has a 50 percent or greater
132 ownership interest in the provider or if the provider is an
133 assisted living facility licensed under chapter 429. The bonds
134 permitted by this section are in addition to the bonds
135 referenced in s. 400.179(2) (d). If the provider is a
136 corporation, partnership, association, or other entity, the
137 agency may require the provider to submit information concerning
138 the background of that entity and of any principal of the
139 entity, including any partner or shareholder having an ownership
140 interest in the entity equal to 5 percent or greater, and any
141 treating provider who participates in or intends to participate
142 in Medicaid through the entity. The information must include:

143 (a) Proof of holding a valid license or operating
144 certificate, as applicable, if required by the state or local
145 jurisdiction in which the provider is located or if required by
146 the Federal Government.

147 (b) Information concerning any prior violation, fine,
148 suspension, termination, or other administrative action taken
149 under the Medicaid laws or, ~~rules, or regulations~~ of this state
150 or ~~of~~ any other state or the Federal Government; any prior
151 violation of the laws or, ~~rules, or regulations~~ relating to the
152 Medicare program; any prior violation of the rules ~~or~~
153 ~~regulations~~ of any other public or private insurer; and any
154 prior violation of the laws or, ~~rules, or regulations~~ of any
155 regulatory body of this or any other state.

156 (c) Full and accurate disclosure of any financial or
157 ownership interest that the provider, or any principal, partner,



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158 or major shareholder thereof, may hold in any other Medicaid
159 provider or health care related entity or any other entity that
160 is licensed by the state to provide health or residential care
161 and treatment to persons.

162 (d) If a group provider, identification of all members of
163 the group and attestation that all members of the group are
164 enrolled in or have applied to enroll in the Medicaid program.

165 (8)~~(a)~~ Each provider, or each principal of the provider if
166 the provider is a corporation, partnership, association, or
167 other entity, seeking to participate in the Medicaid program
168 must submit a complete set of his or her fingerprints to the
169 agency for the purpose of conducting a criminal history record
170 check. Principals of the provider include any officer, director,
171 billing agent, managing employee, or affiliated person, or any
172 partner or shareholder who has an ownership interest equal to 5
173 percent or more in the provider. However, for a hospital
174 licensed under chapter 395 or a nursing home licensed under
175 chapter 400, principals of the provider are those who meet the
176 definition of a controlling interest under s. 408.803. A
177 director of a not-for-profit corporation or organization is not
178 a principal for purposes of a background investigation ~~as~~
179 required by this section if the director: serves solely in a
180 voluntary capacity for the corporation or organization, does not
181 regularly take part in the day-to-day operational decisions of
182 the corporation or organization, receives no remuneration from
183 the not-for-profit corporation or organization for his or her
184 service on the board of directors, has no financial interest in
185 the not-for-profit corporation or organization, and has no
186 family members with a financial interest in the not-for-profit



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187 corporation or organization; and if the director submits an
188 affidavit, under penalty of perjury, to this effect to the
189 agency and the not-for-profit corporation or organization
190 submits an affidavit, under penalty of perjury, to this effect
191 to the agency as part of the corporation's or organization's
192 Medicaid provider agreement application. Notwithstanding the
193 above, the agency may require a background check for any person
194 reasonably suspected by the agency to have been convicted of a
195 crime.

196 (a) This subsection does not apply to:

- 197 ~~1. A hospital licensed under chapter 395;~~
198 ~~2. A nursing home licensed under chapter 400;~~
199 ~~3. A hospice licensed under chapter 400;~~
200 ~~4. An assisted living facility licensed under chapter 429;~~

201 ~~1.5.~~ A unit of local government, except that requirements
202 of this subsection apply to nongovernmental providers and
203 entities contracting with the local government to provide
204 Medicaid services. The actual cost of the state and national
205 criminal history record checks must be borne by the
206 nongovernmental provider or entity; or

207 ~~2.6.~~ Any business that derives more than 50 percent of its
208 revenue from the sale of goods to the final consumer, and the
209 business or its controlling parent is required to file a form
210 10-K or other similar statement with the Securities and Exchange
211 Commission or has a net worth of \$50 million or more.

212 (b) Background screening shall be conducted in accordance
213 with chapter 435 and s. 408.809. The cost of the state and
214 national criminal record check shall be borne by the provider.

215 ~~(c) Proof of compliance with the requirements of level 2~~



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216 ~~screening under chapter 435 conducted within 12 months before~~
217 ~~the date the Medicaid provider application is submitted to the~~
218 ~~agency fulfills the requirements of this subsection.~~

219 (9) Upon receipt of a completed, signed, and dated
220 application, and completion of any necessary background
221 investigation and criminal history record check, the agency must
222 either:

223 (a) Enroll the applicant as a Medicaid provider upon
224 approval of the provider application. The enrollment effective
225 date is ~~shall be~~ the date the agency receives the provider
226 application. With respect to a provider that requires a Medicare
227 certification survey, the enrollment effective date is the date
228 the certification is awarded. With respect to a provider that
229 completes a change of ownership, the effective date is the date
230 the agency received the application, the date the change of
231 ownership was complete, or the date the applicant became
232 eligible to provide services under Medicaid, whichever date is
233 later. With respect to a provider of emergency medical services
234 transportation or emergency services and care, the effective
235 date is the date the services were rendered. Payment for any
236 claims for services provided to Medicaid recipients between the
237 date of receipt of the application and the date of approval is
238 contingent on applying ~~any and~~ all applicable audits and edits
239 contained in the agency's claims adjudication and payment
240 processing systems. The agency may enroll a provider located
241 outside this ~~the~~ state ~~of Florida~~ if the provider's location is
242 no more than 50 miles from the ~~Florida~~ state line, if the
243 provider is actively licensed in this state and provides
244 diagnostic services through telecommunications and information



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245 technology in order to provide clinical health care at a
246 distance, or if the agency determines a need for that provider
247 type to ensure adequate access to care; or

248 (b) Deny the application if the agency finds that it is in
249 the best interest of the Medicaid program to do so. The agency
250 may consider the factors listed in subsection (10), as well as
251 any other factor that could affect the effective and efficient
252 administration of the program, including, but not limited to,
253 the applicant's demonstrated ability to provide services,
254 conduct business, and operate a financially viable concern; the
255 current availability of medical care, services, or supplies to
256 recipients, taking into account geographic location and
257 reasonable travel time; the number of providers of the same type
258 already enrolled in the same geographic area; and the
259 credentials, experience, success, and patient outcomes of the
260 provider for the services that it is making application to
261 provide in the Medicaid program. The agency shall deny the
262 application if the agency finds that a provider; any officer,
263 director, agent, managing employee, or affiliated person; or any
264 partner or shareholder having an ownership interest equal to 5
265 percent or greater in the provider if the provider is a
266 corporation, partnership, or other business entity, has failed
267 to pay all outstanding fines or overpayments assessed by final
268 order of the agency or final order of the Centers for Medicare
269 and Medicaid Services, not subject to further appeal, unless the
270 provider agrees to a repayment plan that includes withholding
271 Medicaid reimbursement until the amount due is paid in full.

272 Section 2. Subsection (17) of section 409.910, Florida
273 Statutes, is amended to read:



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274 409.910 Responsibility for payments on behalf of Medicaid-
275 eligible persons when other parties are liable.-

276 (17) A recipient or his or her legal representative or any
277 person representing, or acting as agent for, a recipient or the
278 recipient's legal representative, who has notice, excluding
279 notice charged solely by reason of the recording of the lien
280 pursuant to paragraph (6) (c), or who has actual knowledge of the
281 agency's rights to third-party benefits under this section, who
282 receives any third-party benefit or proceeds ~~therefrom~~ for a
283 covered illness or injury, must ~~is required either to pay the~~
284 ~~agency,~~ within 60 days after receipt of settlement proceeds, pay
285 the agency the full amount of the third-party benefits, but not
286 more than ~~in excess of~~ the total medical assistance provided by
287 Medicaid, or ~~to~~ place the full amount of the third-party
288 benefits in an interest-bearing ~~a~~ trust account for the benefit
289 of the agency pending an ~~judicial or~~ administrative
290 determination of the agency's right to the benefits ~~thereto~~.
291 Proof that ~~any~~ such person had notice or knowledge that the
292 recipient had received medical assistance from Medicaid, and
293 that third-party benefits or proceeds ~~therefrom~~ were in any way
294 related to a covered illness or injury for which Medicaid had
295 provided medical assistance, and that ~~any~~ such person knowingly
296 obtained possession or control of, or used, third-party benefits
297 or proceeds and failed ~~either~~ to pay the agency the full amount
298 required by this section or to hold the full amount of third-
299 party benefits or proceeds in an interest-bearing trust account
300 pending an ~~judicial or~~ administrative determination, unless
301 adequately explained, gives rise to an inference that such
302 person knowingly failed to credit the state or its agent for



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303 payments received from social security, insurance, or other
304 sources, pursuant to s. 414.39(4)(b), and acted with the intent
305 set forth in s. 812.014(1).

306 (a) A recipient may contest the amount designated as
307 recovered medical expense damages payable to the agency pursuant
308 to the formula specified in paragraph (11)(f) by filing a
309 petition under chapter 120 within 21 days after the date of
310 payment of funds to the agency or after the date of placing the
311 full amount of the third-party benefits in the trust account for
312 the benefit of the agency. The petition shall be filed with the
313 Division of Administrative Hearings. For purposes of chapter
314 120, the payment of funds to the agency or the placement of the
315 full amount of the third-party benefits in the trust account for
316 the benefit of the agency constitutes final agency action and
317 notice thereof. Final order authority for the proceedings
318 specified in this subsection rests with the Division of
319 Administrative Hearings. This procedure is the exclusive method
320 for challenging the amount of third-party benefits payable to
321 the agency.

322 1. In order to successfully challenge the amount payable to
323 the agency, the recipient must prove, by clear and convincing
324 evidence, that a lesser portion of the total recovery should be
325 allocated as reimbursement for past and future medical expenses
326 than the amount calculated by the agency pursuant to the formula
327 set forth in paragraph (11)(f) or that Medicaid provided a
328 lesser amount of medical assistance than that asserted by the
329 agency.

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



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332 agency's claim.

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

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

342 (b)-(a) In cases of suspected criminal violations or
343 fraudulent activity, the agency may take any civil action
344 permitted at law or equity to recover the greatest possible
345 amount, including, without limitation, treble damages under ss.
346 772.11 and 812.035(7).

347 1.(b) The agency may ~~is authorized to~~ investigate and ~~to~~
348 request appropriate officers or agencies of the state to
349 investigate suspected criminal violations or fraudulent activity
350 related to third-party benefits, including, without limitation,
351 ss. 414.39 and 812.014. Such requests may be directed, without
352 limitation, to the Medicaid Fraud Control Unit of the Office of
353 the Attorney General, or to any state attorney. Pursuant to s.
354 409.913, the Attorney General has primary responsibility to
355 investigate and control Medicaid fraud.

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



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361 judicial proceedings.

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

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

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

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

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

374 Section 3. Subsections (9), (13), (15), (16), (21), (22),
375 (25), (28), (30), and (31) of section 409.913, Florida Statutes,
376 are amended to read:

377 409.913 Oversight of the integrity of the Medicaid
378 program.—The agency shall operate a program to oversee the
379 activities of Florida Medicaid recipients, and providers and
380 their representatives, to ensure that fraudulent and abusive
381 behavior and neglect of recipients occur to the minimum extent
382 possible, and to recover overpayments and impose sanctions as
383 appropriate. Beginning January 1, 2003, and each year
384 thereafter, the agency and the Medicaid Fraud Control Unit of
385 the Department of Legal Affairs shall submit a joint report to
386 the Legislature documenting the effectiveness of the state's
387 efforts to control Medicaid fraud and abuse and to recover
388 Medicaid overpayments during the previous fiscal year. The
389 report must describe the number of cases opened and investigated



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390 each year; the sources of the cases opened; the disposition of
391 the cases closed each year; the amount of overpayments alleged
392 in preliminary and final audit letters; the number and amount of
393 fines or penalties imposed; any reductions in overpayment
394 amounts negotiated in settlement agreements or by other means;
395 the amount of final agency determinations of overpayments; the
396 amount deducted from federal claiming as a result of
397 overpayments; the amount of overpayments recovered each year;
398 the amount of cost of investigation recovered each year; the
399 average length of time to collect from the time the case was
400 opened until the overpayment is paid in full; the amount
401 determined as uncollectible and the portion of the uncollectible
402 amount subsequently reclaimed from the Federal Government; the
403 number of providers, by type, that are terminated from
404 participation in the Medicaid program as a result of fraud and
405 abuse; and all costs associated with discovering and prosecuting
406 cases of Medicaid overpayments and making recoveries in such
407 cases. The report must also document actions taken to prevent
408 overpayments and the number of providers prevented from
409 enrolling in or reenrolling in the Medicaid program as a result
410 of documented Medicaid fraud and abuse and must include policy
411 recommendations necessary to prevent or recover overpayments and
412 changes necessary to prevent and detect Medicaid fraud. All
413 policy recommendations in the report must include a detailed
414 fiscal analysis, including, but not limited to, implementation
415 costs, estimated savings to the Medicaid program, and the return
416 on investment. The agency must submit the policy recommendations
417 and fiscal analyses in the report to the appropriate estimating
418 conference, pursuant to s. 216.137, by February 15 of each year.



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419 The agency and the Medicaid Fraud Control Unit of the Department
420 of Legal Affairs each must include detailed unit-specific
421 performance standards, benchmarks, and metrics in the report,
422 including projected cost savings to the state Medicaid program
423 during the following fiscal year.

424 (9) A Medicaid provider shall retain medical, professional,
425 financial, and business records pertaining to services and goods
426 furnished to a Medicaid recipient and billed to Medicaid for 6 a
427 ~~period of 5~~ years after the date of furnishing such services or
428 goods. The agency may investigate, review, or analyze such
429 records, which must be made available during normal business
430 hours. However, 24-hour notice must be provided if patient
431 treatment would be disrupted. The provider must keep ~~is~~
432 ~~responsible for furnishing to the agency, and keeping~~ the agency
433 informed of the location of, the provider's Medicaid-related
434 records. The authority of the agency to obtain Medicaid-related
435 records from a provider is neither curtailed nor limited during
436 a period of litigation between the agency and the provider.

437 (13) The agency shall ~~immediately~~ terminate participation
438 of a Medicaid provider in the Medicaid program and may seek
439 civil remedies or impose other administrative sanctions against
440 a Medicaid provider, if the provider or any principal, officer,
441 director, agent, managing employee, or affiliated person of the
442 provider, or any partner or shareholder having an ownership
443 interest in the provider equal to 5 percent or greater, has been
444 convicted of a criminal offense under federal law or the law of
445 any state relating to the practice of the provider's profession,
446 or a criminal offense listed under s. 408.809(4), s.
447 409.907(10), or s. 435.04(2) ~~has been:~~



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448 ~~(a) Convicted of a criminal offense related to the delivery~~
449 ~~of any health care goods or services, including the performance~~
450 ~~of management or administrative functions relating to the~~
451 ~~delivery of health care goods or services;~~

452 ~~(b) Convicted of a criminal offense under federal law or~~
453 ~~the law of any state relating to the practice of the provider's~~
454 ~~profession; or~~

455 ~~(c) Found by a court of competent jurisdiction to have~~
456 ~~neglected or physically abused a patient in connection with the~~
457 ~~delivery of health care goods or services. If the agency~~
458 ~~determines that the a provider did not participate or acquiesce~~
459 ~~in the an offense specified in paragraph (a), paragraph (b), or~~
460 ~~paragraph (c), termination will not be imposed. If the agency~~
461 ~~effects a termination under this subsection, the agency shall~~
462 ~~take final agency action issue an immediate final order pursuant~~
463 ~~to s. 120.569(2)(n).~~

464 (15) The agency shall seek a remedy provided by law,
465 including, but not limited to, any remedy provided in
466 subsections (13) and (16) and s. 812.035, if:

467 (a) The provider's license has not been renewed, or has
468 been revoked, suspended, or terminated, for cause, by the
469 licensing agency of any state;

470 (b) The provider has failed to make available or has
471 refused access to Medicaid-related records to an auditor,
472 investigator, or other authorized employee or agent of the
473 agency, the Attorney General, a state attorney, or the Federal
474 Government;

475 (c) The provider has not furnished or has failed to make
476 available such Medicaid-related records as the agency has found



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477 necessary to determine whether Medicaid payments are or were due
478 and the amounts thereof;

479 (d) The provider has failed to maintain medical records
480 made at the time of service, or prior to service if prior
481 authorization is required, demonstrating the necessity and
482 appropriateness of the goods or services rendered;

483 (e) The provider is not in compliance with provisions of
484 Medicaid provider publications that have been adopted by
485 reference as rules in the Florida Administrative Code; with
486 provisions of state or federal laws, rules, or regulations; with
487 provisions of the provider agreement between the agency and the
488 provider; or with certifications found on claim forms or on
489 transmittal forms for electronically submitted claims that are
490 submitted by the provider or authorized representative, as such
491 provisions apply to the Medicaid program;

492 (f) The provider or person who ordered, authorized, or
493 prescribed the care, services, or supplies has furnished, or
494 ordered or authorized the furnishing of, goods or services to a
495 recipient which are inappropriate, unnecessary, excessive, or
496 harmful to the recipient or are of inferior quality;

497 (g) The provider has demonstrated a pattern of failure to
498 provide goods or services that are medically necessary;

499 (h) The provider or an authorized representative of the
500 provider, or a person who ordered, authorized, or prescribed the
501 goods or services, has submitted or caused to be submitted false
502 or a pattern of erroneous Medicaid claims;

503 (i) The provider or an authorized representative of the
504 provider, or a person who has ordered, authorized, or prescribed
505 the goods or services, has submitted or caused to be submitted a



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506 Medicaid provider enrollment application, a request for prior
507 authorization for Medicaid services, a drug exception request,
508 or a Medicaid cost report that contains materially false or
509 incorrect information;

510 (j) The provider or an authorized representative of the
511 provider has collected from or billed a recipient or a
512 recipient's responsible party improperly for amounts that should
513 not have been so collected or billed by reason of the provider's
514 billing the Medicaid program for the same service;

515 (k) The provider or an authorized representative of the
516 provider has included in a cost report costs that are not
517 allowable under a Florida Title XIX reimbursement plan, after
518 the provider or authorized representative had been advised in an
519 audit exit conference or audit report that the costs were not
520 allowable;

521 (l) The provider is charged by information or indictment
522 with fraudulent billing practices or an offense referenced in
523 subsection (13). The sanction applied for this reason is limited
524 to suspension of the provider's participation in the Medicaid
525 program for the duration of the indictment unless the provider
526 is found guilty pursuant to the information or indictment;

527 (m) The provider or a person who ~~has~~ ordered, authorized,
528 or prescribed the goods or services is found liable for
529 negligent practice resulting in death or injury to the
530 provider's patient;

531 (n) The provider fails to demonstrate that it had available
532 during a specific audit or review period sufficient quantities
533 of goods, or sufficient time in the case of services, to support
534 the provider's billings to the Medicaid program;



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535 (o) The provider has failed to comply with the notice and
536 reporting requirements of s. 409.907;

537 (p) The agency has received reliable information of patient
538 abuse or neglect or of any act prohibited by s. 409.920; or

539 (q) The provider has failed to comply with an agreed-upon
540 repayment schedule.

541
542 A provider is subject to sanctions for violations of this
543 subsection as the result of actions or inactions of the
544 provider, or actions or inactions of any principal, officer,
545 director, agent, managing employee, or affiliated person of the
546 provider, or any partner or shareholder having an ownership
547 interest in the provider equal to 5 percent or greater, in which
548 the provider participated or acquiesced.

549 (16) The agency shall impose any of the following sanctions
550 or disincentives on a provider or a person for any of the acts
551 described in subsection (15):

552 (a) Suspension for a specific period of time of not more
553 than 1 year. Suspension precludes ~~shall preclude~~ participation
554 in the Medicaid program, which includes any action that results
555 in a claim for payment to the Medicaid program for ~~as a result~~
556 ~~of~~ furnishing, supervising a person who is furnishing, or
557 causing a person to furnish goods or services.

558 (b) Termination for a specific period of time ranging ~~of~~
559 from more than 1 year to 20 years. Termination precludes ~~shall~~
560 ~~preclude~~ participation in the Medicaid program, which includes
561 any action that results in a claim for payment to the Medicaid
562 program for ~~as a result of~~ furnishing, supervising a person who
563 is furnishing, or causing a person to furnish goods or services.



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564 (c) Imposition of a fine of up to \$5,000 for each
565 violation. Each day that an ongoing violation continues, such as
566 refusing to furnish Medicaid-related records or refusing access
567 to records, is considered, ~~for the purposes of this section, to~~
568 ~~be~~ a separate violation. Each instance of improper billing of a
569 Medicaid recipient; each instance of including an unallowable
570 cost on a hospital or nursing home Medicaid cost report after
571 the provider or authorized representative has been advised in an
572 audit exit conference or previous audit report of the cost
573 unallowability; each instance of furnishing a Medicaid recipient
574 goods or professional services that are inappropriate or of
575 inferior quality as determined by competent peer judgment; each
576 instance of knowingly submitting a materially false or erroneous
577 Medicaid provider enrollment application, request for prior
578 authorization for Medicaid services, drug exception request, or
579 cost report; each instance of inappropriate prescribing of drugs
580 for a Medicaid recipient as determined by competent peer
581 judgment; and each false or erroneous Medicaid claim leading to
582 an overpayment to a provider is considered, ~~for the purposes of~~
583 ~~this section, to be~~ a separate violation.

584 (d) Immediate suspension, if the agency has received
585 information of patient abuse or neglect or of any act prohibited
586 by s. 409.920. Upon suspension, the agency must issue an
587 immediate final order under s. 120.569(2)(n).

588 (e) A fine, not to exceed \$10,000, for a violation of
589 paragraph (15)(i).

590 (f) Imposition of liens against provider assets, including,
591 but not limited to, financial assets and real property, not to
592 exceed the amount of fines or recoveries sought, upon entry of



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593 an order determining that such moneys are due or recoverable.

594 (g) Prepayment reviews of claims for a specified period of
595 time.

596 (h) Comprehensive followup reviews of providers every 6
597 months to ensure that they are billing Medicaid correctly.

598 (i) Corrective-action plans that ~~would~~ remain in effect ~~for~~
599 ~~providers~~ for up to 3 years and that are ~~would be~~ monitored by
600 the agency every 6 months while in effect.

601 (j) Other remedies as permitted by law to effect the
602 recovery of a fine or overpayment.

603

604 If a provider voluntarily relinquishes its Medicaid provider
605 number or an associated license, or allows the associated
606 licensure to expire after receiving written notice that the
607 agency is conducting, or has conducted, an audit, survey,
608 inspection, or investigation and that a sanction of suspension
609 or termination will or would be imposed for noncompliance
610 discovered as a result of the audit, survey, inspection, or
611 investigation, the agency shall impose the sanction of
612 termination for cause against the provider. The Secretary of
613 Health Care Administration may make a determination that
614 imposition of a sanction or disincentive is not in the best
615 interest of the Medicaid program, in which case a sanction or
616 disincentive may ~~shall~~ not be imposed.

617 (21) When making a determination that an overpayment has
618 occurred, the agency shall prepare and issue an audit report to
619 the provider showing the calculation of overpayments. The
620 agency's determination must be based solely upon information
621 available to it before issuance of the audit report and, in the



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622 case of documentation obtained to substantiate claims for
623 Medicaid reimbursement, based solely upon contemporaneous
624 records.

625 (22) The audit report, supported by agency work papers,
626 showing an overpayment to a provider constitutes evidence of the
627 overpayment. A provider may not present or elicit testimony,
628 ~~either~~ on direct examination or cross-examination in any court
629 or administrative proceeding, regarding the purchase or
630 acquisition by any means of drugs, goods, or supplies; sales or
631 divestment by any means of drugs, goods, or supplies; or
632 inventory of drugs, goods, or supplies, unless such acquisition,
633 sales, divestment, or inventory is documented by written
634 invoices, written inventory records, or other competent written
635 documentary evidence maintained in the normal course of the
636 provider's business. A provider may not present records to
637 contest an overpayment or sanction unless such records are
638 contemporaneous and, if requested during the audit process, were
639 furnished to the agency or its agent upon request. This
640 limitation does not apply to Medicaid cost report audits.
641 Notwithstanding the applicable rules of discovery, all
642 documentation to that ~~will~~ be offered as evidence at an
643 administrative hearing on a Medicaid overpayment or an
644 administrative sanction must be exchanged by all parties at
645 least 14 days before the administrative hearing or ~~must~~ be
646 excluded from consideration.

647 (25) (a) The agency shall withhold Medicaid payments, in
648 whole or in part, to a provider upon receipt of reliable
649 evidence that the circumstances giving rise to the need for a
650 withholding of payments involve fraud, willful



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651 misrepresentation, or abuse under the Medicaid program, or a
652 crime committed while rendering goods or services to Medicaid
653 recipients. If it is determined that fraud, willful
654 misrepresentation, abuse, or a crime did not occur, the payments
655 withheld must be paid to the provider within 14 days after such
656 determination ~~with interest at the rate of 10 percent a year.~~
657 Amounts not paid within 14 days accrue interest at the rate of
658 10 percent a year, beginning after the 14th day Any money
659 ~~withheld in accordance with this paragraph shall be placed in a~~
660 ~~suspended account, readily accessible to the agency, so that any~~
661 ~~payment ultimately due the provider shall be made within 14~~
662 ~~days.~~

663 (b) The agency shall deny payment, or require repayment, if
664 the goods or services were furnished, supervised, or caused to
665 be furnished by a person who has been suspended or terminated
666 from the Medicaid program or Medicare program by the Federal
667 Government or any state.

668 (c) Overpayments owed to the agency bear interest at the
669 rate of 10 percent per year from the date of final determination
670 of the overpayment by the agency, and payment arrangements must
671 be made within 30 days after the date of the final order, which
672 is not subject to further appeal ~~at the conclusion of legal~~
673 ~~proceedings. A provider who does not enter into or adhere to an~~
674 ~~agreed-upon repayment schedule may be terminated by the agency~~
675 ~~for nonpayment or partial payment.~~

676 (d) The agency, upon entry of a final agency order, a
677 judgment or order of a court of competent jurisdiction, or a
678 stipulation or settlement, may collect the moneys owed by all
679 means allowable by law, including, but not limited to, notifying



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680 any fiscal intermediary of Medicare benefits that the state has
681 a superior right of payment. Upon receipt of such written
682 notification, the Medicare fiscal intermediary shall remit to
683 the state the sum claimed.

684 (e) The agency may institute amnesty programs to allow
685 Medicaid providers the opportunity to voluntarily repay
686 overpayments. The agency may adopt rules to administer such
687 programs.

688 (28) Venue for all Medicaid program integrity ~~overpayment~~
689 cases lies ~~shall lie~~ in Leon County, at the discretion of the
690 agency.

691 (30) The agency shall terminate a provider's participation
692 in the Medicaid program if the provider fails to reimburse an
693 overpayment or pay an agency-imposed fine that has been
694 determined by final order, not subject to further appeal, within
695 30 ~~35~~ days after the date of the final order, unless the
696 provider and the agency have entered into a repayment agreement.

697 (31) If a provider requests an administrative hearing
698 pursuant to chapter 120, such hearing must be conducted within
699 90 days following assignment of an administrative law judge,
700 absent exceptionally good cause shown as determined by the
701 administrative law judge or hearing officer. Upon issuance of a
702 final order, the outstanding balance of the amount determined to
703 constitute the overpayment and fines is ~~shall become~~ due. If a
704 provider fails to make payments in full, fails to enter into a
705 satisfactory repayment plan, or fails to comply with the terms
706 of a repayment plan or settlement agreement, the agency shall
707 withhold ~~medical assistance~~ reimbursement payments for Medicaid
708 services until the amount due is paid in full.



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709 Section 4. Subsection (8) of section 409.920, Florida
710 Statutes, is amended to read:

711 409.920 Medicaid provider fraud.—

712 (8) A person who provides the state, any state agency, any
713 of the state's political subdivisions, or any agency of the
714 state's political subdivisions with information about fraud or
715 suspected fraudulent acts ~~fraud~~ by a Medicaid provider,
716 including a managed care organization, is immune from civil
717 liability for libel, slander, or any other relevant tort for
718 providing ~~the~~ information about fraud or suspected fraudulent
719 acts unless the person acted with knowledge that the information
720 was false or with reckless disregard for the truth or falsity of
721 the information. Such immunity extends to reports of fraudulent
722 acts or suspected fraudulent acts conveyed to or from the agency
723 in any manner, including any forum and with any audience as
724 directed by the agency, and includes all discussions subsequent
725 to the report and subsequent inquiries from the agency, unless
726 the person acted with knowledge that the information was false
727 or with reckless disregard for the truth or falsity of the
728 information. As used in this subsection, the term "fraudulent
729 acts" includes actual or suspected fraud and abuse, insurance
730 fraud, licensure fraud, or public assistance fraud, including
731 any fraud-related matters that a provider or health plan is
732 required to report to the agency or a law enforcement agency.

733 Section 5. Subsection (3) of section 624.351, Florida
734 Statutes, is amended, and subsection (8) is added to that
735 section, to read:

736 624.351 Medicaid and Public Assistance Fraud Strike Force.—

737 (3) MEMBERSHIP.—The strike force shall consist of the



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738 following 11 members or their designees. A designee shall serve
739 in the same capacity as the designating member ~~who may not~~
740 ~~designate anyone to serve in their place:~~

741 (a) The Chief Financial Officer, who shall serve as chair.

742 (b) The Attorney General, who shall serve as vice chair.

743 (c) The executive director of the Department of Law
744 Enforcement.

745 (d) The Secretary of Health Care Administration.

746 (e) The Secretary of Children and Family Services.

747 (f) The State Surgeon General.

748 (g) Five members appointed by the Chief Financial Officer,
749 consisting of two sheriffs, two chiefs of police, and one state
750 attorney. When making these appointments, the Chief Financial
751 Officer shall consider representation by geography, population,
752 ethnicity, and other relevant factors in order to ensure that
753 the membership of the strike force is representative of the
754 state as a whole.

755 (8) EXPIRATION.—This section is repealed June 30, 2014.

756 Section 6. Subsection (3) is added to section 624.352,
757 Florida Statutes, to read:

758 624.352 Interagency agreements to detect and deter Medicaid
759 and public assistance fraud.—

760 (3) This section is repealed June 30, 2014.

761 Section 7. This act shall take effect July 1, 2013.

762
763 ===== T I T L E A M E N D M E N T =====

764 And the title is amended as follows:

765 Delete everything before the enacting clause
766 and insert:



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767 A bill to be entitled
768 An act relating to Medicaid; amending s. 409.907,
769 F.S.; increasing the number of years a provider must
770 keep records; adding an additional provision relating
771 to a change in principal that must be included in a
772 Medicaid provider agreement with the Agency for Health
773 Care Administration; adding the definitions of the
774 terms "administrative fines" and "outstanding
775 overpayment"; revising provisions relating to the
776 agency's onsite inspection responsibilities; revising
777 provisions relating to who is subject to background
778 screening; authorizing the agency to enroll a provider
779 who is licensed in this state and provides diagnostic
780 services through telecommunications technology;
781 amending s. 409.910, F.S.; revising provisions
782 relating to responsibility for Medicaid payments in
783 settlement proceedings; providing procedures for a
784 recipient to contest the amount payable to the agency;
785 amending s. 409.913, F.S.; increasing the number of
786 years a provider must keep records; revising
787 provisions specifying grounds for terminating a
788 provider from the program, for seeking certain
789 remedies for violations, and for imposing certain
790 sanctions; providing a limitation on the information
791 the agency may consider when making a determination of
792 overpayment; specifying the type of records a provider
793 must present to contest an overpayment; deleting the
794 requirement that the agency place payments withheld
795 from a provider in a suspended account and revising



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796 when a provider must reimburse overpayments; revising
797 venue requirements; adding provisions relating to the
798 payment of fines; amending s. 409.920, F.S.;
799 clarifying provisions relating to immunity from
800 liability for persons who provide information about
801 Medicaid fraud; amending s. 624.351, F.S.; providing
802 for the expiration of the Medicaid and Public
803 Assistance Fraud Strike Force; amending s. 624.352,
804 F.S.; providing for the expiration of provisions
805 relating to "Strike Force" agreements; providing an
806 effective date.

The Florida Senate
BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Appropriations Subcommittee on Health and Human Services

BILL: CS/SB 844

INTRODUCER: Health Policy Committee and Senator Grimsley

SUBJECT: Medicaid Fraud

DATE: April 15, 2013 **REVISED:** _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Stovall	HP	Fav/CS
2.	Johnson	Burgess	BI	Favorable
3.	Brown	Pigott	AHS	Pre-meeting
4.			AP	
5.				
6.				

Please see Section VIII. for Additional Information:

- | | | |
|------------------------------|-------------------------------------|---|
| A. COMMITTEE SUBSTITUTE..... | <input checked="" type="checkbox"/> | Statement of Substantial Changes |
| B. AMENDMENTS..... | <input type="checkbox"/> | Technical amendments were recommended |
| | <input type="checkbox"/> | Amendments were recommended |
| | <input type="checkbox"/> | Significant amendments were recommended |

I. Summary:

CS/SB 844 modifies existing statutory provisions relating to fraud and abuse, provider controls and accountability in the Medicaid program.

The bill is expected to have no fiscal impact. Potential increases in workload at the Agency for Health Care Administration (AHCA) under the bill can be absorbed within existing resources.

The bill:

- Increases the records retention time for all medical and Medicaid-related records from five to six years for Medicaid providers;
- Requires Medicaid providers to report a change in any principal of the provider to the AHCA in writing no later than 30 days after the change occurs;
- Defines “administrative fines” for purposes of liability for payment of such fines in the event of a change of ownership;
- Authorizes, rather than requires, the AHCA to perform onsite inspections of the service location of a provider applying for a provider agreement to determine that provider’s ability to provide services in compliance with Medicaid regulations;

- Provides a definition for principals of a provider with a controlling interest for hospitals and nursing homes, for purposes of conducting criminal background checks;
- Removes certain exceptions to background screenings requirements for Medicaid providers;
- Expands the list of offenses for which the AHCA may terminate the participation of a Medicaid provider;
- Requires the AHCA to impose the sanction of termination for cause against providers that voluntarily relinquish their Medicaid provider numbers under certain circumstances;
- Requires that when the AHCA determines that an overpayment has been made, the AHCA must base its determination solely on the information available before the issuance of an audit report and upon contemporaneous records;
- Clarifies when the interest rate accrues on provider payments paid by the AHCA that had been withheld on a suspicion of fraud or abuse, if it is determined that there was no fraud or abuse;
- Removes the 30-day provision related to records that may be presented to contest an overpayment or sanction;
- Requires overpayments or fines be paid to the AHCA within 30 days after the date of the final order; and,
- Clarifies the scope of immunity from civil liability for persons who report fraudulent acts or suspected fraudulent acts.

The bill has an effective date of July 1, 2013.

This bill substantially amends the following sections of the Florida Statutes: 409.907, 409.913, and 409.920.

II. Present Situation:

Health Care Fraud

In 2009, the Legislature passed CS/CS/CS/SB 1986 to comprehensively address systematic health care fraud in Florida. That bill increased the Medicaid program's authority to address fraud, particularly as it relates to home health services and health care facility and health care practitioner standards to keep fraudulent actors from obtaining a health care license in Florida. The bill also created disincentives to commit Medicaid fraud and created additional criminal felonies for committing health care fraud.

With more than three years of history with the implementation of CS/CS/CS/SB 1986, some changes have been identified that would enhance Florida's efforts to prevent health care fraud and abuse in the Medicaid program. This bill addresses some of the gaps in enforcement authority, strengthens the reporting requirements by Medicaid providers and Medicaid managed care organizations, and defines the consequences for failure to comply with the requirements.

Regulatory Authority of AHCA

The AHCA regulates hospitals and nursing homes under the authority of chapters 395 and 400, F.S., respectively, along with dozens of other health care entities such as clinical laboratories, ambulatory surgical centers, hospices, and home health agencies. General licensing provisions for these providers are found in part II of ch. 408, F.S. The Bureau for Health Facility Regulation conducts the activities that certify and license the entities under the AHCA's jurisdiction.

Medicaid

Medicaid is the medical assistance program that provides access to health care for low-income families and individuals. Medicaid also assists aged and disabled persons with costs of nursing facility care and other medical expenses. The AHCA is designated as the single state agency responsible for Medicaid. Medicaid serves approximately 3.3 million people in Florida. The statutory authority for the Medicaid program is contained in ch. 409, F.S.

Medicaid reimburses health care providers that have a provider agreement with the AHCA only for covered goods and services and only for individuals who are eligible for Medicaid assistance from Medicaid. Section 409.907, F.S., establishes requirements for Medicaid provider agreements, which include background screening requirements, notification requirements for change of ownership of a Medicaid provider, authority for AHCA site visits of provider service locations, and surety bond requirements.

Under s. 409.913, F.S., the AHCA is responsible for overseeing the integrity of the Medicaid program, to ensure that fraudulent and abusive behavior and neglect of recipients is minimized, and to recover overpayments and impose sanctions as appropriate.

Sections 409.920, 409.9201, 409.9203, and 409.9205, F.S., contain provisions relating specifically to Medicaid fraud. A person who provides the state with information about fraud or suspected fraud by a Medicaid provider, including a managed care organization, is immune from civil liability for providing that information unless the person knew the information was false or acted with reckless disregard for the truth or falsity of the information.¹

Part IV of ch. 409, F.S., requires all Medicaid recipients to enroll in a managed care plan unless they are specifically exempted. The Statewide Medicaid Managed Care (SMMC) program includes a long-term care managed care component and a managed medical assistance component. The law directs the AHCA to begin implementation of the long-term managed care program by July 1, 2012, with full implementation in all regions of the State by October 1, 2013. The state received federal approval of this component on February 1, 2013.² Although the

¹ See s. 409.920(8), F.S.

² Agency for Health Care Administration, *February 1, 2013 Waiver Approval Letter*, http://ahca.myflorida.com/medicaid/statewide_mc/pdf/Signed_approval_FL0962_new_1915c_02-01-2013.pdf (Last visited on March 4, 2013).

AHCA has received conditional approval,³ the AHCA is still awaiting final approval of the managed medical assistance program; full implementation is anticipated by October 1, 2014.

Background Screening

Chapter 435, F.S., establishes standards for background screening for employment. Section 435.03, F.S., sets standards for Level 1 background screening. Level 1 background screening includes, but is not limited to, employment history checks and statewide criminal correspondence checks through the Department of Law Enforcement and a check of the Dru Sjodin National Sex Offender Public Website, and may include local criminal records checks through local law enforcement agencies.

Level 2 background screenings includes, but is not limited to, fingerprinting for statewide criminal history records checks through the Department of Law Enforcement and national criminal history records checks through the Federal Bureau of Investigation. They may also include local criminal records checks through local law enforcement agencies. Section 435.04(2), F.S., lists the offenses that will disqualify an applicant from employment.

Section 408.809, F.S., establishes background screening requirements and procedures for entities licensed by the AHCA. The AHCA must conduct Level 2 background screening for specified individuals. Each person subject to this section is subject to Level 2 background screening every five years. This section of law also specifies additional disqualifying offenses beyond those included in s. 435.04(2), F.S.

III. Effect of Proposed Changes:

Section 1 amends s. 409.907, F.S., relating to Medicaid provider agreements, to require Medicaid providers to retain all medical and Medicaid-related records for six years, rather than the current statutory retention period of five years, consistent with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 administrative simplification regulations.⁴

The bill requires a Medicaid provider to report in writing any change of any principal of the provider whose ownership interest is equal to five percent or more to the AHCA no later than 30 days after the change occurs. The bill specifies who is included in the term “principal.” The definition of a controlling interest is already defined by statute under s. 408.803(7), F.S., and includes:

- The applicant or licensee;
- A person or entity that serves as an officer of, is on the board or has a five percent or greater ownership interest in the applicant or licensee; or

³ Agency for Health Care Administration, *February 20, 2013 Agreement in Principle Letter*, http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/Letter_from_CMS_re_Agreement_in_Principal_2013-02-20.pdf (Last visited on March 4, 2013).

⁴ See 45 CFR 164.316(b)(2). Found at: <<http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=be9877c2440a17a8ebe3b02b0948a06a&rgn=div8&view=text&node=45:1.0.1.3.79.3.27.8&idno=45>> (Last visited on March 1, 2013).

- A person or entity that serves as an officer of, is on the board, or has a five percent or greater management interest in the management company or other entity, related or unrelated, that the applicant or licensee contracts with to manage the provider.
- The term does not include a voluntary board member.

The bill clarifies the statutory provisions relating to the liability of Medicaid providers in a change of ownership for outstanding overpayments, administrative fines, and any other moneys owed to the AHCA. The bill defines “administrative fines” to include any amount identified in any notice of a monetary penalty or fine that has been issued by the AHCA or any other regulatory or licensing agency that governs the provider.

The requirement for the AHCA to conduct random onsite inspections of Medicaid providers’ service locations within 60 days after receipt of a fully complete new provider’s application and prior to making the first payment to the provider for Medicaid services, is amended to authorize, rather than require, the AHCA to perform onsite inspections. The inspection would be conducted prior to the AHCA entering into a Medicaid provider agreement with the provider and would be used to determine the applicant’s ability to provide services in compliance with the Medicaid program and professional regulations. The law currently only requires the AHCA to determine the applicant’s ability to provide the services for which they will seek Medicaid payment.

The bill also removes an exception to the current onsite-inspection requirement for a provider or program that is licensed by the AHCA, that provides services under waiver programs for home and community-based services, or that is licensed as a medical foster home by the Department of Children and Families, since the selection of providers for onsite inspections is no longer a random selection, but is left up to the discretion of the AHCA under the bill.

The bill amends existing surety bond requirements for certain Medicaid providers. The bill clarifies that the additional bond required by the AHCA, if a provider’s billing during the first year exceeds the bond amount, need not exceed \$50,000 for certain providers. A provider could have a bond greater than \$50,000, if the provider so elects.

The bill amends the requirements for a criminal history record check of each Medicaid provider, or each principal of the provider, to remove an exemption from such checks for hospitals, nursing homes, hospices, and assisted living facilities. The bill specifies that for hospitals and nursing homes, the principals of the provider are those who meet the definition of a controlling interest in s. 408.803, F.S., under the general licensing provisions for health care facilities regulated by the AHCA.

The bill removes the provision that proof of compliance with Level 2 background screening under ch. 435, F.S., conducted within 12 months before the date the Medicaid provider application is submitted to the AHCA, satisfies the requirements for a criminal history background check. This conforms to screening provisions in ch. 435, F.S., and ch. 408, F.S.

Section 2 amends s. 409.913, F.S., relating to oversight of the integrity of the Medicaid program. The bill amends the length of time that Medicaid providers are required to retain their records to be consistent with federal law. Medicaid providers are required to retain medical, professional, financial, and business records pertaining to services and goods furnished to a Medicaid recipient

and billed to Medicaid for six years, rather than the current statutory retention period of five years.

The bill deletes a requirement that the AHCA *immediately* terminate participation of a Medicaid provider that has been convicted of certain offenses. In order to terminate a provider immediately, the AHCA must show an immediate harm to the public health, which is not always possible. The AHCA still must terminate a Medicaid provider from participation in the Medicaid program, unless the AHCA determines that the provider did not participate or acquiesce in the offense. The change will resolve a current conflict with the Administrative Procedure Act.⁵

The AHCA may seek civil remedies or impose administrative sanctions if a provider *has been convicted* of any of the following offenses:

- A criminal offense under federal law or the law of any state relating to the practice of the provider's profession;
- An offense listed in s. 409.907(10), F.S., relating to factors the AHCA may consider when reviewing an application for a Medicaid provider agreement, which includes:
 - Making a false representation or omission of any material fact in making an application for a provider agreement;
 - Exclusion, suspension, termination, or involuntary withdrawal from participation in any Medicaid program or other governmental or private health care or health insurance program;
 - Being convicted of a criminal offense relating to the delivery of any goods or services under Medicaid or Medicare or any other public or private health care or health insurance program including the performance of management or administrative services relating to the delivery of goods or services under any such program;
 - Being convicted of a criminal offense under federal or state law related to the neglect or abuse of a patient in connection with the delivery of any health care goods or services;
 - Being convicted of a criminal offense under federal or state law related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance;
 - Being convicted of any criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct;
 - Being convicted of a criminal offense under federal or state law punishable by imprisonment of one year or more which involves moral turpitude;
 - Being convicted in connection with the interference or obstruction of any investigation into any criminal offense listed above;
 - Violation of federal or state laws, rules, or regulations governing any Medicaid program, the Medicare program, or any other publicly funded federal or state health care or health insurance program, if they have been sanctioned accordingly;
 - Violation of the standards or conditions relating to professional licensure or certification or the quality of services provided; or
 - Failure to pay fines and overpayments under the Medicaid program;

⁵ See s. 120.569(2)(n), F.S. which requires that "if any agency head finds that an immediate danger to the public health, safety, or welfare requires an immediate final order, it shall recite with particularity the facts underlying such finding in the final order, which shall be appealable or enjoined from the date ordered."

- An offense listed in s. 408.809(4), F.S., relating to background screening of licensees, which includes the following offenses or any similar offense of another jurisdiction:
 - Any authorizing statutes, if the offense was a felony;
 - Chapter 408, F.S., if the offense was a felony;
 - Section 409.920, F.S., relating to Medicaid provider fraud;
 - Section 409.9201, F.S., relating to Medicaid fraud;
 - Section 741.28, F.S., relating to domestic violence;
 - Section 817.034, F.S., relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems;
 - Section 817.234, F.S., relating to false and fraudulent insurance claims;
 - Section 817.505, F.S., relating to patient brokering;
 - Section 817.568, F.S., relating to criminal use of personal identification information;
 - Section 817.60, F.S., relating to obtaining a credit card through fraudulent means;
 - Section 817.61, F.S., relating to fraudulent use of credit cards, if the offense was a felony;
 - Section 831.01, F.S., relating to forgery;
 - Section 831.02, F.S., relating to uttering forged instruments;
 - Section 831.07, F.S., relating to forging bank bills, checks, drafts, or promissory notes;
 - Section 831.09, F.S., relating to uttering forged bank bills, checks, drafts, or promissory notes;
 - Section 831.30, F.S., relating to fraud in obtaining medicinal drugs; or
 - Section 831.31, F.S., relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony;
- An offense listed in s. 435.04(2), F.S., relating to employee background screening, which includes the following offenses or any similar offense of another jurisdiction:
 - Section 393.135, F.S., relating to sexual misconduct with certain developmentally disabled clients and reporting of such sexual misconduct;
 - Section 394.4593, F.S., relating to sexual misconduct with certain mental health patients and reporting of such sexual misconduct;
 - Section 415.111, F.S., relating to adult abuse, neglect, or exploitation of aged persons or disabled adults;
 - Section 782.04, F.S., relating to murder;
 - Section 782.07, F.S., relating to manslaughter, aggravated manslaughter of an elderly person or disabled adult, or aggravated manslaughter of a child;
 - Section 782.071, F.S., relating to vehicular homicide;
 - Section 782.09, F.S., relating to killing of an unborn quick child by injury to the mother;
 - Chapter 784, F.S., relating to assault, battery, and culpable negligence, if the offense was a felony;
 - Section 784.011, F.S., relating to assault, if the victim of the offense was a minor;
 - Section 784.03, F.S., relating to battery, if the victim of the offense was a minor;
 - Section 787.01, F.S., relating to kidnapping;
 - Section 787.02, F.S., relating to false imprisonment;
 - Section 787.025, F.S., relating to luring or enticing a child;
 - Section 787.04(2), F.S., relating to taking, enticing, or removing a child beyond the state limits with criminal intent pending custody proceedings;

- Section 787.04(3), F.S., relating to carrying a child beyond the state lines with criminal intent to avoid producing a child at a custody hearing or delivering the child to the designated person;
- Section 790.115(1), F.S., relating to exhibiting firearms or weapons within 1,000 feet of a school;
- Section 790.115(2)(b), F.S., relating to possessing an electric weapon or device, destructive device, or other weapon on school property;
- Section 794.011, F.S., relating to sexual battery;
- Former s. 794.041, F.S., relating to prohibited acts of persons in familial or custodial authority;
- Section 794.05, F.S., relating to unlawful sexual activity with certain minors;
- Chapter 796, F.S., relating to prostitution;
- Section 798.02, F.S., relating to lewd and lascivious behavior;
- Chapter 800, F.S., relating to lewdness and indecent exposure;
- Section 806.01, F.S., relating to arson;
- Section 810.02, F.S., relating to burglary;
- Section 810.14, F.S., relating to voyeurism, if the offense is a felony;
- Section 810.145, F.S., relating to video voyeurism, if the offense is a felony;
- Chapter 812, F.S., relating to theft, robbery, and related crimes, if the offense is a felony;
- Section 817.563, F.S., relating to fraudulent sale of controlled substances, only if the offense was a felony;
- Section 825.102, F.S., relating to abuse, aggravated abuse, or neglect of an elderly person or disabled adult;
- Section 825.1025, F.S., relating to lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled adult;
- Section 825.103, F.S., relating to exploitation of an elderly person or disabled adult, if the offense was a felony;
- Section 826.04, F.S., relating to incest;
- Section 827.03, F.S., relating to child abuse, aggravated child abuse, or neglect of a child;
- Section 827.04, F.S., relating to contributing to the delinquency or dependency of a child;
- Former s. 827.05, F.S., relating to negligent treatment of children;
- Section 827.071, F.S., relating to sexual performance by a child;
- Section 843.01, F.S., relating to resisting arrest with violence;
- Section 843.025, F.S., relating to depriving a law enforcement, correctional, or correctional probation officer means of protection or communication;
- Section 843.12, F.S., relating to aiding in an escape;
- Section 843.13, F.S., relating to aiding in the escape of juvenile inmates in correctional institutions;
- Chapter 847, F.S., relating to obscene literature;
- Section 874.05(1), F.S., relating to encouraging or recruiting another to join a criminal gang;
- Chapter 893, F.S., relating to drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a minor;
- Section 916.1075, F.S., relating to sexual misconduct with certain forensic clients and reporting of such sexual misconduct;
- Section 944.35(3), F.S., relating to inflicting cruel or inhuman treatment on an inmate resulting in great bodily harm;

- Section 944.40, F.S., relating to escape;
- Section 944.46, F.S., relating to harboring, concealing, or aiding an escaped prisoner;
- Section 944.47, F.S., relating to introduction of contraband into a correctional facility;
- Section 985.701, F.S., relating to sexual misconduct in juvenile justice programs; or
- Section 985.711, F.S., relating to contraband introduced into detention facilities.

The bill amends provisions relating to noncriminal actions of Medicaid providers for which the AHCA may impose sanctions, to include the act of *authorizing* certain services that are inappropriate, unnecessary, excessive, or harmful to the recipient or are of inferior quality, or *authorizing* certain requests and reports that contain materially false or incorrect information. The bill also authorizes the AHCA to sanction a provider if the provider is charged by information or indictment with any offense listed above. The AHCA may impose sanctions if the provider or certain persons affiliated with the provider participated or acquiesced in the proscribed activity.

The bill provides that if a Medicaid provider voluntarily relinquishes its Medicaid provider number after receiving notice of an audit or investigation for which the sanction of suspension or termination will be imposed, the AHCA must impose the sanction of termination for cause against the provider. Under current law, if a Medicaid provider receives notification that it is going to be suspended or terminated, the provider is able to voluntarily terminate its contract. By doing so, a provider has the ability to avoid sanctions of suspension or termination, which would affect the ability of the provider to reenter the program in the future. Current law gives the secretary of the AHCA authority to make a determination that imposition of a sanction is not in the best interest of the Medicaid program, in which case a sanction may not be imposed.

The bill specifies that when the AHCA is making a determination that an overpayment has occurred, the determination must be based solely upon information available before it issues the audit report and, in the case of documentation obtained to substantiate claims for Medicaid reimbursement, based solely upon contemporaneous records.

In addition, the bill provides that a provider may not present records to contest an overpayment or sanction unless the records are contemporaneous and, if requested during the audit process, were provided to the AHCA or its agent. Also, all documentation to be offered as evidence in an administrative hearing on an administrative sanction (in addition to Medicaid overpayments) must be exchanged by all parties at least 14 days before the administrative hearing or excluded from consideration.

The bill clarifies when interest will accrue on provider payments withheld by the AHCA based on suspected fraud or criminal activity, if it is determined later that there was no fraud or that a crime did not occur. Interest on provider payments to be paid after an investigation will accrue at 10 percent a year, beginning after the 14th day after the determination. A provision relating to the placement of funds in a suspended account held by the AHCA is deleted and a payment deadline of 14 days to the provider is removed. Payment arrangements for overpayments and fines owed to the AHCA must be made within 30 days after the date of the final order and are not subject to further appeal.

The bill requires the AHCA to terminate a provider's participation in the Medicaid program if the provider fails to pay a fine within 30 days after the date of the final order imposing the fine. The time within which a provider must reimburse an overpayment is reduced from 35 to 30 days after the date of the final order. The bill requires that fines, as well as overpayments, are due upon the issuance of a final order at the conclusion of a requested administrative hearing.

Section 3 amends s. 409.920, F.S., relating to Medicaid provider fraud, to clarify that the existing immunity from civil liability extended to persons who provide information about fraud or suspected fraudulent acts pertains to civil liability for libel, slander, or any other relevant tort. The bill defines "fraudulent acts" for purposes of immunity from civil liability to include actual or suspected fraud and abuse, insurance fraud, licensure fraud, or public insurance fraud; including any fraud-related matters that a provider or health plan is required to report to the AHCA or a law enforcement agency. The immunity from civil liability extends to reports conveyed to the AHCA in any manner, including forums, and incorporates all discussions subsequent to the report and subsequent inquiries from the AHCA, unless the person reporting acted with knowledge that the information was false or with reckless disregard for the truth or falsity of the information.

Section 4 provides an effective date of July 1, 2013.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Entities and individual health care providers under Medicaid currently exempt from background checks will be required to complete the same requirements as other Medicaid providers.

The total fee for a Level 2 background screening is \$64.50 (\$24.00 for the state portion, \$16.50 for the national portion, and \$24.00 for retention). There is an additional fee of

\$11-to-\$16 for electronic screening, depending on the provider. The cost of the screening is borne by the individual provider.⁶

C. **Government Sector Impact:**

The AHCA reports no fiscal impact. Medicaid contract management believes the bill may result in an increase in initial screenings of registered treating providers performed by AHCA staff, but any potential increase in workload under the bill can be absorbed within existing resources.⁷

To the extent that a governmental entity has providers or is a provider that are not currently required to provide a completed background checks prior to Medicaid provider enrollment and not otherwise exempt, additional costs may be incurred to comply with this requirement.

VI. **Technical Deficiencies:**

None.

VII. **Related Issues:**

None.

VIII. **Additional Information:**

A. **Committee Substitute – Statement of Substantial Changes:**

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Health Policy on March 7, 2013

CS/SB 844 deletes a separate requirement for Level 2 background checks of providers under contract with Medicaid managed care networks. All Medicaid providers participating under fee for service must still comply with this requirement. The CS removed a provision relating to the coordination of anti-fraud report reviews between the Department of Financial Services and the AHCA. The CS does not include the provision allowing the AHCA to consider information from non-Medicaid providers during an investigation. The CS also removed the 30-day provision related to records that may be presented to contest an overpayment or sanction. Interest payments to the providers that had been withheld are reinstated and the timeframe for when interest is applied is clarified.

B. **Amendments:**

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

⁶ Agency for Health Care Administration, *supra*, note 1 at 6.

⁷ Agency for Health Care Administration, *supra*, note 1 at 5.

By the Committee on Health Policy; and Senator Grimsley

588-02020-13

2013844c1

1 A bill to be entitled
 2 An act relating to Medicaid fraud; amending s.
 3 409.907, F.S.; increasing the number of years a
 4 provider must keep records; adding an additional
 5 provision relating to a change in principal that must
 6 be included in a Medicaid provider agreement with the
 7 Agency for Health Care Administration; adding
 8 definitions for "administrative fines" and
 9 "outstanding overpayment"; revising provisions
 10 relating to the agency's onsite inspection
 11 responsibilities; revising provisions relating to who
 12 is subject to background screening; amending s.
 13 409.913, F.S.; increasing the number of years a
 14 provider must keep records; revising provisions
 15 specifying grounds for terminating a provider from the
 16 program, for seeking certain remedies for violations,
 17 and for imposing certain sanctions; providing a
 18 limitation on the information the agency may consider
 19 when making a determination of overpayment; specifying
 20 the type of records a provider must present to contest
 21 an overpayment; deleting the requirement that the
 22 agency place payments withheld from a provider in a
 23 suspended account and revising when a provider must
 24 reimburse overpayments; revising venue requirements;
 25 adding provisions relating to the payment of fines;
 26 amending s. 409.920, F.S.; clarifying provisions
 27 relating to immunity from liability for persons who
 28 provide information about Medicaid fraud; providing an
 29 effective date.

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

588-02020-13

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30
 31 Be It Enacted by the Legislature of the State of Florida:
 32
 33 Section 1. Paragraph (c) of subsection (3) of section
 34 409.907, Florida Statutes, is amended and paragraph (k) is added
 35 to that subsection, and subsections (6), (7), and (8) of that
 36 section are amended to read:
 37 409.907 Medicaid provider agreements.—The agency may make
 38 payments for medical assistance and related services rendered to
 39 Medicaid recipients only to an individual or entity who has a
 40 provider agreement in effect with the agency, who is performing
 41 services or supplying goods in accordance with federal, state,
 42 and local law, and who agrees that no person shall, on the
 43 grounds of handicap, race, color, or national origin, or for any
 44 other reason, be subjected to discrimination under any program
 45 or activity for which the provider receives payment from the
 46 agency.
 47 (3) The provider agreement developed by the agency, in
 48 addition to the requirements specified in subsections (1) and
 49 (2), shall require the provider to:
 50 (c) Retain all medical and Medicaid-related records for 6 ~~a~~
 51 ~~period of 5~~ years to satisfy all necessary inquiries by the
 52 agency.
 53 (k) Report a change in any principal of the provider,
 54 including any officer, director, agent, managing employee, or
 55 affiliated person, or any partner or shareholder who has an
 56 ownership interest equal to 5 percent or more in the provider,
 57 to the agency in writing within 30 days after the change occurs.
 58 For a hospital licensed under chapter 395 or a nursing home

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59 licensed under part II of chapter 400, a principal of the
 60 provider is one who meets the definition of a controlling
 61 interest under s. 408.803.

62 (6) A Medicaid provider agreement may be revoked, at the
 63 option of the agency, ~~due to as the result of~~ a change of
 64 ownership of any facility, association, partnership, or other
 65 entity named as the provider in the provider agreement.

66 (a) If there is ~~In the event of~~ a change of ownership, the
 67 transferor remains liable for all outstanding overpayments,
 68 administrative fines, and any other moneys owed to the agency
 69 before the effective date of the change ~~of ownership. In~~
 70 ~~addition to the continuing liability of the transferor,~~ The
 71 transferee is also liable to the agency for all outstanding
 72 overpayments identified by the agency on or before the effective
 73 date of the change of ownership. ~~For purposes of this~~
 74 ~~subsection, the term "outstanding overpayment" includes any~~
 75 ~~amount identified in a preliminary audit report issued to the~~
 76 ~~transferor by the agency on or before the effective date of the~~
 77 ~~change of ownership.~~ In the event of a change of ownership for a
 78 skilled nursing facility or intermediate care facility, the
 79 Medicaid provider agreement shall be assigned to the transferee
 80 if the transferee meets all other Medicaid provider
 81 qualifications. In the event of a change of ownership involving
 82 a skilled nursing facility licensed under part II of chapter
 83 400, liability for all outstanding overpayments, administrative
 84 fines, and any moneys owed to the agency before the effective
 85 date of the change of ownership shall be determined in
 86 accordance with s. 400.179.

87 (b) At least 60 days before the anticipated date of the

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

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2013844c1

88 change of ownership, the transferor must ~~shall~~ notify the agency
 89 of the intended change ~~of ownership~~ and the transferee must
 90 ~~shall~~ submit to the agency a Medicaid provider enrollment
 91 application. If a change of ownership occurs without compliance
 92 with the notice requirements of this subsection, the transferor
 93 and transferee are ~~shall be~~ jointly and severally liable for all
 94 overpayments, administrative fines, and other moneys due to the
 95 agency, regardless of whether the agency identified the
 96 overpayments, administrative fines, or other moneys before or
 97 after the effective date of the change ~~of ownership~~. The agency
 98 may not approve a transferee's Medicaid provider enrollment
 99 application if the transferee or transferor has not paid or
 100 agreed in writing to a payment plan for all outstanding
 101 overpayments, administrative fines, and other moneys due to the
 102 agency. This subsection does not preclude the agency from
 103 seeking any other legal or equitable remedies available to the
 104 agency for the recovery of moneys owed to the Medicaid program.
 105 In the event of a change of ownership involving a skilled
 106 nursing facility licensed under part II of chapter 400,
 107 liability for all outstanding overpayments, administrative
 108 fines, and any moneys owed to the agency before the effective
 109 date of the change of ownership shall be determined in
 110 accordance with s. 400.179 if the Medicaid provider enrollment
 111 application for change of ownership is submitted before the
 112 change ~~of ownership~~.

113 (c) As used in this subsection, the term:

114 1. "Administrative fines" includes any amount identified in
 115 a notice of a monetary penalty or fine which has been issued by
 116 the agency or other regulatory or licensing agency that governs

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117 the provider.

118 2. "Outstanding overpayment" includes any amount identified
 119 in a preliminary audit report issued to the transferor by the
 120 agency on or before the effective date of a change of ownership.

121 ~~(7) The agency may require,~~ As a condition of participating
 122 in the Medicaid program and before entering into the provider
 123 agreement, the agency may require ~~that~~ the provider to submit
 124 information, in an initial and any required renewal
 125 applications, concerning the professional, business, and
 126 personal background of the provider and permit an onsite
 127 inspection of the provider's service location by agency staff or
 128 other personnel designated by the agency to perform this
 129 function. Before entering into a provider agreement, the agency
 130 may shall perform an a random onsite inspection, within 60 days
 131 after receipt of a fully complete new provider's application, of
 132 the provider's service location prior to making its first
 133 payment to the provider for Medicaid services to determine the
 134 applicant's ability to provide the services in compliance with
 135 the Medicaid program and professional regulations ~~that the~~
 136 ~~applicant is proposing to provide for Medicaid reimbursement.~~
 137 ~~The agency is not required to perform an onsite inspection of a~~
 138 ~~provider or program that is licensed by the agency, that~~
 139 ~~provides services under waiver programs for home and community-~~
 140 ~~based services, or that is licensed as a medical foster home by~~
 141 ~~the Department of Children and Family Services.~~ As a continuing
 142 condition of participation in the Medicaid program, a provider
 143 must shall immediately notify the agency of any current or
 144 pending bankruptcy filing. Before entering into the provider
 145 agreement, or as a condition of continuing participation in the

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146 Medicaid program, the agency may also require that Medicaid
 147 providers reimbursed on a fee-for-services basis or fee schedule
 148 basis ~~that which~~ is not cost-based, post a surety bond not to
 149 exceed \$50,000 or the total amount billed by the provider to the
 150 program during the current or most recent calendar year,
 151 whichever is greater. For new providers, the amount of the
 152 surety bond shall be determined by the agency based on the
 153 provider's estimate of its first year's billing. If the
 154 provider's billing during the first year exceeds the bond
 155 amount, the agency may require the provider to acquire an
 156 additional bond equal to the actual billing level of the
 157 provider. A provider's bond need shall not exceed \$50,000 if a
 158 physician or group of physicians licensed under chapter 458,
 159 chapter 459, or chapter 460 has a 50 percent or greater
 160 ownership interest in the provider or if the provider is an
 161 assisted living facility licensed under chapter 429. The bonds
 162 permitted by this section are in addition to the bonds
 163 referenced in s. 400.179(2)(d). If the provider is a
 164 corporation, partnership, association, or other entity, the
 165 agency may require the provider to submit information concerning
 166 the background of that entity and of any principal of the
 167 entity, including any partner or shareholder having an ownership
 168 interest in the entity equal to 5 percent or greater, and any
 169 treating provider who participates in or intends to participate
 170 in Medicaid through the entity. The information must include:
 171 (a) Proof of holding a valid license or operating
 172 certificate, as applicable, if required by the state or local
 173 jurisdiction in which the provider is located or if required by
 174 the Federal Government.

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175 (b) Information concerning any prior violation, fine,
 176 suspension, termination, or other administrative action taken
 177 under the Medicaid laws ~~or, rules, or regulations~~ of this state
 178 or of any other state or the Federal Government; any prior
 179 violation of the laws ~~or, rules, or regulations~~ relating to the
 180 Medicare program; any prior violation of the rules ~~or~~
 181 ~~regulations~~ of any other public or private insurer; and any
 182 prior violation of the laws ~~or, rules, or regulations~~ of any
 183 regulatory body of this or any other state.

184 (c) Full and accurate disclosure of any financial or
 185 ownership interest that the provider, or any principal, partner,
 186 or major shareholder thereof, may hold in any other Medicaid
 187 provider or health care related entity or any other entity that
 188 is licensed by the state to provide health or residential care
 189 and treatment to persons.

190 (d) If a group provider, identification of all members of
 191 the group and attestation that all members of the group are
 192 enrolled in or have applied to enroll in the Medicaid program.

193 (8) ~~(a)~~ Each provider, or each principal of the provider if
 194 the provider is a corporation, partnership, association, or
 195 other entity, seeking to participate in the Medicaid program
 196 must submit a complete set of his or her fingerprints to the
 197 agency for the purpose of conducting a criminal history record
 198 check. Principals of the provider include any officer, director,
 199 billing agent, managing employee, or affiliated person, or any
 200 partner or shareholder who has an ownership interest equal to 5
 201 percent or more in the provider. However, for a hospital
 202 licensed under chapter 395 or a nursing home licensed under
 203 chapter 400, principals of the provider are those who meet the

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204 definition of a controlling interest under s. 408.803. A
 205 director of a not-for-profit corporation or organization is not
 206 a principal for purposes of a background investigation ~~as~~
 207 required by this section if the director: serves solely in a
 208 voluntary capacity for the corporation or organization, does not
 209 regularly take part in the day-to-day operational decisions of
 210 the corporation or organization, receives no remuneration from
 211 the not-for-profit corporation or organization for his or her
 212 service on the board of directors, has no financial interest in
 213 the not-for-profit corporation or organization, and has no
 214 family members with a financial interest in the not-for-profit
 215 corporation or organization; and if the director submits an
 216 affidavit, under penalty of perjury, to this effect to the
 217 agency and the not-for-profit corporation or organization
 218 submits an affidavit, under penalty of perjury, to this effect
 219 to the agency as part of the corporation's or organization's
 220 Medicaid provider agreement application. Notwithstanding the
 221 above, the agency may require a background check for any person
 222 reasonably suspected by the agency to have been convicted of a
 223 crime.

224 (a) This subsection does not apply to:
 225 ~~1. A hospital licensed under chapter 395,~~
 226 ~~2. A nursing home licensed under chapter 400,~~
 227 ~~3. A hospice licensed under chapter 400,~~
 228 ~~4. An assisted living facility licensed under chapter 429,~~
 229 1.5. A unit of local government, except that requirements
 230 of this subsection apply to nongovernmental providers and
 231 entities contracting with the local government to provide
 232 Medicaid services. The actual cost of the state and national

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233 criminal history record checks must be borne by the
234 nongovernmental provider or entity; or

235 ~~2.6.~~ Any business that derives more than 50 percent of its
236 revenue from the sale of goods to the final consumer, and the
237 business or its controlling parent is required to file a form
238 10-K or other similar statement with the Securities and Exchange
239 Commission or has a net worth of \$50 million or more.

240 (b) Background screening shall be conducted in accordance
241 with chapter 435 and s. 408.809. The cost of the state and
242 national criminal record check shall be borne by the provider.

243 ~~(c) Proof of compliance with the requirements of level 2
244 screening under chapter 435 conducted within 12 months before
245 the date the Medicaid provider application is submitted to the
246 agency fulfills the requirements of this subsection.~~

247 Section 2. Subsections (9), (13), (15), (16), (21), (22),
248 (25), (28), (30) and (31) of section 409.913, Florida Statutes,
249 are amended to read:

250 409.913 Oversight of the integrity of the Medicaid
251 program.—The agency shall operate a program to oversee the
252 activities of Florida Medicaid recipients, and providers and
253 their representatives, to ensure that fraudulent and abusive
254 behavior and neglect of recipients occur to the minimum extent
255 possible, and to recover overpayments and impose sanctions as
256 appropriate. Beginning January 1, 2003, and each year
257 thereafter, the agency and the Medicaid Fraud Control Unit of
258 the Department of Legal Affairs shall submit a joint report to
259 the Legislature documenting the effectiveness of the state's
260 efforts to control Medicaid fraud and abuse and to recover
261 Medicaid overpayments during the previous fiscal year. The

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262 report must describe the number of cases opened and investigated
263 each year; the sources of the cases opened; the disposition of
264 the cases closed each year; the amount of overpayments alleged
265 in preliminary and final audit letters; the number and amount of
266 fines or penalties imposed; any reductions in overpayment
267 amounts negotiated in settlement agreements or by other means;
268 the amount of final agency determinations of overpayments; the
269 amount deducted from federal claiming as a result of
270 overpayments; the amount of overpayments recovered each year;
271 the amount of cost of investigation recovered each year; the
272 average length of time to collect from the time the case was
273 opened until the overpayment is paid in full; the amount
274 determined as uncollectible and the portion of the uncollectible
275 amount subsequently reclaimed from the Federal Government; the
276 number of providers, by type, that are terminated from
277 participation in the Medicaid program as a result of fraud and
278 abuse; and all costs associated with discovering and prosecuting
279 cases of Medicaid overpayments and making recoveries in such
280 cases. The report must also document actions taken to prevent
281 overpayments and the number of providers prevented from
282 enrolling in or reenrolling in the Medicaid program as a result
283 of documented Medicaid fraud and abuse and must include policy
284 recommendations necessary to prevent or recover overpayments and
285 changes necessary to prevent and detect Medicaid fraud. All
286 policy recommendations in the report must include a detailed
287 fiscal analysis, including, but not limited to, implementation
288 costs, estimated savings to the Medicaid program, and the return
289 on investment. The agency must submit the policy recommendations
290 and fiscal analyses in the report to the appropriate estimating

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291 conference, pursuant to s. 216.137, by February 15 of each year.
 292 The agency and the Medicaid Fraud Control Unit of the Department
 293 of Legal Affairs each must include detailed unit-specific
 294 performance standards, benchmarks, and metrics in the report,
 295 including projected cost savings to the state Medicaid program
 296 during the following fiscal year.

297 (9) A Medicaid provider shall retain medical, professional,
 298 financial, and business records pertaining to services and goods
 299 furnished to a Medicaid recipient and billed to Medicaid for 6 ~~a~~
 300 ~~period of 5 years~~ after the date of furnishing such services or
 301 goods. The agency may investigate, review, or analyze such
 302 records, which must be made available during normal business
 303 hours. However, 24-hour notice must be provided if patient
 304 treatment would be disrupted. The provider must keep ~~is~~
 305 ~~responsible for furnishing to the agency, and keeping~~ the agency
 306 informed of the location of, the provider's Medicaid-related
 307 records. The authority of the agency to obtain Medicaid-related
 308 records from a provider is neither curtailed nor limited during
 309 a period of litigation between the agency and the provider.

310 (13) The agency shall ~~immediately~~ terminate participation
 311 of a Medicaid provider in the Medicaid program and may seek
 312 civil remedies or impose other administrative sanctions against
 313 a Medicaid provider, if the provider or any principal, officer,
 314 director, agent, managing employee, or affiliated person of the
 315 provider, or any partner or shareholder having an ownership
 316 interest in the provider equal to 5 percent or greater, has been
 317 convicted of a criminal offense under federal law or the law of
 318 any state relating to the practice of the provider's profession,
 319 or a criminal offense listed under s. 409.907(10), s.

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320 408.809(4), or s. 435.04(2) has been:

321 ~~(a) Convicted of a criminal offense related to the delivery~~
 322 ~~of any health care goods or services, including the performance~~
 323 ~~of management or administrative functions relating to the~~
 324 ~~delivery of health care goods or services;~~

325 ~~(b) Convicted of a criminal offense under federal law or~~
 326 ~~the law of any state relating to the practice of the provider's~~
 327 ~~profession; or~~

328 ~~(c) Found by a court of competent jurisdiction to have~~
 329 ~~neglected or physically abused a patient in connection with the~~
 330 ~~delivery of health care goods or services. If the agency~~
 331 ~~determines that the~~ ~~a~~ provider did not participate or acquiesce
 332 in the ~~an~~ offense ~~specified in paragraph (a), paragraph (b), or~~
 333 ~~paragraph (c),~~ termination will not be imposed. If the agency
 334 effects a termination under this subsection, the agency shall
 335 take final agency action ~~issue an immediate final order pursuant~~
 336 ~~to s. 120.569(2)(a).~~

337 (15) The agency shall seek a remedy provided by law,
 338 including, but not limited to, any remedy provided in
 339 subsections (13) and (16) and s. 812.035, if:

340 (a) The provider's license has not been renewed, or has
 341 been revoked, suspended, or terminated, for cause, by the
 342 licensing agency of any state;

343 (b) The provider has failed to make available or has
 344 refused access to Medicaid-related records to an auditor,
 345 investigator, or other authorized employee or agent of the
 346 agency, the Attorney General, a state attorney, or the Federal
 347 Government;

348 (c) The provider has not furnished or has failed to make

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349 available such Medicaid-related records as the agency has found
 350 necessary to determine whether Medicaid payments are or were due
 351 and the amounts thereof;

352 (d) The provider has failed to maintain medical records
 353 made at the time of service, or prior to service if prior
 354 authorization is required, demonstrating the necessity and
 355 appropriateness of the goods or services rendered;

356 (e) The provider is not in compliance with provisions of
 357 Medicaid provider publications that have been adopted by
 358 reference as rules in the Florida Administrative Code; with
 359 provisions of state or federal laws, rules, or regulations; with
 360 provisions of the provider agreement between the agency and the
 361 provider; or with certifications found on claim forms or on
 362 transmittal forms for electronically submitted claims that are
 363 submitted by the provider or authorized representative, as such
 364 provisions apply to the Medicaid program;

365 (f) The provider or person who ordered, authorized, or
 366 prescribed the care, services, or supplies has furnished, or
 367 ordered or authorized the furnishing of, goods or services to a
 368 recipient which are inappropriate, unnecessary, excessive, or
 369 harmful to the recipient or are of inferior quality;

370 (g) The provider has demonstrated a pattern of failure to
 371 provide goods or services that are medically necessary;

372 (h) The provider or an authorized representative of the
 373 provider, or a person who ordered, authorized, or prescribed the
 374 goods or services, has submitted or caused to be submitted false
 375 or a pattern of erroneous Medicaid claims;

376 (i) The provider or an authorized representative of the
 377 provider, or a person who has ordered, authorized, or prescribed

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378 the goods or services, has submitted or caused to be submitted a
 379 Medicaid provider enrollment application, a request for prior
 380 authorization for Medicaid services, a drug exception request,
 381 or a Medicaid cost report that contains materially false or
 382 incorrect information;

383 (j) The provider or an authorized representative of the
 384 provider has collected from or billed a recipient or a
 385 recipient's responsible party improperly for amounts that should
 386 not have been so collected or billed by reason of the provider's
 387 billing the Medicaid program for the same service;

388 (k) The provider or an authorized representative of the
 389 provider has included in a cost report costs that are not
 390 allowable under a Florida Title XIX reimbursement plan, after
 391 the provider or authorized representative had been advised in an
 392 audit exit conference or audit report that the costs were not
 393 allowable;

394 (l) The provider is charged by information or indictment
 395 with fraudulent billing practices or an offense referenced in
 396 subsection (13). The sanction applied for this reason is limited
 397 to suspension of the provider's participation in the Medicaid
 398 program for the duration of the indictment unless the provider
 399 is found guilty pursuant to the information or indictment;

400 (m) The provider or a person who ~~has~~ ordered, authorized,
 401 or prescribed the goods or services is found liable for
 402 negligent practice resulting in death or injury to the
 403 provider's patient;

404 (n) The provider fails to demonstrate that it had available
 405 during a specific audit or review period sufficient quantities
 406 of goods, or sufficient time in the case of services, to support

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407 the provider's billings to the Medicaid program;

408 (o) The provider has failed to comply with the notice and
409 reporting requirements of s. 409.907;

410 (p) The agency has received reliable information of patient
411 abuse or neglect or of any act prohibited by s. 409.920; or

412 (q) The provider has failed to comply with an agreed-upon
413 repayment schedule.

414

415 A provider is subject to sanctions for violations of this
416 subsection as the result of actions or inactions of the
417 provider, or actions or inactions of any principal, officer,
418 director, agent, managing employee, or affiliated person of the
419 provider, or any partner or shareholder having an ownership
420 interest in the provider equal to 5 percent or greater, in which
421 the provider participated or acquiesced.

422 (16) The agency shall impose any of the following sanctions
423 or disincentives on a provider or a person for any of the acts
424 described in subsection (15):

425 (a) Suspension for a specific period of time of not more
426 than 1 year. Suspension precludes ~~shall preclude~~ participation
427 in the Medicaid program, which includes any action that results
428 in a claim for payment to the Medicaid program for as a result
429 ~~of~~ furnishing, supervising a person who is furnishing, or
430 causing a person to furnish goods or services.

431 (b) Termination for a specific period of time ranging of
432 from more than 1 year to 20 years. Termination precludes ~~shall~~
433 ~~preclude~~ participation in the Medicaid program, which includes
434 any action that results in a claim for payment to the Medicaid
435 program for as a result of furnishing, supervising a person who

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436 is furnishing, or causing a person to furnish goods or services.

437 (c) Imposition of a fine of up to \$5,000 for each
438 violation. Each day that an ongoing violation continues, such as
439 refusing to furnish Medicaid-related records or refusing access
440 to records, is considered, ~~for the purposes of this section, to~~
441 ~~be~~ a separate violation. Each instance of improper billing of a
442 Medicaid recipient; each instance of including an unallowable
443 cost on a hospital or nursing home Medicaid cost report after
444 the provider or authorized representative has been advised in an
445 audit exit conference or previous audit report of the cost
446 unallowability; each instance of furnishing a Medicaid recipient
447 goods or professional services that are inappropriate or of
448 inferior quality as determined by competent peer judgment; each
449 instance of knowingly submitting a materially false or erroneous
450 Medicaid provider enrollment application, request for prior
451 authorization for Medicaid services, drug exception request, or
452 cost report; each instance of inappropriate prescribing of drugs
453 for a Medicaid recipient as determined by competent peer
454 judgment; and each false or erroneous Medicaid claim leading to
455 an overpayment to a provider is considered, ~~for the purposes of~~
456 ~~this section, to be~~ a separate violation.

457 (d) Immediate suspension, if the agency has received
458 information of patient abuse or neglect or of any act prohibited
459 by s. 409.920. Upon suspension, the agency must issue an
460 immediate final order under s. 120.569(2)(n).

461 (e) A fine, not to exceed \$10,000, for a violation of
462 paragraph (15)(i).

463 (f) Imposition of liens against provider assets, including,
464 but not limited to, financial assets and real property, not to

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465 exceed the amount of fines or recoveries sought, upon entry of
466 an order determining that such moneys are due or recoverable.

467 (g) Prepayment reviews of claims for a specified period of
468 time.

469 (h) Comprehensive followup reviews of providers every 6
470 months to ensure that they are billing Medicaid correctly.

471 (i) Corrective-action plans that ~~would~~ remain in effect ~~for~~
472 ~~providers~~ for up to 3 years and that are ~~would be~~ monitored by
473 the agency every 6 months while in effect.

474 (j) Other remedies as permitted by law to effect the
475 recovery of a fine or overpayment.

476
477 If a provider voluntarily relinquishes its Medicaid provider
478 number or an associated license, or allows the associated
479 licensure to expire after receiving written notice that the
480 agency is conducting, or has conducted, an audit, survey,
481 inspection, or investigation and that a sanction of suspension
482 or termination will or would be imposed for noncompliance
483 discovered as a result of the audit, survey, inspection, or
484 investigation, the agency shall impose the sanction of
485 termination for cause against the provider. The Secretary of
486 Health Care Administration may make a determination that
487 imposition of a sanction or disincentive is not in the best
488 interest of the Medicaid program, in which case a sanction or
489 disincentive ~~may shall~~ not be imposed.

490 (21) When making a determination that an overpayment has
491 occurred, the agency shall prepare and issue an audit report to
492 the provider showing the calculation of overpayments. The
493 agency's determination must be based solely upon information

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494 available to it before issuance of the audit report and, in the
495 case of documentation obtained to substantiate claims for
496 Medicaid reimbursement, based solely upon contemporaneous
497 records.

498 (22) The audit report, supported by agency work papers,
499 showing an overpayment to a provider constitutes evidence of the
500 overpayment. A provider may not present or elicit testimony,
501 ~~either~~ on direct examination or cross-examination in any court
502 or administrative proceeding, regarding the purchase or
503 acquisition by any means of drugs, goods, or supplies; sales or
504 divestment by any means of drugs, goods, or supplies; or
505 inventory of drugs, goods, or supplies, unless such acquisition,
506 sales, divestment, or inventory is documented by written
507 invoices, written inventory records, or other competent written
508 documentary evidence maintained in the normal course of the
509 provider's business. A provider may not present records to
510 contest an overpayment or sanction unless such records are
511 contemporaneous and, if requested during the audit process, were
512 furnished to the agency or its agent upon request. This
513 limitation does not apply to Medicaid cost report audits.
514 Notwithstanding the applicable rules of discovery, all
515 documentation ~~to that will~~ be offered as evidence at an
516 administrative hearing on a Medicaid overpayment or an
517 administrative sanction must be exchanged by all parties at
518 least 14 days before the administrative hearing or ~~must~~ be
519 excluded from consideration.

520 (25) (a) The agency shall withhold Medicaid payments, in
521 whole or in part, to a provider upon receipt of reliable
522 evidence that the circumstances giving rise to the need for a

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523 withholding of payments involve fraud, willful
 524 misrepresentation, or abuse under the Medicaid program, or a
 525 crime committed while rendering goods or services to Medicaid
 526 recipients. If it is determined that fraud, willful
 527 misrepresentation, abuse, or a crime did not occur, the payments
 528 withheld must be paid to the provider within 14 days after such
 529 determination ~~with interest at the rate of 10 percent a year.~~
 530 ~~Any money withheld in accordance with this paragraph shall be~~
 531 ~~placed in a suspended account, readily accessible to the agency,~~
 532 ~~so that any payment ultimately due the provider shall be made~~
 533 ~~within 14 days. Amounts not paid within 14 days accrue interest~~
 534 ~~at the rate of 10 percent a year, beginning after the 14th day.~~

535 (b) The agency shall deny payment, or require repayment, if
 536 the goods or services were furnished, supervised, or caused to
 537 be furnished by a person who has been suspended or terminated
 538 from the Medicaid program or Medicare program by the Federal
 539 Government or any state.

540 (c) Overpayments owed to the agency bear interest at the
 541 rate of 10 percent per year from the date of final determination
 542 of the overpayment by the agency, and payment arrangements must
 543 be made within 30 days after the date of the final order, which
 544 is not subject to further appeal at the conclusion of legal
 545 ~~proceedings. A provider who does not enter into or adhere to an~~
 546 ~~agreed upon repayment schedule may be terminated by the agency~~
 547 ~~for nonpayment or partial payment.~~

548 (d) The agency, upon entry of a final agency order, a
 549 judgment or order of a court of competent jurisdiction, or a
 550 stipulation or settlement, may collect the moneys owed by all
 551 means allowable by law, including, but not limited to, notifying

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552 any fiscal intermediary of Medicare benefits that the state has
 553 a superior right of payment. Upon receipt of such written
 554 notification, the Medicare fiscal intermediary shall remit to
 555 the state the sum claimed.

556 (e) The agency may institute amnesty programs to allow
 557 Medicaid providers the opportunity to voluntarily repay
 558 overpayments. The agency may adopt rules to administer such
 559 programs.

560 (28) Venue for all Medicaid program integrity ~~overpayment~~
 561 cases lies shall lie in Leon County, at the discretion of the
 562 agency.

563 (30) The agency shall terminate a provider's participation
 564 in the Medicaid program if the provider fails to reimburse an
 565 overpayment or pay an agency-imposed fine that has been
 566 determined by final order, not subject to further appeal, within
 567 30 35 days after the date of the final order, unless the
 568 provider and the agency have entered into a repayment agreement.

569 (31) If a provider requests an administrative hearing
 570 pursuant to chapter 120, such hearing must be conducted within
 571 90 days following assignment of an administrative law judge,
 572 absent exceptionally good cause shown as determined by the
 573 administrative law judge or hearing officer. Upon issuance of a
 574 final order, the outstanding balance of the amount determined to
 575 constitute the overpayment and fines is shall become due. If a
 576 provider fails to make payments in full, fails to enter into a
 577 satisfactory repayment plan, or fails to comply with the terms
 578 of a repayment plan or settlement agreement, the agency shall
 579 withhold ~~medical assistance~~ reimbursement payments for Medicaid
 580 services until the amount due is paid in full.

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581 Section 3. Subsection (8) of section 409.920, Florida
582 Statutes, is amended to read:
583 409.920 Medicaid provider fraud.—
584 (8) A person who provides the state, any state agency, any
585 of the state's political subdivisions, or any agency of the
586 state's political subdivisions with information about fraud or
587 suspected fraudulent acts ~~fraud~~ by a Medicaid provider,
588 including a managed care organization, is immune from civil
589 liability for libel, slander, or any other relevant tort for
590 providing ~~the~~ information about fraud or suspected fraudulent
591 acts, unless the person acted with knowledge that the
592 information was false or with reckless disregard for the truth
593 or falsity of the information. Such immunity extends to reports
594 of fraudulent acts or suspected fraudulent acts conveyed to or
595 from the agency in any manner, including any forum and with any
596 audience as directed by the agency, and includes all discussions
597 subsequent to the report and subsequent inquiries from the
598 agency, unless the person acted with knowledge that the
599 information was false or with reckless disregard for the truth
600 or falsity of the information. For purposes of this subsection,
601 the term "fraudulent acts" includes actual or suspected fraud
602 and abuse, insurance fraud, licensure fraud, or public
603 assistance fraud, including any fraud-related matters that a
604 provider or health plan is required to report to the agency or a
605 law enforcement agency.
606 Section 4. This act shall take effect July 1, 2013.

The Florida Senate
BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Appropriations Subcommittee on Health and Human Services

BILL: CS/SB 1748

INTRODUCER: Children, Families, and Elder Affairs Committee and Senator Evers

SUBJECT: Medicaid Nursing Home Eligibility

DATE: April 16, 2013 REVISED: _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Peterson	Hendon	CF	Fav/CS
2.	Brown	Pigott	AHS	Pre-meeting
3.			AP	
4.				
5.				
6.				

Please see Section VIII. for Additional Information:

- | | | |
|------------------------------|-------------------------------------|---|
| A. COMMITTEE SUBSTITUTE..... | <input checked="" type="checkbox"/> | Statement of Substantial Changes |
| B. AMENDMENTS..... | <input type="checkbox"/> | Technical amendments were recommended |
| | <input type="checkbox"/> | Amendments were recommended |
| | <input type="checkbox"/> | Significant amendments were recommended |

I. Summary:

CS/SB 1748 provides the Department of Children and Families (DCF) with authority to review financial transactions as part of its responsibility for determining an applicant’s eligibility for Medicaid. The bill also directs the DCF to exempt the value of a life insurance policy, annuity, or group certificate that pays burial expenses when determining an applicant’s eligibility for Medicaid. The exclusion applies only to instruments covering burial expenses with a face value of up to \$12,500 which name the state as beneficiary for payment amounts that exceed final burial costs.

The bill has an indeterminate fiscal impact. See Section V.

The bill has an effective date of July 1, 2013.

This bill substantially amends the following sections of the Florida Statutes: 409.902 and 409.9022.

II. Present Situation:

Medicaid

Medicaid is the health care safety net for low-income Floridians. Medicaid serves approximately 3.3 million people in Florida, with over half of those being children and adolescents 20 years of age or younger. Medicaid is a partnership between the federal and state governments where the federal government establishes the structure for the program and pays a share of the cost.¹ Each state operates its own Medicaid program under a state plan that must be approved by the federal Centers for Medicare and Medicaid Services (CMS). The state plan outlines current Medicaid eligibility standards, policies, and reimbursement methodologies.

In Florida, the program is administered by the Agency for Health Care Administration (AHCA). AHCA delegates certain functions to other state agencies, including the DCF, the Agency for Persons with Disabilities (APD), and the Department of Elder Affairs (DOEA). AHCA has overall responsibility for the program and qualifies providers, sets payment levels, and pays for services. The DCF is responsible for determining financial eligibility for Medicaid recipients. The APD operates one of the larger waiver programs under Medicaid – the Home and Community Based Waiver program serving individuals with disabilities. The DOEA assesses Medicaid recipients to determine if they require nursing home care. Specifically, an individual:

- Requires nursing home placement as evidenced by the need for medical observation throughout a 24-hour period and requires care to be performed on a daily basis under the direct supervision of a health professional of medically complex services because of mental or physical incapacitation; or
- Requires or is at imminent risk of nursing home placement as evidenced by the need for observation throughout a 24-hour period and requires care to be performed on a daily basis under the supervision of a health professional because of mental or physical incapacitation; or
- Requires or is at imminent risk of nursing home placement as evidenced by the need for observation throughout a 24-hour period and requires limited care to be performed on a daily basis under the supervision of a health professional because of mild mental or physical incapacitation.

The Medicaid eligibility income threshold for institutional care placement, home and community based care services, and hospice services, is 300 percent of the Supplemental Security Income (SSI) federal benefit rate.² The current SSI federal benefit rate is \$710 for an individual.³ Thus, individuals with incomes under \$2,130 per month are eligible for Medicaid long-term care services.⁴

¹ For the 2012-13 state fiscal year, the federal government pays 57.73 percent of the costs for Medicaid benefits provided in Florida.

² Rule 65A-1.713(1)(d), F.A.C.

³ Social Security Administration, *SSI Federal Payment Amounts for 2013*, available at <http://www.ssa.gov/oact/cola/SSI.html> (last visited April 10, 2013).

⁴ Fla. Dep't. of Children and Families, *SSI-Related Programs Fact Sheets* (April 2013), available at <http://www.dcf.state.fl.us/programs/access/docs/ssifactsheet.pdf> (last visited April 10, 2013).

The February 25, 2013, Social Services Estimating Conference (SSEC) estimated that expenditures for Medicaid for the 2012-2013 fiscal year would be \$20.77 billion, including \$4.75 billion expended on Medicaid long-term care services.

Paying for Long-Term Care

Floridians who need nursing home care but do not qualify for Medicaid must pay for their care privately or through insurance. According to the 2011 MetLife Market Survey of Nursing Home, Assisted Living, Adult Day Services, and Home Care Costs, the national average annual cost of a nursing home was \$78,110 for a semi-private room in 2011. Individuals who need nursing home care may be ineligible for Medicaid because of their financial assets and/or monthly income. Many individuals paying privately for nursing home care spend their assets and then become eligible for Medicaid. Some, however, have monthly income from pensions and other sources that prevent them from becoming eligible for Medicaid.

Some individuals, with assistance from financial planners and attorneys, have developed methods of arranging assets in such a way that they are not countable when Medicaid eligibility is determined. Elder law attorneys across the country actively advertise services to assist elderly individuals with personal service contracts and other asset protection methods.

According to the DCF, some individuals, prior to entering a nursing facility or enrolling in a Medicaid home and community based service waiver program, transfer accumulated assets to a relative through a contract under which the relative will provide personal services to the individual for a specified period of time while receiving all or most of the contracted payment in advance, leaving the individual with an amount of assets low enough for Medicaid eligibility. Current DCF policy does not preclude such personal care contracts with relatives when determining Medicaid eligibility. If the contracts are for an amount significantly higher than rates typically paid for similar services, however, the individual may be attempting to shield assets in order to qualify for Medicaid. DCF indicates that many of the contracted services incorporated into the contracts are services that close relatives would normally provide without charge, such as visitation, transportation, entertainment, and oversight of medical care. Current law does not contain standards for these contracts or enable DCF to monitor or enforce them to ensure that contracted services are actually provided.⁵

Section 1924 of the Social Security Act contains provisions to prevent "spousal impoverishment," which can leave the spouse who is still living at home in the community with little or no income or resources.⁶ When a couple applies for Medicaid, an assessment of the couple's resources is made and a protected resource amount is set aside for the community spouse and the remainder is considered available for the individual applying for Medicaid. This protected amount is known as the Community Spouse Resource Allowance (CSRA). An individual applying for Medicaid cannot be determined ineligible for assistance based on the assets of the individual's spouse when:

⁵Fla. Dep't of Children and Families, *Staff Analysis and Economic Impact- SB 1748* (on file with the Senate Committee on Children, Families, and Elder Affairs).

⁶42 U.S.C. 1396r-5(d).

- The applicant assigns his or her rights to support from the community spouse to the state;
- The applicant is physically or mentally unable to assign his right by the state has the right to bring a support proceeding against the community spouse; or
- The state determines the denial of eligibility would cause an undue hardship.⁷

While federal law provides states the authority to seek financial support from the community spouse under these circumstances, the DCF indicates that no mechanism to recover funds from the community spouse is available in current Florida law.⁸

Federal Deficit Reduction Act of 2005

The Federal Deficit Reduction Act of 2005 (DRA)⁹ contained a number of provisions that were intended to discourage the use of planning techniques and transactions which are intended to protect wealth while enabling access to public benefits.

When an individual applies for Medicaid coverage for long-term care, DCF must conduct a review, or "look-back," to determine whether the individual (or his or her spouse) transferred assets to another person or party for less than fair market value (FMV). The DRA lengthened the "look-back period" to 60 months prior to the date the individual applied for Medicaid. When individuals transfer assets at less than FMV they are subject to a penalty that delays the date they can qualify to receive Medicaid long-term care services. Previously the penalty period began with the month the assets were transferred, which created an opportunity for individuals to avoid part or all of a penalty by transferring assets months or years before they actually entered a nursing home. Under the DRA, the penalty period now begins on either the date of the asset transfer, or the date the individual enters a nursing home and is found eligible for coverage of institutional level services that Medicaid would pay for were it not for the imposition of a transfer penalty – whichever is later.¹⁰

Regulation of Insurance in Florida

The Office of Insurance Regulation (OIR) is responsible for regulating all activities concerning insurers and other risk bearing entities, including licensing, rates, policy forms, market conduct, claims, solvency, viatical settlements, and premium financing.¹¹

Life Insurance

Life insurance is a contract between the owner of a policy and an insurer whereby the insurer agrees, in return for premium payments, to pay a specified sum (the face value or maturity value of the policy) to the designated beneficiary upon the death of the insured. For a whole life insurance policy, premiums are collected during the life of the insured, with a payout occurring

⁷42 U.S.C. 1396r-(5)(c)(3)(C).

⁸ See *supra* note 6.

⁹ Pub. Law No. 109-171, S.1932, 109th Cong. (Feb. 8, 2006).

¹⁰Dep't. of Health and Human Services, Centers for Medicaid and Medicare Services, *Important Facts for State Policymakers Deficit Reduction Act*, (January 8, 2008), available at <http://www.cms.gov/Regulations-and-Guidance/Legislation/DeficitReductionAct/downloads/TOAbackgrounder.pdf> (last visited April 10, 2013).

¹¹ Section 20.121(3)(a), F.S.

at the death of the insured. The premium for whole life insurance remains the same throughout the life of the policy, in large part because the policy accumulates a “dividend” cash value, which permits the insurance company to maintain the same premium level year after year. The insured can also withdraw or borrow against the cash value accumulated by the policy. Some policies will pay a portion (lump sum or monthly payments) of the death benefits for a policy before death occurs if the policyholder is diagnosed with a terminal illness or catastrophic illness, or is confined to a nursing home. Upon the death of the insured, the beneficiary receives the remainder of the death benefits. The insurer may charge a fee for the accelerated benefits.

Life insurance forms and rates are subject to approval by OIR.¹² The OIR has adopted rules relating to the advertisement and disclosure of benefits, limitations, and exclusions of policies sold as life insurance to assure that product descriptions are presented in a manner that prevents unfair, deceptive, and misleading advertising and is conducive to accurate presentations.¹³

III. Effect of Proposed Changes:

Section 1 of the bill amends s. 409.902, F.S., relating to eligibility for Medicaid, to provide that the DCF’s responsibility for Medicaid eligibility determinations includes “reviewing financial transactions affecting eligibility.”

Section 2 of the bill amends s. 409.9022, F.S., and directs the DCF, notwithstanding any other provision of law, to exempt the value of a life insurance policy, annuity, or group certificate that pays burial expenses, when determining an applicant’s eligibility for Medicaid. The exclusion applies only to an instrument covering burial expenses with a face value of up to \$12,500 which irrevocably names the state as beneficiary for benefit amounts that exceed final burial costs, up to the amount of Medicaid expenditures paid by the state on behalf of the policyholder. The bill directs the state to seek federal authority, if necessary, to implement these provisions. The bill also makes technical changes, substituting “Department of Children and Families” in place of “Department of Children and Family Services” where the term appears in this section of statute.

Section 3 provides an effective date of July 1, 2013.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

¹² Section 627.410, F.S.

¹³ Chapter 69O-150 F.A.C.

V. Fiscal Impact Statement:**A. Tax/Fee Issues:**

None.

B. Private Sector Impact:

Under the bill, individuals who purchase a life insurance policy, an annuity, or group certificate with a face value of up to \$12,500 to pay exclusively for their burial expenses will not be determined ineligible for Medicaid due to the value of the coverage.

C. Government Sector Impact:

By exempting the value of a life insurance policy, annuity, or group certificate to pay for burial expenses in determining an applicant's Medicaid eligibility, the bill could result in additional individuals qualifying for Medicaid, which would increase the program's utilization and costs. The potential extent of that effect is indeterminate.

Because of the requirement that the burial coverage must name the state as the beneficiary of proceeds that exceed the final burial expenses, up to the amount of Medicaid assistance provided to the policyholder, the bill would require the AHCA to track and, in some cases, collect, on life insurance benefits. For similar provisions contained in CS/SB 794, the AHCA indicates a need for \$126,647 of general revenue and \$126,647 from the Medical Care Trust Fund to perform this function.

Additionally, the DCF would need to make programming changes to its Medicaid eligibility system to capture additional life insurance information to be used for eligibility determination. The potential costs for those programming changes have not been determined.

VI. Technical Deficiencies:

None.

VII. Related Issues:

The intent and effect of the provision in Section 1 of the bill that the DCF's responsibility for Medicaid eligibility determinations will include "reviewing financial transactions affecting eligibility," are unclear. The bill does not define "financial transactions" nor does it specify how the DCF should use information gathered during the review of an applicant's financial transactions in its determination of Medicaid eligibility.

VIII. Additional Information:

- A. Committee Substitute – Statement of Substantial Changes:**
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Children, Families, and Elder Affairs on April 15, 2013:

The CS:

- Removes the original bill text, which limited the use of personal services contracts for individuals applying for Medicaid long-term care services and provided DCF with authority to recover long-term care costs from the spouse of a Medicaid recipient who has assigned his or her right to the state.
- Provides DCF authority to review financial transactions made by an applicant for Medicaid that might affect eligibility.

B. Amendments:

None.

By the Committee on Children, Families, and Elder Affairs; and
Senator Evers

586-04335-13

20131748c1

A bill to be entitled

An act relating to Medicaid eligibility; amending s. 409.902, F.S.; requiring the Department of Children and Families to review financial transactions affecting eligibility; making technical corrections; creating s. 409.9022, F.S.; exempting the value of a Medicaid applicant's life insurance policy, annuity, or group certificate from the determination of the applicant's Medicaid eligibility under certain circumstances; authorizing a state agency to delay implementation of certain provisions if a federal waiver or authorization is required; specifying limitations; authorizing the department to adopt rules; providing an effective date.

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

Section 1. Subsection (1) and paragraphs (a) and (b) of subsection (8) of section 409.902, Florida Statutes, are amended to read:

409.902 Designated single state agency; payment requirements; program title; release of medical records.—

(1) The Agency for Health Care Administration is designated as the single state agency authorized to make payments for medical assistance and related services under Title XIX of the Social Security Act. These payments shall be made, subject to any limitations or directions provided for in the General Appropriations Act, only for services included in the program, shall be made only on behalf of eligible individuals, and shall

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

586-04335-13

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be made only to qualified providers in accordance with federal requirements for Title XIX of the Social Security Act and the provisions of state law. This program of medical assistance is designated the "Medicaid program." The Department of Children and ~~Families Family Services~~ is responsible for Medicaid eligibility determinations, including, but not limited to, policy, rules, reviewing financial transactions affecting eligibility, and the agreement with the Social Security Administration for Medicaid eligibility determinations for Supplemental Security Income recipients, as well as the actual determination of eligibility. As a condition of Medicaid eligibility, subject to federal approval, the Agency for Health Care Administration and the Department of Children and Families ~~Family Services~~ shall ensure that each recipient of Medicaid consents to the release of her or his medical records to the Agency for Health Care Administration and the Medicaid Fraud Control Unit of the Department of Legal Affairs.

(8) The department shall implement the following project governance structure until the system is implemented:

(a) The Secretary of Children and Families ~~Family Services~~ shall have overall responsibility for the project.

(b) The project shall be governed by an executive steering committee composed of three department staff members appointed by the Secretary of Children and Families ~~Family Services~~; three agency staff members, including at least two state Medicaid program staff members, appointed by the Secretary of the Agency for Health Care Administration; one staff member from Children's Medical Services within the Department of Health appointed by the Surgeon General; and a representative from the Florida

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

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59 Healthy Kids Corporation.

60 Section 2. Section 409.9022, Florida Statutes, is created
61 to read:62 409.9022 Medical eligibility; burial expense exemption.-63 (1) Notwithstanding any other provision of law, the
64 department, in determining an applicant's eligibility for
65 Medicaid, shall exempt the value of a life insurance policy,
66 annuity, or group certificate that:67 (a) Includes terms that preclude the use of its proceeds
68 for anything other than the payment of the owner's final burial
69 expense and has a face amount that does not exceed the limits
70 established under s. 626.785(3);71 (b) Names the state as the irrevocable beneficiary such
72 that any proceeds of the life insurance policy, annuity, or
73 group certificate which exceed the final burial expense will be
74 remitted to the state up to the amount of Medicaid assistance
75 provided to the owner; and76 (c) Provides the owner with the opportunity to name a
77 contingent beneficiary if the proceeds from the policy exceed
78 the cost of:79 1. The owner's final burial expenses; and80 2. The amount of Medicaid benefits provided to the owner.81 (2) This section does not limit other exemptions that apply
82 to a life insurance policy, annuity, or group certificate when
83 determining an applicant's eligibility for Medicaid.84 (3) If a state agency determines that a waiver or
85 authorization from a federal agency is necessary to implement
86 any provision of this section, the agency affected by the
87 provision shall request the waiver or authorization and may

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88 delay implementing such provision until the waiver or
89 authorization is granted.90 (4) The Department of Children and Families may adopt rules
91 to administer this section.

92 Section 3. This act shall take effect July 1, 2013.



306188

LEGISLATIVE ACTION

Senate	.	House
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Appropriations Subcommittee on Health and Human Services
(Grimsley) recommended the following:

Senate Amendment (with title amendment)

Between lines 1345 and 1346
insert:

Section 17. (1) The sum of \$1,258,054,808 from the Medical Care Trust Fund is appropriated to the Agency for Health Care Administration beginning in the 2013-2014 fiscal year to provide coverage for individuals who enroll in the Healthy Florida Program.

(2) The sum of \$254,151 from the General Revenue Fund and \$18,235,833 from the Medical Care Trust Fund is appropriated to the Agency for Health Care Administration beginning in the 2013-



306188

13 2014 fiscal year to comply with federal regulations to
14 compensate insurers and managed care organizations that contract
15 with the Healthy Florida Program for the imposition of the
16 annual fee on health insurance providers under section 9010 of
17 the federal Patient Protection and Affordable Care Act, Pub. L.
18 No. 111-148, as amended by the federal Health Care and Education
19 Reconciliation Act of 2010, Pub. L. No. 111-152.

20 (3) The sum of \$10,676,377 from the General Revenue Fund
21 and \$10,676,377 from the Medical Care Trust Fund is appropriated
22 beginning in the 2013-2014 fiscal year to the Agency for Health
23 Care Administration to contract with the Florida Healthy Kids
24 Corporation under s. 409.818(2)(f), Florida Statutes, to fund
25 administrative costs necessary for implementing and operating
26 the Healthy Florida Program.

27 (4) The Agency for Health Care Administration may submit
28 budget amendments to the Legislative Budget Commission pursuant
29 to chapter 216, Florida Statutes, to fund the Healthy Florida
30 Program for the coverage of children who transfer from the
31 Florida Kidcare Program to the Healthy Florida Program, or to
32 provide additional spending authority from the Medical Care
33 Trust Fund under subsection (1) for the coverage of individuals
34 who enroll in the Healthy Florida Program, during the 2013-2014
35 fiscal year.

36
37 ===== T I T L E A M E N D M E N T =====

38 And the title is amended as follows:

39 Delete line 62

40 and insert:

41 implementation and interpretation clause; providing



306188

42

appropriations; providing an



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LEGISLATIVE ACTION

Senate

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House

Appropriations Subcommittee on Health and Human Services
(Gibson) recommended the following:

Senate Amendment

Delete lines 1254 - 1255
and insert:

(b) An enrollee who has a family income above the federal poverty level may be required to make nominal copayments, in accordance with federal rule, as a condition of receiving a health care service.



201016

LEGISLATIVE ACTION

Senate	.	House
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Appropriations Subcommittee on Health and Human Services (Sobel)
recommended the following:

Senate Amendment

Delete lines 1006 - 1045
and insert:

(6) BOARD OF DIRECTORS AND MANAGEMENT SUPERVISION.—

(a) The Florida Healthy Kids Corporation shall operate
subject to the supervision and approval of a board of directors
chaired by an appointee designated by the Governor ~~Chief~~
~~Financial Officer or her or his designee~~, and composed of 15 ~~12~~
other members. The Senate shall confirm the designated chair and
other board appointees ~~selected~~ for 3-year terms of office as
follows:



201016

13 1. The Secretary of Health Care Administration, or his or
14 her designee, as an ex-officio member.

15 2. The State Surgeon General, or his or her designee, as an
16 ex-officio member ~~One member appointed by the Commissioner of~~
17 ~~Education from the Office of School Health Programs of the~~
18 ~~Florida Department of Education.~~

19 3. The Secretary of Children and Families, or his or her
20 designee, as an ex-officio member ~~One member appointed by the~~
21 ~~Chief Financial Officer from among three members nominated by~~
22 ~~the Florida Pediatric Society.~~

23 4. Four members ~~One member,~~ appointed by the Governor, ~~who~~
24 ~~represents the Children's Medical Services Program.~~

25 5. Two members ~~One member~~ appointed by the President of the
26 Senate Chief Financial Officer ~~from among three members~~
27 ~~nominated by the Florida Hospital Association.~~

28 6. Two members ~~One member,~~ appointed by the Senate Minority
29 Leader ~~Governor, who is an expert on child health policy.~~

30 7. Two members ~~One member,~~ appointed by the Speaker of the
31 House of Representatives Chief Financial Officer, ~~from among~~
32 ~~three members nominated by the Florida Academy of Family~~
33 ~~Physicians.~~

34 8. Two members ~~One member,~~ appointed by the House Minority
35 Leader ~~Governor, who represents the state Medicaid program.~~

36 9. ~~One member, appointed by the Chief Financial Officer,~~
37 ~~from among three members nominated by the Florida Association of~~
38 ~~Counties.~~

39 10. ~~The State Health Officer or her or his designee.~~

40 11. ~~The Secretary of Children and Family Services, or his~~
41 ~~or her designee.~~



201016

42 ~~12. One member, appointed by the Governor, from among three~~
43 ~~members nominated by the Florida Dental Association.~~

44 (b) A member of the board of directors may be removed by
45 the official who appointed that member. The board shall appoint
46 an executive director, who is responsible for other staff
47 authorized by the board.

The Florida Senate
BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Appropriations Subcommittee on Health and Human Services

BILL: SB 1816

INTRODUCER: Appropriations

SUBJECT: Health Care

DATE: April 15, 2013 REVISED: _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Brown	Pigott	AHS	Pre-meeting
2.	_____	_____	AP	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____

I. Summary:

SB 1816 amends several sections of the Florida Kidcare Program Act under Part II of chapter 409, Florida Statutes, to remove obsolete provisions and conform other provisions with changes in federal laws and regulations relating to the implementation of the federal Patient Protection and Affordable Care Act (Public Law 2010-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 2010-288), known collectively as “PPACA,” and the Supreme Court ruling in *National Federation of Independent Business v. Sebelius*.¹

The bill adds definitions for “modified adjusted gross income” and “household income” to align with changes in Medicaid and Children’s Health Insurance Program (CHIP) program eligibility laws and regulations and removes definitions that are no longer applicable to the program. The bill removes authority and provisions for an employer-sponsored insurance premium assistance program component in Florida Kidcare. Notification requirements for certain Florida Kidcare disenrollees regarding other insurance options on the exchange, as defined under PPACA, are added, and the non-subsidized program under Florida Kidcare is phased-out. The bill includes provisions for electronic eligibility matching through the exchange hub and an option for written documentation when matching is not feasible.

The bill would have an estimated fiscal impact of \$10.9 million general revenue (GR) for the 2013-2014 fiscal year. See Section V.

The bill revises the eligibility process to reflect the procedures that will be used under the modified adjusted gross income (MAGI) method beginning January 1, 2014. The bill further

¹ *National Federation of Independent Business v. Sebelius*, 567 U.S. ____ (2012).

revises the responsibilities of the Department of Children and Family Services (DCF), the Agency for Health Care Administration (AHCA), the Department of Health (DOH), the Florida Healthy Kids Corporation (FHKC), and the Office of Insurance Regulation (OIR) under the Florida Kidcare Program. The bill clarifies that the AHCA is directed to contract with the Florida Healthy Kids Corporation for the administration of the Healthy Kids and Healthy Florida programs.

The bill amends s. 624.91, Florida Statutes – the Florida Healthy Kids Corporation Act – to revise legislative intent to include a new program, Healthy Florida. The bill modifies FHKC’s corporate governance structure, medical loss ratio guidelines for health plan contracts, and corporate responsibilities. The bill creates s. 624.917, Florida Statutes, to provide definitions, eligibility criteria, enrollment, and benefits for the Healthy Florida program. The corporation is also authorized to make changes to the program to negotiate for the approval of the Healthy Florida program with the federal Department of Health and Human Services (HHS), if necessary.

The bill repeals the authority for an operating fund for the Florida Healthy Kids Corporation under section 624.915, Florida Statutes.

The bill includes a conflict of laws statement indicating that if there is a conflict between a provision in the bill and the PPACA, the provision must be interpreted to comply with the requirements of federal law.

The bill is effective upon becoming law.

This bill substantially amends the following sections of the Florida Statutes: 409.811, 409.813, 409.8132, 409.8135, 409.814, 409.815, 409.8177, 409.818, 409.820, and 624.91.

The bill creates section 624.917, Florida Statutes.

The bill repeals the following sections the Florida Statutes: 409.817, 409.8175, and 624.915.

II. Present Situation:

Florida provides health insurance coverage options to low income Floridians through a variety of programs utilizing state and federal funds. As of February 28, 2013, more than 3.2 million individuals received coverage through some Medicaid eligibility category.² Enrollment in the Florida Kidcare program (non-Medicaid funded components) for the same time period was an additional 256,721 children.³

Florida’s Medicaid program is expected to expend \$21 billion for the 2012-13 state fiscal year to provide coverage to its enrollees, making it the fifth largest in the nation in terms of

² Agency for Health Care Administration, *Report of Medicaid Eligibles*, http://ahca.myflorida.com/Medicaid/about/pdf/age_assistance_category_130228.pdf (last visited Mar. 17, 2013).

³ Agency for Health Care Administration, *Florida KidCare Enrollment Report – February 2013*, (copy on file with the Senate Health Policy Committee).

expenditures.⁴ The Florida Medicaid program is jointly funded between the state and federal governments; 57.73 percent of the cost for health care services is paid by federal funds and 42.27 percent is state share in the current state fiscal year. Funding for the Florida Kidcare program's Title XXI components has an enhanced federal match of 70.66 percent for federal fiscal year 2012-13.⁵

According to the most recent data from the American Community Survey (ACS) of the federal Census Bureau, an estimated 4 million Floridians are uninsured.⁶ Of that number according to the ACS data, 594,000 are children.⁷ Dividing Florida's uninsured by income level, more than 1.9 million adults are under 139% of the federal poverty level (FPL), according to statistics for 2010-2011.⁸ Lower income adults, or those below 100 percent of the FPL, number at 1.1 million of the 1.9 million for that same time period.⁹

Eligibility for the Medicaid program is based on a number of factors, including age, household or individual income, and assets.

The Department of Children and Families (DCF) determines eligibility for the Medicaid program but the AHCA is the single state Medicaid agency and has the lead responsibility for the overall program.¹⁰

Recipients in the Medicaid program receive their benefits through several different delivery systems, depending on their individual situation. Delivery systems currently include fee-for-service providers, prepaid dental plans, provider service networks, and Medicaid managed care plans. In July 2006, the AHCA implemented the Medicaid Managed Pilot Program as directed by the 2005 Legislature through s. 409.91211, F.S. The pilot program operates under an 1115 Research and Demonstration Waiver approved by the federal Centers for Medicare and Medicaid Services. The pilot program was initially authorized for Broward and Duval counties with expansion to Baker, Clay and Nassau the following year.

Under the current pilot program, most Medicaid recipients in the five pilot counties (Broward, Duval, Baker, Clay, and Nassau counties) are required to receive their benefits through either

⁴ Agency for Health Care Administration, Presentation to House Health and Human Services Committee, *Florida Medicaid: An Overview - December 5, 2012*,

[http://www.myfloridahouse.gov/Sections/Documents/loadoc.aspx?PublicationType=Committees&CommitteeId=2714&Session=2013&DocumentType=Meeting Packets&FileName=HHSC_Mtg_12-5-12_ONLINE.pdf](http://www.myfloridahouse.gov/Sections/Documents/loadoc.aspx?PublicationType=Committees&CommitteeId=2714&Session=2013&DocumentType=Meeting%20Packets&FileName=HHSC_Mtg_12-5-12_ONLINE.pdf) (last visited Mar. 17, 2013).

⁵ Florida KidCare Coordinating Council, *2013 Annual Report and Recommendations*, p. 5, (January 2013), http://www.floridakidcare.org/council/reports/2013_KCC_Report.pdf (last visited Mar. 17, 2013).

⁶ Office of Economic and Demographic Research, Florida Legislature, *Economic Analysis of PPACA and Medicaid Expansion*, Presentation to Senate Select Committee on Patient Protection and Affordable Care Act (Mar. 4, 2013), http://www.floridakidcare.org/council/reports/2013_Recommendations.pdf (last visited Mar. 17, 2013).

⁷ *Ibid.*

⁸ Kaiser Family Foundation, statehealthfacts.org, *Health Insurance Coverage of the Non-Elderly (0-64) with Incomes up to 139% of FPL (2010-2011)*, <http://www.statehealthfacts.org/profileind.jsp?ind=849&cat=3&rgn=11&cmprgn=1> (last visited Mar. 17, 2013).

⁹ Kaiser Family Foundation, statehealthfacts.org, *Health Insurance Coverage of the Non-Elderly (0-64) with Incomes up to 139% of FPL (2010-2011)*, <http://www.statehealthfacts.org/profileind.jsp?ind=849&cat=3&rgn=11&cmprgn=1> (last visited Mar. 17, 2013).

¹⁰ Agency for Health Care Administration, *Welcome to Medicaid!*, <http://ahca.myflorida.com/Medicaid/index.shtml> (last visited Mar. 17, 2013).

health maintenance organizations (HMOs), provider service networks (PSNs), or a specialty plan. In addition to the minimum benefits package, plans may provide enhanced services such as over the counter benefits, preventive dental care for adults, and health and wellness benefits.

Medicaid Statewide Managed Medical Care Program

In 2011, the Legislature passed HB 7107, creating the Statewide Medicaid Managed Medical Assistance (SMMC) Program as part IV of ch. 409, F.S. The SMMC requires the AHCA to create an integrated managed care program for Medicaid enrollees that incorporates all of the minimum benefits, for the delivery of primary and acute care. The SMMC has two components: the Long Term Care Managed Care program and the Managed Medical Assistance (MMA) program.

As the single state agency for Medicaid under s. 409.963, F.S., the AHCA has primary responsibility for the management and operations of the state's Medicaid program, including seeking waiver authority from the federal government. To implement these two programs and receive federal Medicaid funding, the AHCA was required to seek federal authorization through two different Medicaid waivers from the Centers for Medicare and Medicaid Services. The first component authorized was the LTC Managed Care Program's 1915(b) and (c) waiver. Approval was granted on February 1, 2013.

The LTC Managed Care Program will serve those individuals who are 65 years of age or old or who are eligible for Medicaid by reason of a disability, subject to wait list prioritization and availability of funds. The recipients must also be determined to require a nursing facility level of care. Medicaid recipients who qualify will receive all of their long-term care services from the long-term care managed care plan.

The AHCA is responsible for administering the LTC Managed Care Program but may delegate specific duties to the Department of Elderly Affairs and other state agencies. Implementation of the LTC Managed Care program started July 1, 2012, with completion expected by October 1, 2013. The AHCA released an Invitation to Negotiate (ITN) on June 29, 2012, and on January 15, 2013, notices of contract awards to managed care plans under that ITN were announced.

For the SMMC component, the AHCA sought to modify the existing Medicaid Reform 1115 Demonstration waiver with the Centers for Medicare and Medicaid Services to expand the program statewide. The AHCA initiated the SMMC project in January 2012 and released a separate ITN to competitively procure managed care plans on a statewide basis on December 28, 2012. Bids are due to the AHCA on March 29, 2013 and awards are expected to be announced on September 16, 2013.

Plans can supplement the minimum benefits in their bids and offer enhanced options. The number of plans to be selected by region is prescribed under s. 409.974, F.S. Specialty plans that serve specific, targeted populations based on age, medical condition, and diagnosis, are also included under the SMMC program. Under s. 409.967, F.S., accountability provisions for the managed care plans specify several conditions or requirements including emergency care and physician reimbursement standards, access and credentialing requirements, encounter data submission guidelines, grievance and resolutions, and medical loss ratio calculations.

Statewide implementation of SMMC is expected to be completed by October 1, 2014. Final approval of the necessary Medicaid waiver by the federal government has not yet been received; however, on February 20, 2013 the AHCA and the Centers for Medicare and Medicaid Services reached an “Agreement in Principle” on the proposed plan.

Under SMMC, persons meeting applicable eligibility requirements of Title XIX of the Social Security Act must be enrolled in a managed care plan. Medicaid recipients who (a) have other creditable care coverage, excluding Medicare; (b) reside in residential commitment facilities operated through the Department of Juvenile Justice, group care facilities operated by the DCF, and treatment facilities funded through the DCF Substance Abuse and Mental Health Program; (c) are eligible for refugee assistance; or (d) are residents of a developmental disability center, may voluntarily enroll in the SMMC program. Those recipients who elect not to enroll in SMMC voluntarily will be served through the Medicaid fee-for-service system.

Florida Kidcare Program

The Florida Kidcare Program (Program) was created in 1998 by the Florida Legislature in response to the federal enactment of the Children’s Health Insurance Program (CHIP) in 1997. The CHIP provides subsidized health insurance coverage to uninsured children who do not qualify for Medicaid but who have family incomes under 200 percent of the FPL and meet other eligibility criteria. The state statutory authority for the Program is found under part II of chapter 409; ss. 409.810 through 409.821, F.S.

The Program includes four operating components: Medicaid for children, Medikids, the Children’s Medical Services Network, and the Florida Healthy Kids Corporation (corporation). Section 409.813, F.S., includes five components for the Program. The fifth component – the employer sponsored group health insurance plan – has never been implemented. The AHCA submitted a state plan amendment in December 1998 for implementation of that component; however, the plan amendment was disapproved by the federal Centers for Medicare and Medicaid Services in November 1999 and was not re-submitted.¹¹ The Title XXI-funded components of Florida Kidcare serve distinct populations under the program:¹²

- Medicaid for Children: Children from birth until age 1 for family incomes between 185 percent and 200 percent of the FPL.
- Medikids: Title XXI funding is available from age 1 until age 5 for family incomes between 133 percent and 200 percent of the FPL.
- Healthy Kids: Title XXI funding is available from age 5 through age 6 for family incomes between 133 and 200 percent of the FPL. For age 6 through age 18, Title XXI funding is available for family incomes between 100 percent and 200 percent of the FPL.

¹¹ See State of Florida, Florida KidCare Program, Title XXI State Child Health Insurance Plan, Amendment #22, July 1, 2012, pg. 6, <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Childrens-Health-Insurance-Program-CHIP/Downloads/CHIP-SPAs/FL-CSPA-22-FINAL.pdf> (last visited: March 15, 2013).

¹² See State of Florida, Florida KidCare Program, Title XXI State Child Health Insurance Plan, Amendment #22, July 1, 2012, pg.5., <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Childrens-Health-Insurance-Program-CHIP/Downloads/CHIP-SPAs/FL-CSPA-22-FINAL.pdf> (last visited: March 15, 2013).

- Children’s Medical Services Network: Title XXI and Title XIX funds are available from birth until age 19 for family incomes up to 200 percent of the FPL for children with special health care needs. The Department of Health assesses whether children meet the clinical requirements.

Coverage for the non-Medicaid components of the Florida Kidcare Program is funded through Title XXI of the federal Social Security Act (CHIP coverage). Title XIX of the Social Security Act (Medicaid coverage), state funds for CHIP coverage, and family contributions also provide funding for the Florida Kidcare Program. Family contributions are based on family size, household income, and other eligibility factors. Families above the income limits for premium assistance or who are not otherwise eligible for premium assistance are offered the opportunity to participate in the Program at a non-subsidized rate (full-pay). Currently, the income limit for premium assistance is 200 percent of the FPL.

The Medikids program was created under s. 409.8132, F.S., as a Medicaid “look-alike” program for enrollees age 1 through 4. Medikids is administered by the AHCA and enrollees receive the same mandatory and optional benefits covered under ss. 409.905 and 409.906, F.S. Enrollees are offered a choice of health plans or, if two plans are not offered in a particular county, MediPass is provided as one of the options. Many provisions of the Medicaid program also apply to the Medikids program; such as program integrity, provider fraud and abuse preventions, and quality of care.

Under s. 409.814, F.S., the Program’s eligibility guidelines are described in conformity with current Title XIX and Title XXI terminology and requirements for each funding component. Other eligibility factors related to premium assistance under this section include whether a child:

- Is covered under other employer-based coverage costing less than five percent of the family income;
- Is an alien, but does not meet the definition of a qualified alien;
- Is an inmate in a public institution or a patient in an institution for mental disease; or,
- Has dropped employer-sponsored coverage within 60 days of applying for premium assistance. Current law does provide good cause exceptions that may be taken into consideration for individuals that drop employer-sponsored coverage resulting in a waiver of the 60-day waiting period for premium assistances.

Families with income above 200 percent of the FPL or who do not meet the qualifications for premium assistance may still be able to purchase the coverage under Medikids or Healthy Kids at the non-subsidized rate.

To enroll in Kidcare, families utilize a form that is both a Medicaid and a CHIP application. Families may apply using either an online or a paper application. Both formats are available in English, Spanish, or Creole. Eligibility is determined through electronic data matching using available databases, or, when income cannot be verified electronically, through submission of current paystubs, tax returns, or W-2 forms. Families may also apply for Medicaid through the

DCF web portal (ACCESS) online, at an ACCESS community partner site, or with a paper form via the mail, fax, or in person at a Customer Service Center.¹³

Under s. 409.815, F.S., benefits under the Florida Kidcare program vary by program component. For Medicaid, Medikids, and the Children's Medical Services Network, enrollees receive the mandatory and optional medical benefits covered under ss. 409.905 and 409.906, F.S. For Healthy Kids and the employer-sponsored component, a benchmark benefit package is provided. The comprehensive benefit package includes preventive services, specialty care, hospitalization, prescription drug coverage, behavioral health and substance abuse services, dental care, vision and hearing services, and emergency care and transportation.

Limits on premiums and cost sharing in the Program are covered under s. 409.816, F.S., and conform to existing federal law and regulation for Title XIX and XXI. All Title XXI funded enrollees pay monthly premiums of \$15 or \$20 per family per month based on their family size and income. For those families at or below 150 percent of the FPL, the cost is \$15 per family per month. For those between 150 percent of the FPL and 200 percent of the FPL, the cost is \$20 per family per month. Enrollees in the Healthy Kids component also have copayments for non-preventive services that range from \$5 per prescription to \$10 for an inappropriate use of the emergency room visit. There are no copayments for visits related to well-child, preventive health, or dental care.¹⁴

Under s. 409.8175, F.S., a health maintenance organization may reimburse providers in a rural county according to the Medicaid fee schedule provided the provider agrees to such a schedule.

The AHCA contracts for an annual evaluation of the Program to address the statutory components of s. 409.8177, F.S. The annual reports are posted to the AHCA's website for public review and submitted to the Centers for Medicare and Medicaid Services.¹⁵

Several state agencies and the non-profit corporation – Florida Healthy Kids – share responsibilities for the Program. Section 409.818, F.S., delineates the responsibilities for each of the entities under the Program, and subsection (5) preserves the corporation's eligibility determination functions for the Healthy Kids program. Annually, the Legislature provides administrative funds through the AHCA's appropriation to contract with the corporation to conduct the eligibility and administrative functions related to the Program.¹⁶ The DCF determines eligibility for Medicaid and the corporation determines eligibility for CHIP, which includes a Medicaid screening and referral process to the DCF, as appropriate.

¹³ Florida Department of Children and Families, *ACCESS Florida Website*, <http://www.myflfamilies.com/service-programs/access-florida-food-medical-assistance-cash> (last visited March 15, 2013).

¹⁴ See State of Florida, Florida KidCare Program, Title XXI State Child Health Insurance Plan, Amendment #22, July 1, 2012, pp.98-101., <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Childrens-Health-Insurance-Program-CHIP/Downloads/CHIP-SPAs/FL-CSPA-22-FINAL.pdf> (last visited: Mar. 17, 2013).

¹⁵ Agency for Health Care Administration, *Medikids Publications*, <http://www.fdhc.state.fl.us/medicaid/medikids/publications.shtml>, (last visited: Mar. 15, 2013).

¹⁶ See Conference Report on HB 5001, 2012-2013 General Appropriations Act, Proviso for Line Item 162. (<http://www.flsenate.gov/Session/Bill/2012/5001/Amendment/657521/PDF>) (last visited Mar. 15, 2013).

During the 2012 Legislature, the DCF was directed to collaborate with the AHCA to develop an internet-based system for eligibility determination for Medicaid and CHIP.¹⁷ The Legislature provided DCF with specific business and functional requirements for the project and timeframes for project completion.¹⁸

The following chart reflects current roles and responsibilities of the agencies and the FHKC:

Agency for Health Care Administration	Department of Children and Families	Department of Health	Florida Healthy Kids Corporation
Medicaid program and policy	Medicaid eligibility determination	Oversight of the Children’s Medical Services Network program	Oversight of the Florida Healthy Kids Program
Lead state agency for Title XIX and XXI Compliance and federal funding	Manage B-NET program – specialized behavioral health care program	KidCare Coordinating Council	Conduct Title XXI (CHIP) eligibility and administration
Oversight of the Medikids program		Develop Quality Assurance Standards	Conduct Kidcare Outreach and Marketing
Monitor quality assurance standards			
Maintain Kidcare Grievance Process			

The Florida Kidcare Coordinating Council falls under the responsibility of the DOH; the secretary of the DOH chairs the Council. The Coordinating Council is specifically created under s. 409.818(2)(b), F.S., and is charged with making recommendations concerning the implementation and operation of the program. The Council includes representatives from the partner agencies and stakeholder representatives from the insurance industry, consumers, and providers. For 2013, the Council developed a single priority state recommendation: “To fully fund the Florida Kidcare program, including its annualization and medical trend needs, projected growth, outreach and increased medical and dental costs in order to maximize the use of Florida’s CHIP federal funds and include all eligible uninsured children.”¹⁹

The Florida Healthy Kids Program is authorized under s. 624.91, F.S., which is also known as the “William G. ‘Doc’ Myers Healthy Kids Corporation Act.” The Florida Healthy Kids Corporation (FHKC) was created as a private, not-for-profit corporation by the 1990 Florida Legislature in an effort to increase access to health insurance for school-aged children.²⁰

¹⁷ s. 409.902(3), F.S.

¹⁸ ss. 409.902(4) and (5), F.S.

¹⁹ Florida KidCare Website, KidCare Coordinating Council, *2013 Recommendations*, http://www.floridakidcare.org/council/reports/2013_Recommendations.pdf (last visited Mar. 17, 2013).

²⁰ Florida Healthy Kids Corporation, *History*, <https://www.healthykids.org/healthykids/history/> (last visited Mar. 15, 2013).

Eligibility for the state-funded assistance is prescribed under s. 624.91(3), F.S., and provides cross references to the Florida Kidcare Act. The Healthy Kids program is also identified as a non-entitlement program under subsection (4).

Under s. 624.91(5), F.S., the FHKC is managed by an executive director selected by the board with the number of staff determined by the board. The FHKC is authorized to:

- Collect contributions from families, local sources or employer based premiums;
- Accept voluntary local match for Title XXI and Title XXI;
- Accept supplemental local match for Title XXI;
- Establish administrative and accounting procedures;
- Establish preventive health standards for children that do not limit participation to pediatricians in rural areas with consultation from appropriate experts;
- Determine eligibility for children seeking enrollment in Title XXI funded and non-Title XXI components;
- Establish grievance processes;
- Establish participation criteria for administrative services for the corporation;
- Establish enrollment criteria that include penalties or waiting periods for non-payment of premiums of 30 days;
- Contract with authorized insurers and other health care providers meeting standards established by the corporation for the delivery of services and select health plans through a competitive bid process;
- Purchase goods and services in a cost effective manner with a minimum medical loss ratio of 85 percent for health plan contracts;
- Establish disenrollment criteria for insufficient funding levels;
- Develop a plan to publicize the program;
- Secure staff and the necessary funds to administer the program;
- Provide an annual Kidcare report, in consultation with partner agencies, to the governor, chief financial officer, commissioner of education, president of the Senate, speaker of the House of Representatives, and minority leaders of the Senate and House of Representatives;
- Provide quarterly enrollment information on the full pay population; and,
- Establish benefit packages that conform to the Florida Kidcare benchmark benefit.

The FHKC is governed by a 13-member board of directors, chaired by Florida's chief financial officer or his or her designee.²¹ The 12 other board members are:

- Secretary of the AHCA;
- One member appointed by the commissioner of education from the Office of School Health Programs from the Department of Education;
- One member, appointed by the chief financial officer from among three members nominated by the Florida Pediatric Society;
- One member, appointed by the governor, who represents the Children's Medical Services Program;

²¹ See s. 624.91(6), F.S.

- One member appointed by the chief financial officer from among three members nominated by the Florida Hospital Association;
- One member, appointed by the governor, who is an expert on child health policy;
- One member, appointed by the chief financial officer, from among three members nominated by the Florida Academy of Family Physicians;
- One member, appointed by the governor, who represents the state Medicaid program;
- One member, appointed by the chief financial officer, from among three members nominated by the Florida Association of Counties;
- The state health officer or his or her designee;
- The secretary of the DCF, or his or her designee; and,
- One member, appointed by the governor, from among three members nominated by the Florida Dental Association.

Board members do not receive compensation for their service but may receive reimbursement for per diem and travel expenses in accordance with s. 112.061, F.S.²²

The FHKC is not an insurer and is not subject to the licensing requirements of the Department of Financial Services. In addition, the FHKC board is also granted complete fiscal control over the corporation and responsibility for all fiscal operations. Any liquidation of the FHKC would be supervised by the Department of Financial Services.²³

The Patient Protection and Affordable Care Act of 2010

In March 2010, the Congress passed and the President signed the PPACA.²⁴ Under PPACA, one of the key components required the states to expand Medicaid to a minimum national eligibility threshold of 133 percent of the FPL, or, as it is sometimes expressed, 138 percent of the FPL with application of an automatic five percent income disregard, effective January 1, 2014.²⁵ While the funding for the newly eligible under this expansion would be initially funded at 100 percent federal funds for the first 3 calendar years, the states would gradually be required to pay a share of the costs, starting at 5 percent in calendar year 2017 before leveling off at 10 percent in 2020.²⁶ As enacted, PPACA provided that states refusing to expand to the new national eligibility threshold faced the loss of *all* of their federal Medicaid funding.²⁷

Florida, along with 25 other states challenged the constitutionality of the law. In *NFIB v. Sebelius*, the Supreme Court found the enforcement provisions of the Medicaid expansion unconstitutional.²⁸ As a result, states can voluntarily expand their Medicaid eligibility thresholds

²² See s. 624.91(5), F.S.

²³ See s. 624.91(7), F.S.

²⁴ Pub. Law No. 111-148, H.R. 3590, 111th Cong. (Mar. 23, 2010).

²⁵ 42 U.S.C. s. 1396a(1).

²⁶ 42 U.S.C. s. 1396d(y)(1).

²⁷ 42 U.S.C. s. a1396c

²⁸ See *supra* note 1.

to PPACA standards and receive the enhanced federal match for the expansion population, but states cannot be penalized for not doing so.²⁹

Since the decision in *NFIB v. Sebelius*, federal guidance has emphasized state flexibility in how states expand coverage to those defined as the newly eligible population. In a letter to the National Governors Association January 14, 2013, Health and Human Services Secretary Kathleen Sebelius reminded states of their ability to design flexible benefit packages without the need for waivers and the alternative benefit plans that are available.³⁰ This letter was preceded by the Frequently Asked Questions document on Exchange, Market Reforms and Medicaid, issued on December 10, 2012, that discussed promotion of personal responsibility wellness benefits and state flexibility to design benefits.³¹

A state Medicaid director letter on November 20, 2012 (ACA #21) further addressed state options for the adult Medicaid expansion group and the alternative benefit plans available under Section 1937 of the Social Security Act.³² Under Section 1937, state Medicaid programs have the option of providing certain groups with benchmark or benchmark equivalent coverage based on four products: (1) the standard Blue Cross/Blue Shield Preferred Provider option offered to federal employees; (2) state employee coverage that is generally offered to all state employees; (3) the commercial HMO with the largest insured, non-Medicaid enrollment in the state or (4) Secretary-approved coverage.³³ For children under the age of 21, the coverage must include the Early and Periodic Screening, Diagnostic and Treatment Service (EPSDT). Other aspects of the essential health benefit requirements of PPACA, as discussed further below, may also be applicable, depending on the benefit package utilized.

In addition to the Medicaid expansion component, the PPACA imposes a mandate on individuals to acquire health insurance or pay a penalty, which was interpreted by the U.S. Supreme Court as a tax. Currently, many uninsured individuals are eligible for Medicaid or Kidcare coverage but are not enrolled. The existence of the federal mandate to purchase insurance may result in an unknown number of currently eligible individuals coming forward and enrolling Medicaid who had not previously chosen to enroll. Their participation – to the extent it occurs – will result in increased costs that the state would not likely have incurred without the catalyst of the federal legislation.

To facilitate coverage, PPACA authorized the state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges. These exchanges are to be administered by governmental agencies or non-profit organizations and be ready to accept

²⁹ Department of Health and Human Services, *Secretary Sebelius Letter to Governors, July 10, 2012*, <http://capsules.kaiserhealthnews.org/wp-content/uploads/2012/07/Secretary-Sebelius-Letter-to-the-Governors-071012.pdf> (last visited Mar. 16, 2013).

³⁰ *Letter to National Governor's Association from Secretary Sebelius*, January 14, 2013 (copy on file with Senate Health Policy Committee).

³¹ Centers for Medicare and Medicaid Services, *Frequently Asked Questions on Exchanges, Market Reforms and Medicaid*, (December 10, 2012), <http://cciio.cms.gov/resources/factsheets/index.html>, pp. 15-16, (last visited Mar. 17, 2013).

³² Centers for Medicare and Medicaid Services, *State Medicaid Director Letter: Essential Health Benefits in the Medicaid Program* (November 20, 2012), <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-003.pdf> (last visited Mar. 17, 2013).

³³ See *supra* note 30 at 2.

applications for coverage beginning October 1, 2013, for January 1, 2014, coverage dates. The exchanges, at a minimum, must:³⁴

- Certify, re-certify and de-certify plans participating on the exchange;
- Operate a toll-free hotline;
- Maintain a website;
- Provide plan information and plan benefit options;
- Interact with the state's Medicaid and CHIP programs and provide information on eligibility and determination of eligibility for these programs;
- Certify individuals that gain exemptions from the individual responsibility requirement; and,
- Establish a navigator program.

The initial guidance from HHS in November 2010 set forward a number of principles and priorities for the exchanges. Further guidance was issued on May 16, 2012, detailing the proposed operations of a federally-facilitated exchange for those states that elect not to implement a state-based exchange. On November 16, 2012, Florida Governor Rick Scott notified HHS Secretary Sebelius that Florida had too many unanswered questions to commit to a state-based exchange under PPACA for the first enrollment period on January 1, 2014.³⁵

PPACA also includes a tax penalty for those individuals that do not have qualifying health insurance coverage beginning January 1, 2014. The penalty is the greater of \$695 per year up to a maximum of three times that amount per family or 2.5% of household income. The penalty, however, is phased-in and exemptions apply.

The following persons are exempt from the PPACA's requirement to maintain coverage:³⁶

- Individuals with a religious objection;
- individuals not lawfully present; and
- Incarcerated individuals.

The following persons are exempt from the PPACA's penalty for failure to maintain coverage:³⁷

- Individuals who cannot afford coverage, i.e. those whose required premium contributions exceed eight percent of household income;
- Individuals with income below the income tax filing threshold;
- American Indians;
- Individuals without coverage for less than three months; and

³⁴Centers for Medicare and Medicaid Services, Initial Guidance to States on Exchanges, November 18, 2010, http://ccio.cms.gov/resources/files/guidance_to_states_on_exchanges.html (last visited Mar. 16, 2013).

³⁵Letter from Governor Rick Scott to Health and Human Services Secretary Kathleen Sebelius, November 16, 2012 <http://www.flgov.com/2012/11/16/letter-from-governor-rick-scott-to-u-s-secretary-of-health-and-human-services-kathleen-sebelius/> (last visited Mar. 16, 2013).

³⁶See Sec. 5000A(d), Internal Revenue Code of 1986, as created or amended by the Patient Protection and Affordable Care Act of 2010 and/or the Health Care and Education Reconciliation Act of 2010.

³⁷See Sec. 5000A(e), Internal Revenue Code of 1986, as created or amended by the Patient Protection and Affordable Care Act of 2010 and/or the Health Care and Education Reconciliation Act of 2010.

- Individuals determined by the HHS secretary to have suffered a hardship with respect to the capability to obtain coverage under a qualified plan.

Qualifying coverage may be obtained through an employer, the federal or state exchanges created under PPACA, or private individual or group coverage meeting the minimum essential benefits coverage standard.

Employers with more than 50 full time employees also share a financial responsibility under PPACA. Employers with more than 50 full-time employees that do not offer coverage meeting the essential benefits coverage standard and who have at least one employee receive a premium tax credit will be assessed a fee of \$2,000 per full time employee, after the 30th employee.³⁸ If an employer does offer coverage and an employee receives a premium tax credit, the employer is assessed the lesser of \$3,000 per employee receiving the credit or \$2,000 per each employee after the 30th employee.³⁹

Premium credits and other cost sharing subsidies are available to United States citizens and legal immigrants within certain income limits for coverage purchased through the exchanges. Legal immigrants with incomes at or below 100 percent of the FPL who are not eligible for Medicaid during their first five years are eligible for premium credits.⁴⁰ Premium credits are set on a sliding scale based on the percent of FPL for the household and reduce the out-of-pocket costs incurred by individuals and families.

The amount for premium tax credits, as a percentage of income, are set in section 36B of the Internal Revenue Code follows:⁴¹

Premium Tax Credits	
Income Range	Premium Percentage Range (% of income)
Up to 133% FPL	2%
133% to 150%	3% - 4%
150% to 200%	4% - 6.3%
200% to 250%	6.3% - 8.05%
250% to 300%	8.05% - 9.5%
300% to 400%	9.5%

Subsidies for cost sharing are also applicable for those between 100 percent of the FPL and 400 percent of the FPL. The cost sharing credits reduce the out-of-pocket amounts incurred by individuals on essential health benefits and will also impact the actuarial value of a health plan.⁴²

³⁸ Kaiser Family Foundation, *Summary of New Health Reform Law*, Last Modified April 15, 2011, <http://www.kff.org/healthreform/upload/8061.pdf> (last viewed Mar. 16, 2013).

³⁹ Kaiser Family Foundation, *Summary of New Health Reform Law*, Last Modified April 15, 2011, <http://www.kff.org/healthreform/upload/8061.pdf> (last viewed Mar. 16, 2013).

⁴⁰ 26 U.S.C. s. 36B(c).

⁴¹ 26 U.S.C. s. 36B(c).

⁴² Kaiser Family Foundation, *Summary of New Health Reform Law*, Last Modified April 15, 2011, <http://www.kff.org/healthreform/upload/8061.pdf> (last viewed Mar. 16, 2013).

Actuarial value reflects the average share of covered benefits paid by the insurer or health plan.⁴³ For example, if the actuarial value of a plan is 90 percent, the health plan is paying 90 percent of the costs and the enrollee 10 percent. Under the PPACA, the maximum amount of cost sharing under this component range from 94 percent for those between 100 percent to 150 percent of the FPL, to 70 percent for those between 250 percent and 400 percent of the FPL.⁴⁴

III. Effect of Proposed Changes:

Section 1 amends s. 409.811, F.S. adding, deleting, and modifying definitions relating to the Florida Kidcare Act. Definitions applicable to the overall Act, which is identified as ss. 409.810 through 409.821, F.S., are updated or added to align with requirements under PPACA:

- CHIP (Children’s Health Insurance Program)
- Combined Eligibility Notice
- Household Income
- Modified Adjusted Gross Income (MAGI)
- Patient Protection and Affordable Care Act (Act)

Other definitions under this section are deleted as obsolete if related to the employer-sponsored component of the Florida Kidcare program. This program component was never implemented and is deleted under this bill. Definitions that have been modified or rendered obsolete by PPACA have also been deleted.

Section 2 amends s. 409.813, F.S., relating to the program components of the Florida Kidcare program. The bill also adds the FHKC to the list of entities for which a cause of action cannot be brought if coverage is not provided under the non-entitlement portion of the program. The FHKC is the only Kidcare component excluded.

Section 3 amends s. 409.8132, F.S., relating to the Medikids program component of the Florida Kidcare program. The bill deletes language permitting a Medikids enrollee who is a younger sibling of a Healthy Kids enrollee, to enroll in a Healthy Kids plan. An obsolete reference to receiving approval from the predecessor agency to the Centers for Medicare and Medicaid Services for MediPass coverage authorization is removed. The MediPass option in Medikids has been approved since the program was implemented in 1998.

Section 4 makes technical changes to s. 409.8134, F.S., relating to program expenditures and enrollment in the Florida Kidcare program.

Section 5 amends section s. 409.814, F.S., relating to eligibility for the Florida Kidcare program. The bill modifies references to align with changes under PPACA. Obsolete references related to the employer-sponsored component have been deleted. An option has been provided to Medicaid

⁴³ Lisa Bowen Garrett, et al., The Urban Institute, *Premium and Cost Sharing Subsidies under Health Reform: Implications for Coverage, Costs and Affordability* (December 2009), http://www.urban.org/UploadedPDF/411992_health_reform.pdf (last visited Mar. 16, 2013).

⁴⁴ Kaiser Family Foundation, *Summary of New Health Reform Law*, Last Modified April 15, 2011, <http://www.kff.org/healthreform/upload/8061.pdf> (last viewed Mar. 16, 2013).

enrollees to elect coverage under the CHIP component and permit a transfer back to Medicaid at any time without a break in coverage.

Under s. 409.814(6)(c), F.S., the FHKC is directed to notify full pay enrollees of the availability of coverage under the exchanges, as created under PPACA. No new applications for full-pay or non-subsidized coverage are permitted after September 30, 2013.

Modifications to the eligibility determination process are made under s. 409.814(8), F.S., to reflect changes in the eligibility process under PPACA and the role of the federal data hub.

Section 6 amends s. 409.815, F.S., relating to the benefits under the Florida Kidcare program. Obsolete dates and references are deleted under certain benefits.

Section 7 amends s. 409.816, F.S., relating to lifetime benefits on premiums and limitations on cost sharing. References to “family,” “family income,” and “modified adjusted income” are updated to align with federal definitions under PPACA.

Section 8 repeals s. 409.817, F.S., relating to approval of health benefits, coverage, and financial assistance. The other requirements of this section have been preempted under PPACA.

Section 9 repeals s. 409.8175, F.S., relating to the delivery of services in rural counties. Health maintenance organizations and health insurers may contract with providers in accordance with any fee schedule that may be agreed upon by the parties. The language under this section is permissive and not mandatory under current law.

Section 10 amends s. 409.8177, F.S., relating to evaluation of the Florida Kidcare program. A reference to family income is updated to household income to align with PPACA.

Section 11 amends s. 409.818, F.S., relating to the administration of the Florida Kidcare program. The duties and responsibilities of the DCF are modified to recognize the modernization efforts and process changes under PPACA. The department is required to develop a combined eligibility notice, in consultation with the AHCA and the FHKC. A reference to a centralized coordinating office is deleted.

Specific administrative responsibilities for the Florida Kidcare program for the DOH are deleted. Obsolete provisions for designing the eligibility intake process are removed, as is the requirement for the DOH to establish a toll-free hotline. The FHKC provides customer service for the Florida Kidcare program, including operation of the toll-free hotline, under its Florida Kidcare eligibility determination responsibilities.

The responsibilities for the AHCA under this section are modified to reflect the removal of the employer-sponsored component and accompanying deletion of the OIR involvement. Technical references to a more general definition of managed care organizations rather than the more limited term of HMOs are made in this section. References to specific topics for rulemaking are deleted. A direction to contract with the corporation for the Healthy Kids program and the Healthy Florida program is added. Direction to the AHCA for Healthy Kids has been included annually in proviso or implementing bill language in the past.

Responsibilities under the Florida Kidcare program for the OIR have been deleted. Their removal reflects the deletion of the employer sponsored component from the program.

Section 12 amends s. 409.820, F.S., relating to the quality assurance and access standards for the Florida Kidcare program. The quality assurance and access standards are clarified to show that such standards are for the pediatric and adolescent populations.

Section 13 amends s. 624.91, F.S., relating to the FHKC. The legislative intent for the Florida Healthy Kids Corporation Act is expanded to include a new program called “Healthy Florida.” The legislative intent states that Healthy Florida will cover uninsured adults utilizing a unique network of providers and contracts through which enrollees will receive a comprehensive set of benefits and services.

The Florida Healthy Kids Corporation Act is modified in several subsections to reflect the addition of the Healthy Florida program. Cross references are added to the Florida Kidcare program and the Florida Medicaid program, as appropriate.

Section 624.91(5)(b), F.S., is amended to incorporate the Healthy Florida program and to align with changes made to the Florida Kidcare Act.

Provisions under s. 624.91(5)(b)10., F.S., are separated into individual sub-subparagraphs by topic. No substantive change is made in sub-subparagraphs a. and b. The medical loss ratio requirement for the Healthy Kids program is modified under sub-subparagraph c. to include all health care contracts and language relating to the exemption of dental contracts is deleted. Clarification on how the calculations for the medical loss ratios will be computed is added and a cross reference to federal guidelines for classification of funds is included.

Under s. 624.91(5)(b)12., F.S., the corporation’s responsibility for the development of a plan for publicity of the Florida Kidcare program, public awareness, eligibility procedures, and requirements and to maintain public awareness is expanded to include both the Florida Kidcare program and the Healthy Florida program.

Requirements for separate reporting on the full-pay program by the FHKC are repealed effective December 31, 2013. The repeal aligns with the closure of new enrollment in the full-pay program effective September 30, 2013, and the availability of the exchange on January 1, 2014. A new subparagraph 16 requires the corporation to notify existing full-pay enrollees of the availability of the exchange and how to access services. No new applications for full-pay coverage may be accepted after September 30, 2013.

Amendments to s. 624.91(5)(d), F.S., provides that the corporation and any committees formed by the corporation are subject to the conflict of interest provisions of ch. 112, F.S., the public records provisions of ch. 119, F.S., and the public meeting requirements of ch. 286, F.S.

The membership of the FHKC board of directors is changed to require that the chair of the board be appointed by the governor, rather than the chief financial officer or his or her designee. The specific membership and nominating guidelines for the 12 other members of the FHKC board are repealed and replaced with a board of 12 members appointed by the governor, with confirmation

by the Senate for the chair and members. Members of the board will serve three-year terms at the pleasure of the governor. A provision is also included that any current board member serving at the time of enactment may remain until July 1, 2013, to provide the governor time to appoint a new board after the enactment of the law.

An executive steering committee of agency secretaries is created to provide management direction and support to the board and its programs. The steering committee comprises the secretary of the AHCA, the secretary of the DCF, and the state surgeon general.

Section 14 repeals s. 624.915, F.S., relating to the Florida Healthy Kids Corporation Operating Fund. This language is obsolete and the option is not being utilized by the corporation.

Section 15 creates a new section of statute, s. 624.917, F.S., relating to the Healthy Florida program. Healthy Florida will be administered by the FHKC as a program for lower income, uninsured adults who meet eligibility guidelines established by the corporation. Definitions are provided that are specific to the Healthy Florida program under s. 624.917(2), F.S.

Eligibility for the Healthy Florida program is prescribed under s. 624.917(3), F.S. To be eligible and remain eligible, an individual must be a Florida resident and meet the definition of being “newly eligible” under PPACA, maintain their eligibility with the corporation, and meet any renewal requirements to renew their coverage at least annually.

Under s. 624.917(4), F.S., enrollment may begin on October 1, 2013, with coverage effective no earlier than January 1, 2014. Enrollment in the program may occur through a third party administrator, referrals from other agencies, or through the exchange, as defined under PPACA. When an enrollee leaves the program, the FHKC is required to provide information about other insurance affordability options that may be available.

Delivery of services under Healthy Florida is provided for under s. 624.917(5), F.S. The FHKC is directed to contract with authorized insurers licensed under ch. 627, F.S., or managed care organizations under ch. 624, F.S., meeting standards established by the corporation to deliver services to enrollees. The FHKC must also establish access and network standards to ensure an adequate number of providers are available to deliver the benefits and services. Standards are to be developed in consultation with and under consideration of National Committee on Quality Assurance recommendations, stakeholders, and other existing performance standards for public and commercial populations.

Under this subsection, enrollees must also be provided a choice of plans. A lock-in period is specifically included and the corporation is directed to offer exceptions to that lock-in period that take into consideration good cause reasons and qualifying events.

The bill permits the FHKC to consider contracts that include family plans that would provide coverage for members that are enrolled across multiple state or federally funded programs. The medical loss ratio provisions of s. 624.91, F.S., are applicable to the Healthy Florida program. These provisions mirror those used for the Healthy Kids contracts.

Under s. 624.917(6), F.S., the bill provides the benefits for the Healthy Florida program. The FHKC is directed to establish a benefit plan for the program that is actuarially equivalent to the Florida Kidcare benchmark plan, excluding dental. The benefits package must also meet the alternative benefits package requirements under section 1937 of the Social Security Act. Benefits must be offered as an integrated, single package, without carve-outs.

The bill also requires that a health reimbursement account or comparable health savings account be established for Healthy Florida enrollees. The account may be established and managed either by the FHKC directly or by a contractor. Under s. 624.917(6)(a), F.S., the bill provides examples of the types of behaviors for which enrollees may be rewarded and how funds may be utilized by enrollees. Paragraph (b) of this same subsection also permits the offering of other enhanced benefits and services, provided these services generate savings to the overall plan. Paragraph (c) requires the FHKC to establish a process for the delivery of medically necessary wrap-around services that are not covered by the benchmark plan but that may be required under PPACA. The corporation's capitation process with its contracted plans for the wrap-around services will be subject to a separate reconciliation process, and the medical loss ratio provisions will also apply to the wrap-around capitation. Prior authorization processes and other utilization controls for any benefit are authorized under this subsection, if approved by the corporation.

Under s. 624.917(7), F.S., the bill establishes requirements for cost sharing under the Healthy Florida program. The FHKC is authorized to collect premiums and copayments from enrollees in accordance with federal law and in amounts that will be established annually in the General Appropriations Act. The bill provides that payment of a monthly premium may be required prior to an enrollee receiving a coverage start date under the program. Enrollees may also be required to make copayments as a condition of receiving a health care service. Providers will be responsible for collecting any copayment for a service and failure to collect any amount due from the enrollee will reduce the provider's reimbursement by the uncollected enrollee's copayment amount.

Management of the Healthy Florida program is described under s. 624.917(8), F.S. The FHKC is designated as the entity responsible for the oversight of the program. The AHCA is directed to seek the necessary state plan amendment to implement the program and to consult with the FHKC on the development of the amendment. The bill provides an amendment submission deadline by the AHCA of June 14, 2013. The AHCA is also directed under this subsection to contract with the FHKC for the administration of this program and for the purposes of the timely release of state and federal funds. The AHCA is recognized as the state's single entity for the administration of the Medicaid program.

Under s. 624.917(8)(a), F.S., the FHKC is directed to establish a grievance and resolutions process under which Healthy Florida recipients can be notified of their rights under the Medicaid Fair Hearing process as well as of any other processes that may be adopted by the corporation for the program.

Under paragraph (b), the corporation is required to establish a program integrity process to ensure compliance with the program's guidelines and to combat applicant and enrollee fraud. Timelines for the notification of when benefits may be withheld, reasons for loss of benefits, and

the identification of individuals who can be prosecuted for fraud under s. 414.39, F.S., are specified.

Cross references to the applicability of certain Medicaid statutes to the Healthy Florida program are included under s. 624.917(9), F.S. The referenced statutes are s. 409.902, F.S., relating to the AHCA as the designated single state agency for Medicaid; s. 409.9128, F.S., relating to providing emergency services and care; and, s. 409.920, F.S., relating to Medicaid provider fraud. These provisions would apply to the Healthy Florida program in the same manner in which they apply in Medicaid.

The requirement for an evaluation of the Healthy Florida program is added under s. 624.917(10), F.S. The FHKC is required to collect eligibility and enrollment data on its applicants and enrollees and utilization and encounter data from its contracted entities for health care services. Monthly enrollment reports to the Legislature are also required. The bill provides for an interim evaluation by July 1, 2015, with annual evaluations thereafter. Components of the evaluation report are detailed and include information on application and enrollment trends, utilization and cost data, and customer satisfaction.

Section 624.917(11), F.S., sets an expiration date for the program for the end of the state fiscal year in which any of several conditions happen, whichever occurs first. The trigger events are identified as the federal match falling below 90 percent; the federal match contribution falling below the “Increased FMAP for Medical Assistance for Newly Eligible Mandatory Individuals” as specified under PPACA; or a blended federal match formula for Healthy Florida and the Medicaid program is enacted under federal law or regulation which causes the overall federal contribution to be reduced compared to separate, non-blended federal contributions under the status quo.

Section 16 creates an undesignated section of law that authorizes the FHKC to make program changes to comply with objections raised by HHS that are necessary to gain approval of the Healthy Florida program in compliance with PPACA, upon giving notice to the Legislature of the proposed changes. The Healthy Florida program requires approval of an amendment to the state’s Medicaid state plan prior to implementation and to receive federal funds. The section also includes a conflict of laws interpretation clause that provides that if there is conflict between any provision in this section and PPACA, the provision should be interpreted as an intention to comply with federal requirements.

Section 17 provides that the act takes effect upon becoming law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

The bill explicitly requires the Florida Healthy Kids Corporation to conduct its activities and those of any committees formed by the corporation, in accordance with chapters 119

and 286, F.S. The FHKC currently provides notice of meetings of its board and committees on its website at www.healthykids.org and posts materials for board meetings on the same site within timeframes set through board policy.

The FHKC also responds to requests for public records, within the additional exemptions and limitations of s. 409.821, F.S. and federal law which protect certain individual and identifying information of applicants and enrollees to the Florida Kidcare program.

The provisions of this bill would expressly require compliance with state public records and open meetings requirements.

C. Trust Funds Restrictions:

None.

D. Other Constitutional Issues:

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Florida's Social Services Estimating Conference (SSEC) estimates that 438,113 individuals would become newly eligible and would enroll in Florida Medicaid during the 2013-2014 state fiscal year if the program's eligibility threshold were expanded to 138 percent of FPL beginning January 1, 2014. An estimated 377,813 of those newly eligible enrollees are currently uninsured while the remaining 60,300 are likely to terminate their existing individual coverage in favor of Medicaid after becoming eligible. The Healthy Florida program would expect roughly the same estimated enrollment if implemented.

The bill contemplates the corporation contracting with insurers and managed care organizations to deliver comprehensive health insurance coverage to uninsured individuals who may or may not be seeking health care services now. Physicians, hospitals, and other health care providers may be impacted by a potentially higher demand for their services after Healthy Florida is implemented.

C. Government Sector Impact:

The bill directs the AHCA to seek the PPACA's enhanced federal match for the Healthy Florida program, which would result in 100 percent federal funding for newly eligible enrollees until January 1, 2017. To cover the estimated 438,113 new enrollees in Fiscal Year 2013-2014, \$1.26 billion would be expended, according to the SSEC.

Additionally, under eligibility expansion, the SSEC estimates that 70,647 Kidcare enrollees would become newly eligible for Medicaid and could transfer out of Kidcare. In such a transfer, the federal match would be the same as the Kidcare matching rate, which is 71.03 percent for the 2013-2014 state fiscal year. The state and federal expenditures to cover those children would be the same between the two programs.

The PPACA also imposes a federal health insurance tax (HIT) on health insurance providers beginning January 1, 2014, to be divided among insurers according to a formula based on each insurer's net premiums, including those contracted under Medicaid or Healthy Florida. Federal guidance indicates that states must account for the HIT to be incurred by managed care plans when calculating rates paid by a state Medicaid program to the plans. For the newly eligible population, the federal match for the HIT mirrors the match provided in the PPACA, which means a 100 percent federal match for the HIT during the 2013-2014 state fiscal year. For Kidcare transfers, however, the federal match will mirror the Kidcare matching rate. If all 70,647 children described above were to transfer from Kidcare to Healthy Florida, an estimated \$254,151 GR would be required to compensate insurers and managed care plans for the HIT in the 2013-2014 state fiscal year.

The FHKC will need additional resources to adapt its existing eligibility and enrollment systems to accommodate a new program. Also, the FHKC will need to adjust and expand its administrative structure and professional staff to manage new contracts for the Healthy Florida program. Additionally, these needs will vary somewhat depending on the number of persons who enroll in the Healthy Florida program. Based on existing enrollment projections, the fiscal impact of the FHKC's additional resource needs is estimated to be a total of \$21.2 million for the 2013-2014 state fiscal year, half of which would be state funds, or \$10.6 million GR.

VI. Technical Deficiencies:

None.

VII. Related Issues:

In December 2012, Florida Senate President Don Gaetz formed the Select Committee on the PPACA to launch a comprehensive assessment on the impact of the law on Florida, evaluate the state's options under the law, and to make recommendations to the full Senate membership on any actions necessary to mitigate cost increases, preserve a competitive insurance market, and protect Florida's consumers.⁴⁵ The Select Committee received public testimony, expert presentations, and staff reports over nine meetings before it developed three specific recommendations relating to the development of a health care exchange, coverage for certain state employees, and the expansion of Medicaid. On the question of Medicaid expansion, the

⁴⁵ See Florida Senate, *Patient Protection and Affordable Care Act*, <http://www.flsenate.gov/topics/ppaca> (last visited: April 1, 2013).

Select Committee voted 7-4 to recommend to the full Senate to not expand the existing Medicaid program under the current state plan or pending waivers.⁴⁶

VIII. Additional Information:

- A. **Committee Substitute – Statement of Substantial Changes:**
(Summarizing differences between the Committee Substitute and the prior version of the bill.)
- None.
- B. **Amendments:**
- None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

⁴⁶ Florida Senate Select Committee on Patient Protection and Affordable Care Act, *Letter to Senate President Don Gaetz on Medicaid Recommendation* <http://www.flsenate.gov/usercontent/topics/ppaca/03-12-13MedicaidRecommendation.pdf> (last visited: April 1, 2013).

By the Committee on Appropriations

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1 A bill to be entitled
 2 An act relating to health care; amending s. 409.811,
 3 F.S.; revising and providing definitions; amending s.
 4 409.813, F.S.; revising the components of the Florida
 5 Kidcare program; prohibiting a cause of action from
 6 arising against the Florida Healthy Kids Corporation
 7 for failure to make health services available;
 8 amending s. 409.8132, F.S.; revising the eligibility
 9 of the Medikids program component; revising the
 10 enrollment requirements of the Medikids program
 11 component; amending s. 409.8134, F.S.; conforming
 12 provisions to changes made by the act; amending s.
 13 409.814, F.S.; revising eligibility requirements for
 14 the Florida Kidcare program; amending s. 409.815,
 15 F.S.; revising the minimum health benefits coverage
 16 under the Florida Kidcare Act; deleting obsolete
 17 provisions; amending ss. 409.816 and 409.8177, F.S.;
 18 conforming provisions to changes made by the act;
 19 repealing s. 409.817, F.S., relating to the approval
 20 of health benefits coverage and financial assistance;
 21 repealing s. 409.8175, F.S., relating to delivery of
 22 services in rural counties; amending s. 409.818, F.S.;
 23 revising the duties of the Department of Children and
 24 Families and the Agency for Health Care Administration
 25 with regard to the Florida Kidcare Act; deleting the
 26 duties of the Department of Health and the Office of
 27 Insurance Regulation with regard to the Florida
 28 Kidcare Act; amending s. 409.820, F.S.; requiring the
 29 Department of Health, in consultation with the agency

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

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30 and the Florida Healthy Kids Corporation, to develop a
 31 minimum set of pediatric and adolescent quality
 32 assurance and access standards for all program
 33 components; amending s. 624.91, F.S.; revising the
 34 legislative intent of the Florida Healthy Kids
 35 Corporation Act to include the Healthy Florida
 36 program; revising participation guidelines for
 37 nonsubsidized enrollees in the Healthy Kids program;
 38 revising the medical loss ratio requirements for the
 39 contracts for the Florida Healthy Kids Corporation;
 40 modifying the membership of the Florida Healthy Kids
 41 Corporation's board of directors; creating an
 42 executive steering committee; requiring additional
 43 corporate compliance requirements for the Florida
 44 Healthy Kids Corporation; repealing s. 624.915, F.S.,
 45 relating to the operating fund of the Florida Healthy
 46 Kids Corporation; creating s. 624.917, F.S.; creating
 47 the Healthy Florida program; providing definitions;
 48 providing eligibility and enrollment requirements;
 49 authorizing the Florida Healthy Kids Corporation to
 50 contract with certain insurers; requiring the
 51 corporation to establish a benefits package and a
 52 process for payment of services; authorizing the
 53 corporation to collect premiums and copayments;
 54 requiring the corporation to oversee the Healthy
 55 Florida program and to establish a grievance process
 56 and integrity process; providing applicability of
 57 certain state laws for administration of the Healthy
 58 Florida program; requiring the corporation to collect

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59 certain data and to submit enrollment reports and
 60 interim independent evaluations to the Legislature;
 61 providing for expiration of the program; providing an
 62 implementation and interpretation clause; providing an
 63 effective date.

64
 65 Be It Enacted by the Legislature of the State of Florida:

66
 67 Section 1. Section 409.811, Florida Statutes, is amended to
 68 read:

69 409.811 Definitions relating to Florida Kidcare Act.—As
 70 used in ss. 409.810-409.821, the term:

71 (1) "Actuarially equivalent" means that:

72 (a) The aggregate value of the benefits included in health
 73 benefits coverage is equal to the value of the benefits in the
 74 benchmark benefit plan; and

75 (b) The benefits included in health benefits coverage are
 76 substantially similar to the benefits included in the benchmark
 77 benefit plan, except that preventive health services must be the
 78 same as in the benchmark benefit plan.

79 (2) "Agency" means the Agency for Health Care
 80 Administration.

81 (3) "Applicant" means a parent or guardian of a child or a
 82 child whose disability of nonage has been removed under chapter
 83 743, who applies for determination of eligibility for health
 84 benefits coverage under ss. 409.810-409.821.

85 (4) "Child benchmark benefit plan" means the form and level
 86 of health benefits coverage established in s. 409.815.

87 (5) "Child" means any person younger than ~~under~~ 19 years of

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88 age.

89 (6) "Child with special health care needs" means a child
 90 whose serious or chronic physical or developmental condition
 91 requires extensive preventive and maintenance care beyond that
 92 required by typically healthy children. Health care utilization
 93 by such a child exceeds the statistically expected usage of the
 94 normal child adjusted for chronological age, and such a child
 95 often needs complex care requiring multiple providers,
 96 rehabilitation services, and specialized equipment in a number
 97 of different settings.

98 (7) "Children's Medical Services Network" or "network"
 99 means a statewide managed care service system as defined in s.
 100 391.021(1).

101 (8) "CHIP" means the Children's Health Insurance Program as
 102 authorized under Title XXI of the Social Security Act, and its
 103 regulations, ss. 409.810-409.820, and as administered in this
 104 state by the agency, the department, and the Florida Healthy
 105 Kids Corporation, as appropriate to their respective
 106 responsibilities.

107 (9) "Combined eligibility notice" means an eligibility
 108 notice that informs an applicant, an enrollee, or multiple
 109 family members of a household, when feasible, of eligibility for
 110 each of the insurance affordability programs and enrollment into
 111 a program or exchange plan. A combined eligibility form must be
 112 issued by the last agency or department to make an eligibility,
 113 renewal or denial determination. The form must meet all of the
 114 federal and state law and regulatory requirements no later than
 115 January 1, 2014.

116 ~~(8) "Community rate" means a method used to develop~~

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117 ~~premiums for a health insurance plan that spreads financial risk~~
 118 ~~across a large population and allows adjustments only for age,~~
 119 ~~gender, family composition, and geographic area.~~

120 ~~(10)(9)~~ "Department" means the Department of Health.

121 ~~(11)(10)~~ "Enrollee" means a child who has been determined
 122 eligible for and is receiving coverage under ss. 409.810-
 123 409.821.

124 ~~(11) "Family" means the group or the individuals whose~~
 125 ~~income is considered in determining eligibility for the Florida~~
 126 ~~Kidcare program. The family includes a child with a parent or~~
 127 ~~caretaker relative who resides in the same house or living unit~~
 128 ~~or, in the case of a child whose disability of nonage has been~~
 129 ~~removed under chapter 742, the child. The family may also~~
 130 ~~include other individuals whose income and resources are~~
 131 ~~considered in whole or in part in determining eligibility of the~~
 132 ~~child.~~

133 ~~(12) "Family income" means cash received at periodic~~
 134 ~~intervals from any source, such as wages, benefits,~~
 135 ~~contributions, or rental property. Income also may include any~~
 136 ~~money that would have been counted as income under the Aid to~~
 137 ~~Families with Dependent Children (AFDC) state plan in effect~~
 138 ~~prior to August 22, 1996.~~

139 ~~(12)(13)~~ "Florida Kidcare program," "Kidcare program," or
 140 "program" means the health benefits program administered through
 141 ss. 409.810-409.821.

142 ~~(13)(14)~~ "Guarantee issue" means that health benefits
 143 coverage must be offered to an individual regardless of the
 144 individual's health status, preexisting condition, or claims
 145 history.

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146 ~~(14)(15)~~ "Health benefits coverage" means protection that
 147 provides payment of benefits for covered health care services or
 148 that otherwise provides, either directly or through arrangements
 149 with other persons, covered health care services on a prepaid
 150 per capita basis or on a prepaid aggregate fixed-sum basis.

151 ~~(15)(16)~~ "Health insurance plan" means health benefits
 152 coverage under the following:

153 (a) A health plan offered by any certified health
 154 maintenance organization or authorized health insurer, except a
 155 plan that is limited to the following: a limited benefit,
 156 specified disease, or specified accident; hospital indemnity;
 157 accident only; limited benefit convalescent care; Medicare
 158 supplement; credit disability; dental; vision; long-term care;
 159 disability income; coverage issued as a supplement to another
 160 health plan; workers' compensation liability or other insurance;
 161 or motor vehicle medical payment only; or

162 (b) An employee welfare benefit plan that includes health
 163 benefits established under the Employee Retirement Income
 164 Security Act of 1974, as amended.

165 ~~(16) "Household income" means the group or the individual~~
 166 ~~whose income is considered in determining eligibility for the~~
 167 ~~Florida Kidcare program. The term "household" has the same~~
 168 ~~meaning as provided in s. 36B(d)(2) of the Internal Revenue Code~~
 169 ~~of 1986.~~

170 (17) "Medicaid" means the medical assistance program
 171 authorized by Title XIX of the Social Security Act, and
 172 regulations thereunder, and ss. 409.901-409.920, as administered
 173 in this state by the agency.

174 (18) "Medically necessary" means the use of any medical

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175 treatment, service, equipment, or supply necessary to palliate
 176 the effects of a terminal condition, or to prevent, diagnose,
 177 correct, cure, alleviate, or preclude deterioration of a
 178 condition that threatens life, causes pain or suffering, or
 179 results in illness or infirmity and which is:

180 (a) Consistent with the symptom, diagnosis, and treatment
 181 of the enrollee's condition;

182 (b) Provided in accordance with generally accepted
 183 standards of medical practice;

184 (c) Not primarily intended for the convenience of the
 185 enrollee, the enrollee's family, or the health care provider;

186 (d) The most appropriate level of supply or service for the
 187 diagnosis and treatment of the enrollee's condition; and

188 (e) Approved by the appropriate medical body or health care
 189 specialty involved as effective, appropriate, and essential for
 190 the care and treatment of the enrollee's condition.

191 (19) "Medikids" means a component of the Florida Kidcare
 192 program of medical assistance authorized by Title XXI of the
 193 Social Security Act, and regulations thereunder, and s.
 194 409.8132, as administered in the state by the agency.

195 (20) "Modified adjusted gross income" means the
 196 individual's or household's annual adjusted gross income as
 197 defined in s. 36B(d)(2) of the Internal Revenue Code of 1986
 198 which is used to determine eligibility under the Florida Kidcare
 199 program.

200 (21) "Patient Protection and Affordable Care Act" or "Act"
 201 means the federal law enacted as Pub. L. No. 111-148, as further
 202 amended by the federal Health Care and Education Reconciliation
 203 Act of 2010, Pub. L. No. 111-152, and any amendments,

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204 regulations, or guidance issued under those acts.

205 ~~(22)(20)~~ "Preexisting condition exclusion" means, with
 206 respect to coverage, a limitation or exclusion of benefits
 207 relating to a condition based on the fact that the condition was
 208 present before the date of enrollment for such coverage, whether
 209 or not any medical advice, diagnosis, care, or treatment was
 210 recommended or received before such date.

211 ~~(23)(21)~~ "Premium" means the entire cost of a health
 212 insurance plan, including the administration fee or the risk
 213 assumption charge.

214 ~~(24)(22)~~ "Premium assistance payment" means the monthly
 215 consideration paid by the agency per enrollee in the Florida
 216 Kidcare program towards health insurance premiums.

217 ~~(25)(23)~~ "Qualified alien" means an alien as defined in 8
 218 U.S.C. s. 1641 (b) and (c) e. 431 of the Personal Responsibility
 219 and Work Opportunity Reconciliation Act of 1996, as amended,
 220 Pub. L. No. 104-193.

221 ~~(26)(24)~~ "Resident" means a United States citizen, or
 222 qualified alien, who is domiciled in this state.

223 ~~(27)(25)~~ "Rural county" means a county having a population
 224 density of less than 100 persons per square mile, or a county
 225 defined by the most recent United States Census as rural, in
 226 which there is no prepaid health plan participating in the
 227 Medicaid program as of July 1, 1998.

228 ~~(26) "Substantially similar" means that, with respect to~~
 229 ~~additional services as defined in s. 2103(c)(2) of Title XXI of~~
 230 ~~the Social Security Act, these services must have an actuarial~~
 231 ~~value equal to at least 75 percent of the actuarial value of the~~
 232 ~~coverage for that service in the benchmark benefit plan and,~~

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233 ~~with respect to the basic services as defined in s. 2103(e)(1)~~
 234 ~~of Title XXI of the Social Security Act, these services must be~~
 235 ~~the same as the services in the benchmark benefit plan.~~

236 Section 2. Section 409.813, Florida Statutes, is amended to
 237 read:

238 409.813 Health benefits coverage; program components;
 239 entitlement and nonentitlement.—

240 (1) The Florida Kidcare program includes health benefits
 241 coverage provided to children through the following program
 242 components, which shall be marketed as the Florida Kidcare
 243 program:

244 (a) Medicaid;

245 (b) Medikids as created in s. 409.8132;

246 (c) The Florida Healthy Kids Corporation as created in s.
 247 624.91; and

248 ~~(d) Employer sponsored group health insurance plans~~
 249 ~~approved under ss. 409.810-409.821; and~~

250 (d)(e) The Children's Medical Services network established
 251 in chapter 391.

252 (2) Except for Title XIX-funded Florida Kidcare program
 253 coverage under the Medicaid program, coverage under the Florida
 254 Kidcare program is not an entitlement. No cause of action shall
 255 arise against the state, the department, the Department of
 256 Children and ~~Families Family Services, or~~ the agency, or the
 257 Florida Healthy Kids Corporation for failure to make health
 258 services available to any person under ss. 409.810-409.821.

259 Section 3. Subsections (6) and (7) of section 409.8132,
 260 Florida Statutes, are amended to read:

261 409.8132 Medikids program component.—

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262 (6) ELIGIBILITY.—

263 (a) A child who has attained the age of 1 year but who is
 264 under the age of 5 years is eligible to enroll in the Medikids
 265 program component of the Florida Kidcare program, if the child
 266 is a member of a family that has a family income which exceeds
 267 the Medicaid applicable income level as specified in s. 409.903,
 268 but which is equal to or below 200 percent of the current
 269 federal poverty level. In determining the eligibility of such a
 270 child, an assets test is not required. ~~A child who is eligible~~
 271 ~~for Medikids may elect to enroll in Florida Healthy Kids~~
 272 ~~coverage or employer sponsored group coverage. However, a child~~
 273 ~~who is eligible for Medikids may participate in the Florida~~
 274 ~~Healthy Kids program only if the child has a sibling~~
 275 ~~participating in the Florida Healthy Kids program and the~~
 276 ~~child's county of residence permits such enrollment.~~

277 (b) The provisions of s. 409.814 apply to the Medikids
 278 program.

279 (7) ENROLLMENT.—Enrollment in the Medikids program
 280 component may occur at any time throughout the year. A child may
 281 not receive services under the Medikids program until the child
 282 is enrolled in a managed care plan or MediPass. Once determined
 283 eligible, an applicant may receive choice counseling and select
 284 a managed care plan or MediPass. The agency may initiate
 285 mandatory assignment for a Medikids applicant who has not chosen
 286 a managed care plan or MediPass provider after the applicant's
 287 voluntary choice period ends. An applicant may select MediPass
 288 under the Medikids program component only in counties that have
 289 fewer than two managed care plans available to serve Medicaid
 290 recipients ~~and only if the federal Health Care Financing~~

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291 ~~Administration determines that MediPass constitutes "health~~
 292 ~~insurance coverage" as defined in Title XXI of the Social~~
 293 ~~Security Act.~~

294 Section 4. Subsection (2) of section 409.8134, Florida
 295 Statutes, is amended to read:

296 409.8134 Program expenditure ceiling; enrollment.—

297 (2) The Florida Kidcare program may conduct enrollment
 298 continuously throughout the year.

299 (a) Children eligible for coverage under the Title XXI-
 300 funded Florida Kidcare program shall be enrolled on a first-
 301 come, first-served basis using the date the enrollment
 302 application is received. Enrollment shall immediately cease when
 303 the expenditure ceiling is reached. Year-round enrollment shall
 304 only be held if the Social Services Estimating Conference
 305 determines that sufficient federal and state funds will be
 306 available to finance the increased enrollment.

307 (b) The application for the Florida Kidcare program is
 308 valid for a period of 120 days after the date it was received.
 309 At the end of the 120-day period, if the applicant has not been
 310 enrolled in the program, the application is invalid and the
 311 applicant shall be notified of the action. The applicant may
 312 reactivate the application after notification of the action
 313 taken by the program.

314 (c) Except for the Medicaid program, whenever the Social
 315 Services Estimating Conference determines that there are
 316 presently, or will be by the end of the current fiscal year,
 317 insufficient funds to finance the current or projected
 318 enrollment in the Florida Kidcare program, all additional
 319 enrollment must cease and additional enrollment may not resume

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320 until sufficient funds are available to finance such enrollment.

321 Section 5. Section 409.814, Florida Statutes, is amended to
 322 read:

323 409.814 Eligibility.—A child who has not reached 19 years
 324 of age whose household ~~family~~ income is equal to or below 200
 325 percent of the federal poverty level is eligible for the Florida
 326 Kidcare program as provided in this section. If an enrolled
 327 individual is determined to be ineligible for coverage, he or
 328 she must be immediately disenrolled from the respective Florida
 329 Kidcare program component and referred to another insurance
 330 affordability program, if appropriate, through a combined
 331 eligibility notice.

332 (1) A child who is eligible for Medicaid coverage under s.
 333 409.903 or s. 409.904 must be offered the opportunity to enroll
 334 enrolled in Medicaid and is not eligible to receive health
 335 benefits under any other health benefits coverage authorized
 336 under the Florida Kidcare program. A child who is eligible for
 337 Medicaid and opts to enroll in CHIP may disenroll from CHIP at
 338 any time and transition to Medicaid. This transition must occur
 339 without any break in coverage.

340 (2) A child who is not eligible for Medicaid, but who is
 341 eligible for the Florida Kidcare program, may obtain health
 342 benefits coverage under any of the other components listed in s.
 343 409.813 if such coverage is approved and available in the county
 344 in which the child resides.

345 (3) A Title XXI-funded child who is eligible for the
 346 Florida Kidcare program who is a child with special health care
 347 needs, as determined through a medical or behavioral screening
 348 instrument, is eligible for health benefits coverage from and

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349 shall be assigned to and may opt out of the Children's Medical
350 Services Network.

351 (4) The following children are not eligible to receive
352 Title XXI-funded premium assistance for health benefits coverage
353 under the Florida Kidcare program, except under Medicaid if the
354 child would have been eligible for Medicaid under s. 409.903 or
355 s. 409.904 as of June 1, 1997:

356 (a) A child who is covered under a family member's group
357 health benefit plan or under other private or employer health
358 insurance coverage, if the cost of the child's participation is
359 not greater than 5 percent of the household's ~~family's~~ income.
360 If a child is otherwise eligible for a subsidy under the Florida
361 Kidcare program and the cost of the child's participation in the
362 family member's health insurance benefit plan is greater than 5
363 percent of the household's ~~family's~~ income, the child may enroll
364 in the appropriate subsidized Kidcare program.

365 ~~(b) A child who is seeking premium assistance for the~~
366 ~~Florida Kidcare program through employer sponsored group~~
367 ~~coverage, if the child has been covered by the same employer's~~
368 ~~group coverage during the 60 days before the family submitted an~~
369 ~~application for determination of eligibility under the program.~~

370 ~~(b)(c)~~ A child who is an alien, but who does not meet the
371 definition of qualified alien, in the United States.

372 ~~(c)(d)~~ A child who is an inmate of a public institution or
373 a patient in an institution for mental diseases.

374 ~~(d)(e)~~ A child who is otherwise eligible for premium
375 assistance for the Florida Kidcare program and has had his or
376 her coverage in an employer-sponsored or private health benefit
377 plan voluntarily canceled in the last 60 days, except those

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378 children whose coverage was voluntarily canceled for good cause,
379 including, but not limited to, the following circumstances:

380 1. The cost of participation in an employer-sponsored
381 health benefit plan is greater than 5 percent of the household's
382 modified adjusted gross ~~family's~~ income;

383 2. The parent lost a job that provided an employer-
384 sponsored health benefit plan for children;

385 3. The parent who had health benefits coverage for the
386 child is deceased;

387 4. The child has a medical condition that, without medical
388 care, would cause serious disability, loss of function, or
389 death;

390 5. The employer of the parent canceled health benefits
391 coverage for children;

392 6. The child's health benefits coverage ended because the
393 child reached the maximum lifetime coverage amount;

394 7. The child has exhausted coverage under a COBRA
395 continuation provision;

396 8. The health benefits coverage does not cover the child's
397 health care needs; or

398 9. Domestic violence led to loss of coverage.

399 ~~(5) A child who is otherwise eligible for the Florida~~
400 ~~Kidcare program and who has a preexisting condition that~~
401 ~~prevents coverage under another insurance plan as described in~~
402 ~~paragraph (4)(a) which would have disqualified the child for the~~
403 ~~Florida Kidcare program if the child were able to enroll in the~~
404 ~~plan is eligible for Florida Kidcare coverage when enrollment is~~
405 ~~possible.~~

406 ~~(5)(6)~~ A child whose household's modified adjusted gross

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407 ~~family~~ income is above 200 percent of the federal poverty level
 408 or a child who is excluded under the provisions of subsection
 409 (4) may participate in the Florida Kidcare program as provided
 410 in s. 409.8132 or, if the child is ineligible for Medikids by
 411 reason of age, in the Florida Healthy Kids program, subject to
 412 the following:

413 (a) The family is not eligible for premium assistance
 414 payments and must pay the full cost of the premium, including
 415 any administrative costs.

416 (b) The board of directors of the Florida Healthy Kids
 417 Corporation may offer a reduced benefit package to these
 418 children in order to limit program costs for such families.

419 (c) By August 15, 2013, the Florida Healthy Kids
 420 Corporation shall notify all current full-pay enrollees of the
 421 availability of the exchange and how to access other insurance
 422 affordability options. New applications for full-pay coverage
 423 may not be accepted after September 30, 2013.

424 (6)(7) Once a child is enrolled in the Florida Kidcare
 425 program, the child is eligible for coverage for 12 months
 426 without a redetermination or reverification of eligibility, if
 427 the family continues to pay the applicable premium. Eligibility
 428 for program components funded through Title XXI of the Social
 429 Security Act terminates when a child attains the age of 19. A
 430 child who has not attained the age of 5 and who has been
 431 determined eligible for the Medicaid program is eligible for
 432 coverage for 12 months without a redetermination or
 433 reverification of eligibility.

434 (7)(8) When determining or reviewing a child's eligibility
 435 under the Florida Kidcare program, the applicant shall be

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436 provided with reasonable notice of changes in eligibility which
 437 may affect enrollment in one or more of the program components.
 438 If a transition from one program component to another is
 439 authorized, there shall be cooperation between the program
 440 components and the affected family which promotes continuity of
 441 health care coverage. Any authorized transfers must be managed
 442 within the program's overall appropriated or authorized levels
 443 of funding. Each component of the program shall establish a
 444 reserve to ensure that transfers between components will be
 445 accomplished within current year appropriations. These reserves
 446 shall be reviewed by each convening of the Social Services
 447 Estimating Conference to determine the adequacy of such reserves
 448 to meet actual experience.

449 (8)(9) In determining the eligibility of a child, an assets
 450 test is not required. Each applicant shall provide documentation
 451 during the application process and the redetermination process,
 452 including, but not limited to, the following:

453 (a) Proof of household ~~family~~ income, which must be
 454 verified electronically to determine financial eligibility for
 455 the Florida Kidcare program. Written documentation, which may
 456 include wages and earnings statements or pay stubs, W-2 forms,
 457 or a copy of the applicant's most recent federal income tax
 458 return, is required only if the electronic verification is not
 459 available or does not substantiate the applicant's income. This
 460 paragraph expires December 31, 2013.

461 (b) A statement from all applicable, employed household
 462 ~~family~~ members that:

463 1. Their employers do not sponsor health benefit plans for
 464 employees;

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465 2. The potential enrollee is not covered by an employer-
466 sponsored health benefit plan; or

467 3. The potential enrollee is covered by an employer-
468 sponsored health benefit plan and the cost of the employer-
469 sponsored health benefit plan is more than 5 percent of the
470 household's modified adjusted gross ~~family's~~ income.

471 (c) To enroll in the Children's Medical Services Network, a
472 completed application, including a clinical screening.

473 (d) Effective January 1, 2014, eligibility shall be
474 determined through electronic matching using the federally
475 managed data services hub and other resources. Written
476 documentation from the applicant may be accepted if the
477 electronic verification does not substantiate the applicant's
478 income or if there has been a change in circumstances.

479 (9)(10) Subject to paragraph (4) (a), the Florida Kidcare
480 program shall withhold benefits from an enrollee if the program
481 obtains evidence that the enrollee is no longer eligible,
482 submitted incorrect or fraudulent information in order to
483 establish eligibility, or failed to provide verification of
484 eligibility. The applicant or enrollee shall be notified that
485 because of such evidence program benefits will be withheld
486 unless the applicant or enrollee contacts a designated
487 representative of the program by a specified date, which must be
488 within 10 working days after the date of notice, to discuss and
489 resolve the matter. The program shall make every effort to
490 resolve the matter within a timeframe that will not cause
491 benefits to be withheld from an eligible enrollee.

492 (10)(11) The following individuals may be subject to
493 prosecution in accordance with s. 414.39:

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494 (a) An applicant obtaining or attempting to obtain benefits
495 for a potential enrollee under the Florida Kidcare program when
496 the applicant knows or should have known the potential enrollee
497 does not qualify for the Florida Kidcare program.

498 (b) An individual who assists an applicant in obtaining or
499 attempting to obtain benefits for a potential enrollee under the
500 Florida Kidcare program when the individual knows or should have
501 known the potential enrollee does not qualify for the Florida
502 Kidcare program.

503 Section 6. Paragraphs (g), (k), (q), and (w) of subsection
504 (2) of section 409.815, Florida Statutes, are amended to read:

505 409.815 Health benefits coverage; limitations.-

506 (2) BENCHMARK BENEFITS.-In order for health benefits
507 coverage to qualify for premium assistance payments for an
508 eligible child under ss. 409.810-409.821, the health benefits
509 coverage, except for coverage under Medicaid and Medikids, must
510 include the following minimum benefits, as medically necessary.

511 (g) *Behavioral health services.*-

512 1. Mental health benefits include:

513 a. Inpatient services, ~~limited to 30 inpatient days per~~
514 ~~contract year~~ for psychiatric admissions, or residential
515 services in facilities licensed under s. 394.875(6) or s.
516 395.003 in lieu of inpatient psychiatric admissions, ~~however, a~~
517 ~~minimum of 10 of the 30 days shall be available only for~~
518 ~~inpatient psychiatric services~~ if authorized by a physician; and

519 b. Outpatient services, including outpatient visits for
520 psychological or psychiatric evaluation, diagnosis, and
521 treatment by a licensed mental health professional, ~~limited to~~
522 ~~40 outpatient visits each contract year.~~

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523 2. Substance abuse services include:

524 a. Inpatient services, ~~limited to 7 inpatient days per~~
 525 ~~contract year~~ for medical detoxification only and ~~30 days of~~
 526 residential services; and

527 b. Outpatient services, including evaluation, diagnosis,
 528 and treatment by a licensed practitioner, ~~limited to 40~~
 529 ~~outpatient visits per contract year.~~

530
 531 ~~Effective October 1, 2009,~~ Covered services include inpatient
 532 and outpatient services for mental and nervous disorders as
 533 defined in the most recent edition of the Diagnostic and
 534 Statistical Manual of Mental Disorders published by the American
 535 Psychiatric Association. Such benefits include psychological or
 536 psychiatric evaluation, diagnosis, and treatment by a licensed
 537 mental health professional and inpatient, outpatient, and
 538 residential treatment of substance abuse disorders. Any benefit
 539 limitations, including duration of services, number of visits,
 540 or number of days for hospitalization or residential services,
 541 shall not be any less favorable than those for physical
 542 illnesses generally. The program may also implement appropriate
 543 financial incentives, peer review, utilization requirements, and
 544 other methods used for the management of benefits provided for
 545 other medical conditions in order to reduce service costs and
 546 utilization without compromising quality of care.

547 (k) *Hospice services.*—Covered services include reasonable
 548 and necessary services for palliation or management of an
 549 enrollee's terminal illness, ~~with the following exceptions:~~

550 ~~1. Once a family elects to receive hospice care for an~~
 551 ~~enrollee, other services that treat the terminal condition will~~

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552 ~~not be covered; and~~

553 ~~2. Services required for conditions totally unrelated to~~
 554 ~~the terminal condition are covered to the extent that the~~
 555 ~~services are included in this section.~~

556 (q) *Dental services.*—~~Effective October 1, 2009,~~ Dental
 557 services shall be covered as required under federal law and may
 558 also include those dental benefits provided to children by the
 559 Florida Medicaid program under s. 409.906(6).

560 (w) *Reimbursement of federally qualified health centers and*
 561 *rural health clinics.*—~~Effective October 1, 2009,~~ Payments for
 562 services provided to enrollees by federally qualified health
 563 centers and rural health clinics under this section shall be
 564 reimbursed using the Medicaid Prospective Payment System as
 565 provided for under s. 2107(e)(1)(D) of the Social Security Act.
 566 If such services are paid for by health insurers or health care
 567 providers under contract with the Florida Healthy Kids
 568 Corporation, such entities are responsible for this payment. The
 569 agency may seek any available federal grants to assist with this
 570 transition.

571 Section 7. Section 409.816, Florida Statutes, is amended to
 572 read:

573 409.816 Limitations on premiums and cost-sharing.—The
 574 following limitations on premiums and cost-sharing are
 575 established for the program.

576 (l) Enrollees who receive coverage under the Medicaid
 577 program may not be required to pay:

578 (a) Enrollment fees, premiums, or similar charges; or
 579 (b) Copayments, deductibles, coinsurance, or similar
 580 charges.

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581 (2) Enrollees in households that have ~~families with~~ a
 582 modified adjusted gross ~~family~~ income equal to or below 150
 583 percent of the federal poverty level, who are not receiving
 584 coverage under the Medicaid program, may not be required to pay:

585 (a) Enrollment fees, premiums, or similar charges that
 586 exceed the maximum monthly charge permitted under s. 1916(b)(1)
 587 of the Social Security Act; or

588 (b) Copayments, deductibles, coinsurance, or similar
 589 charges that exceed a nominal amount, as determined consistent
 590 with regulations referred to in s. 1916(a)(3) of the Social
 591 Security Act. However, such charges may not be imposed for
 592 preventive services, including well-baby and well-child care,
 593 age-appropriate immunizations, and routine hearing and vision
 594 screenings.

595 (3) Enrollees in households that have ~~families with~~ a
 596 modified adjusted gross ~~family~~ income above 150 percent of the
 597 federal poverty level who are not receiving coverage under the
 598 Medicaid program or who are not eligible under s. 409.814(5) ~~or~~
 599 ~~409.814(6)~~ may be required to pay enrollment fees, premiums,
 600 copayments, deductibles, coinsurance, or similar charges on a
 601 sliding scale related to income, except that the total annual
 602 aggregate cost-sharing with respect to all children in a
 603 household ~~family~~ may not exceed 5 percent of the household's
 604 modified adjusted ~~family's~~ income. However, copayments,
 605 deductibles, coinsurance, or similar charges may not be imposed
 606 for preventive services, including well-baby and well-child
 607 care, age-appropriate immunizations, and routine hearing and
 608 vision screenings.

609 Section 8. Section 409.817, Florida Statutes, is repealed.

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610 Section 9. Section 409.8175, Florida Statutes, is repealed.

611 Section 10. Paragraph (c) of subsection (1) of section
 612 409.8177, Florida Statutes, is amended to read:

613 409.8177 Program evaluation.—

614 (1) The agency, in consultation with the Department of
 615 Health, the Department of Children and Families ~~Family Services~~,
 616 and the Florida Healthy Kids Corporation, shall contract for an
 617 evaluation of the Florida Kidcare program and shall by January 1
 618 of each year submit to the Governor, the President of the
 619 Senate, and the Speaker of the House of Representatives a report
 620 of the program. In addition to the items specified under s. 2108
 621 of Title XXI of the Social Security Act, the report shall
 622 include an assessment of crowd-out and access to health care, as
 623 well as the following:

624 (c) The characteristics of the children and families
 625 assisted under the program, including ages of the children,
 626 household ~~family~~ income, and access to or coverage by other
 627 health insurance prior to the program and after disenrollment
 628 from the program.

629 Section 11. Section 409.818, Florida Statutes, is amended
 630 to read:

631 409.818 Administration.—In order to implement ss. 409.810-
 632 409.821, the following agencies shall have the following duties:

633 (1) The Department of Children and Families ~~Family Services~~
 634 shall:

635 (a) Maintain ~~Develop~~ a simplified eligibility determination
 636 and renewal process ~~application mail in form to be used for~~
 637 ~~determining the eligibility of children for coverage~~ under the
 638 Florida Kidcare program, in consultation with the agency, the

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639 Department of Health, and the Florida Healthy Kids Corporation.
 640 The simplified eligibility process ~~application form~~ must include
 641 ~~an item that provides~~ an opportunity for the applicant to
 642 indicate whether coverage is being sought for a child with
 643 special health care needs. Families applying for children's
 644 Medicaid coverage must also be able to use the simplified
 645 application process ~~form~~ without having to pay a premium.

646 (b) Establish and maintain the eligibility determination
 647 process under the program except as specified in subsection (3),
 648 which includes the following: (5)-

649 1. The department shall directly, or through the services
 650 of a contracted third-party administrator, establish and
 651 maintain a process for determining eligibility of children for
 652 coverage under the program. The eligibility determination
 653 process must be used solely for determining eligibility of
 654 applicants for health benefits coverage under the program. The
 655 eligibility determination process must include an initial
 656 determination of eligibility for any coverage offered under the
 657 program, as well as a redetermination or reverification of
 658 eligibility each subsequent 6 months. ~~Effective January 1, 1999,~~
 659 A child who has not attained the age of 5 and who has been
 660 determined eligible for the Medicaid program is eligible for
 661 coverage for 12 months without a redetermination or
 662 reverification of eligibility. In conducting an eligibility
 663 determination, the department shall determine if the child has
 664 special health care needs.

665 2. The department, in consultation with the Agency for
 666 Health Care Administration and the Florida Healthy Kids
 667 Corporation, shall develop procedures for redetermining

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668 eligibility which enable applicants and enrollees ~~a family~~ to
 669 easily update any change in circumstances which could affect
 670 eligibility.

671 3. The department may accept changes in ~~a family's~~ status
 672 as reported to the department by the Florida Healthy Kids
 673 Corporation or the exchange without requiring a new application
 674 ~~from the family~~. Redetermination of a child's eligibility for
 675 Medicaid may not be linked to a child's eligibility
 676 determination for other programs.

677 4. The department, in consultation with the agency and the
 678 Florida Healthy Kids Corporation, shall develop a combined
 679 eligibility notice to inform applicants and enrollees of their
 680 application or renewal status, as appropriate. The content must
 681 be coordinated to meet all federal and state requirements under
 682 the federal Patient Protection and Affordable Care Act.

683 (c) Inform program applicants about eligibility
 684 determinations and provide information about eligibility of
 685 applicants to the Florida Kidcare program and to insurers and
 686 their agents, ~~through a centralized coordinating office.~~

687 (d) Adopt rules necessary for conducting program
 688 eligibility functions.

689 ~~(2) The Department of Health shall:~~

690 ~~(a) Design an eligibility intake process for the program,~~
 691 ~~in coordination with the Department of Children and Family~~
 692 ~~Services, the agency, and the Florida Healthy Kids Corporation.~~
 693 ~~The eligibility intake process may include local intake points~~
 694 ~~that are determined by the Department of Health in coordination~~
 695 ~~with the Department of Children and Family Services.~~

696 ~~(b) Chair a state-level Florida Kidcare coordinating~~

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697 ~~council to review and make recommendations concerning the~~
 698 ~~implementation and operation of the program. The coordinating~~
 699 ~~council shall include representatives from the department, the~~
 700 ~~Department of Children and Family Services, the agency, the~~
 701 ~~Florida Healthy Kids Corporation, the Office of Insurance~~
 702 ~~Regulation of the Financial Services Commission, local~~
 703 ~~government, health insurers, health maintenance organizations,~~
 704 ~~health care providers, families participating in the program,~~
 705 ~~and organizations representing low income families.~~

706 ~~(e) In consultation with the Florida Healthy Kids~~
 707 ~~Corporation and the Department of Children and Family Services,~~
 708 ~~establish a toll free telephone line to assist families with~~
 709 ~~questions about the program.~~

710 ~~(d) Adopt rules necessary to implement outreach activities.~~

711 (2)(3) The Agency for Health Care Administration, under the
 712 authority granted in s. 409.914(1), shall:

713 (a) Calculate the premium assistance payment necessary to
 714 comply with the premium and cost-sharing limitations specified
 715 in s. 409.816 and the federal Patient Protection and Affordable
 716 Care Act. The premium assistance payment for each enrollee in a
 717 health insurance plan participating in the Florida Healthy Kids
 718 Corporation shall equal the premium approved by the Florida
 719 Healthy Kids Corporation ~~and the Office of Insurance Regulation~~
 720 ~~of the Financial Services Commission pursuant to ss. 627.410 and~~
 721 ~~641.31, less any enrollee's share of the premium established~~
 722 ~~within the limitations specified in s. 409.816. The premium~~
 723 ~~assistance payment for each enrollee in an employer sponsored~~
 724 ~~health insurance plan approved under ss. 409.810 409.821 shall~~
 725 ~~equal the premium for the plan adjusted for any benchmark~~

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726 ~~benefit plan actuarial equivalent benefit rider approved by the~~
 727 ~~Office of Insurance Regulation pursuant to ss. 627.410 and~~
 728 ~~641.31, less any enrollee's share of the premium established~~
 729 ~~within the limitations specified in s. 409.816. In calculating~~
 730 ~~the premium assistance payment levels for children with family~~
 731 ~~coverage, the agency shall set the premium assistance payment~~
 732 ~~levels for each child proportionately to the total cost of~~
 733 ~~family coverage.~~

734 (b) Make premium assistance payments to health insurance
 735 plans on a periodic basis. The agency may use its Medicaid
 736 fiscal agent or a contracted third-party administrator in making
 737 these payments. The agency may require health insurance plans
 738 that participate in the Medikids program ~~or employer sponsored~~
 739 ~~group health insurance~~ to collect premium payments from an
 740 enrollee's family. Participating health insurance plans shall
 741 report premium payments collected on behalf of enrollees in the
 742 program to the agency in accordance with a schedule established
 743 by the agency.

744 (c) Monitor compliance with quality assurance and access
 745 standards developed under s. 409.820 and in accordance with s.
 746 2103(f) of the Social Security Act, 42 U.S.C. s. 1397cc(f).

747 (d) Establish a mechanism for investigating and resolving
 748 complaints and grievances from program applicants, enrollees,
 749 and health benefits coverage providers, and maintain a record of
 750 complaints and confirmed problems. In the case of a child who is
 751 enrolled in a managed care health maintenance organization, the
 752 agency must use the provisions of s. 641.511 to address
 753 grievance reporting and resolution requirements.

754 ~~(e) Approve health benefits coverage for participation in~~

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755 ~~the program, following certification by the Office of Insurance~~
756 ~~Regulation under subsection (4).~~

757 ~~(e)(f) Adopt rules necessary for calculating premium~~
758 ~~assistance payment levels, making premium assistance payments,~~
759 ~~monitoring access and quality assurance standards and,~~
760 ~~investigating and resolving complaints and grievances,~~
761 ~~administering the Medikids program, and approving health~~
762 ~~benefits coverage.~~

763 (f) Contract with the Florida Healthy Kids Corporation for
764 the administration of the Florida Kidcare program and the
765 Healthy Florida program and to facilitate the release of any
766 federal and state funds.

767
768 The agency is designated the lead state agency for Title XXI of
769 the Social Security Act for purposes of receipt of federal
770 funds, for reporting purposes, and for ensuring compliance with
771 federal and state regulations and rules.

772 ~~(4) The Office of Insurance Regulation shall certify that~~
773 ~~health benefits coverage plans that seek to provide services~~
774 ~~under the Florida Kidcare program, except those offered through~~
775 ~~the Florida Healthy Kids Corporation or the Children's Medical~~
776 ~~Services Network, meet, exceed, or are actuarially equivalent to~~
777 ~~the benchmark benefit plan and that health insurance plans will~~
778 ~~be offered at an approved rate. In determining actuarial~~
779 ~~equivalence of benefits coverage, the Office of Insurance~~
780 ~~Regulation and health insurance plans must comply with the~~
781 ~~requirements of s. 2103 of Title XXI of the Social Security Act.~~
782 ~~The department shall adopt rules necessary for certifying health~~
783 ~~benefits coverage plans.~~

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784 ~~(3)(5)~~ The Florida Healthy Kids Corporation shall retain
785 its functions as authorized in s. 624.91, including eligibility
786 determination for participation in the Healthy Kids program.

787 ~~(4)(6)~~ The agency, the Department of Health, the Department
788 of Children and ~~Families~~ Family Services, and the Florida
789 Healthy Kids Corporation, ~~and the Office of Insurance~~
790 ~~Regulation~~, after consultation with and approval of the Speaker
791 of the House of Representatives and the President of the Senate,
792 ~~may are authorized to~~ make program modifications that are
793 necessary to overcome any objections of the United States
794 Department of Health and Human Services to obtain approval of
795 the state's child health insurance plan under Title XXI of the
796 Social Security Act.

797 Section 12. Section 409.820, Florida Statutes, is amended
798 to read:

799 409.820 Quality assurance and access standards.—Except for
800 Medicaid, the Department of Health, in consultation with the
801 agency and the Florida Healthy Kids Corporation, shall develop a
802 minimum set of pediatric and adolescent quality assurance and
803 access standards for all program components. The standards must
804 include a process for granting exceptions to specific
805 requirements for quality assurance and access. Compliance with
806 the standards shall be a condition of program participation by
807 health benefits coverage providers. These standards shall comply
808 with the provisions of this chapter and chapter 641 and Title
809 XXI of the Social Security Act.

810 Section 13. Section 624.91, Florida Statutes, is amended to
811 read:

812 624.91 The Florida Healthy Kids Corporation Act.—

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813 (1) SHORT TITLE.—This section may be cited as the “William
814 G. ‘Doc’ Myers Healthy Kids Corporation Act.”

815 (2) LEGISLATIVE INTENT.—

816 (a) The Legislature finds that increased access to health
817 care services could improve children’s health and reduce the
818 incidence and costs of childhood illness and disabilities among
819 children in this state. Many children do not have comprehensive,
820 affordable health care services available. It is the intent of
821 the Legislature that the Florida Healthy Kids Corporation
822 provide comprehensive health insurance coverage to such
823 children. The corporation is encouraged to cooperate with any
824 existing health service programs funded by the public or the
825 private sector.

826 (b) It is the intent of the Legislature that the Florida
827 Healthy Kids Corporation serve as one of several providers of
828 services to children eligible for medical assistance under Title
829 XXI of the Social Security Act. Although the corporation may
830 serve other children, the Legislature intends the primary
831 recipients of services provided through the corporation be
832 school-age children with a family income below 200 percent of
833 the federal poverty level, who do not qualify for Medicaid. It
834 is also the intent of the Legislature that state and local
835 government Florida Healthy Kids funds be used to continue
836 coverage, subject to specific appropriations in the General
837 Appropriations Act, to children not eligible for federal
838 matching funds under Title XXI.

839 (c) It is further the intent of the Legislature that the
840 Florida Healthy Kids Corporation administer and manage services
841 for Healthy Florida, a health care program for uninsured adults

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842 using a unique network of providers and contracts. Enrollees in
843 Healthy Florida will receive comprehensive health care services
844 from private, licensed health insurers who meet standards
845 established by the corporation. It is further the intent of the
846 Legislature that these enrollees participate in their own health
847 care decisionmaking and contribute financially toward their
848 medical costs. The Legislature intends to provide an alternative
849 benefit package that includes a full range of services which
850 meet the needs of residents of this state. As a new program, the
851 Legislature shall also ensure that a comprehensive evaluation is
852 conducted to measure the overall impact of the program and
853 identify whether to renew the program after an initial 3-year
854 term.

855 (3) ELIGIBILITY FOR STATE-FUNDED ASSISTANCE.—Only the
856 following individuals are eligible for state-funded assistance
857 in paying premiums for Healthy Florida or Florida Healthy Kids
858 premiums:

859 (a) Residents of this state who are eligible for the
860 Florida Kidcare program pursuant to s. 409.814 or the Healthy
861 Florida pursuant to s. 624.917.

862 (b) Notwithstanding s. 409.814, legal aliens who are
863 enrolled in the Florida Healthy Kids program as of January 31,
864 2004, who do not qualify for Title XXI federal funds because
865 they are not qualified aliens as defined in s. 409.811.

866 (4) NONENTITLEMENT.—Nothing in this section shall be
867 construed as providing an individual with an entitlement to
868 health care services. No cause of action shall arise against the
869 state, the Florida Healthy Kids Corporation, or a unit of local
870 government for failure to make health services available under

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871 this section.

872 (5) CORPORATION AUTHORIZATION, DUTIES, POWERS.—

873 (a) There is created the Florida Healthy Kids Corporation,
874 a not-for-profit corporation.

875 (b) The Florida Healthy Kids Corporation shall:

876 1. Arrange for the collection of any family, individual, or
877 local contributions, ~~or employer payment or premium~~, in an
878 amount to be determined by the board of directors, to provide
879 for payment of premiums for comprehensive insurance coverage and
880 for the actual or estimated administrative expenses.

881 2. Arrange for the collection of any voluntary
882 contributions to provide for payment of premiums for enrollees
883 in the Florida Kidcare program or Healthy Florida premiums for
884 ~~children who are not eligible for medical assistance under Title~~
885 ~~XIX or Title XXI of the Social Security Act.~~

886 3. Subject to the provisions of s. 409.8134, accept
887 voluntary supplemental local match contributions that comply
888 with the requirements of Title XXI of the Social Security Act
889 for the purpose of providing additional Florida Kidcare coverage
890 in contributing counties under Title XXI.

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

893 5. Establish, with consultation from appropriate
894 professional organizations, standards for preventive health
895 services and providers and comprehensive insurance benefits
896 appropriate to children, provided that such standards for rural
897 areas shall not limit primary care providers to board-certified
898 pediatricians.

899 6. Determine eligibility for children seeking to

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900 participate in the Title XXI-funded components of the Florida
901 Kidcare program consistent with the requirements specified in s.
902 409.814, as well as the non-Title-XXI-eligible children as
903 provided in subsection (3).

904 7. Establish procedures under which providers of local
905 match to, applicants to and participants in the program may have
906 grievances reviewed by an impartial body and reported to the
907 board of directors of the corporation.

908 8. Establish participation criteria and, if appropriate,
909 contract with an authorized insurer, health maintenance
910 organization, or third-party administrator to provide
911 administrative services to the corporation.

912 9. Establish enrollment criteria that include penalties or
913 waiting periods of 30 days for reinstatement of coverage upon
914 voluntary cancellation for nonpayment of family and individual
915 premiums under the programs.

916 10. Contract with authorized insurers or any provider of
917 health care services, meeting standards established by the
918 corporation, for the provision of comprehensive insurance
919 coverage to participants. Such standards shall include criteria
920 under which the corporation may contract with more than one
921 provider of health care services in program sites.

922 a. Health plans shall be selected through a competitive bid
923 process.

924 b. The Florida Healthy Kids Corporation shall purchase
925 goods and services in the most cost-effective manner consistent
926 with the delivery of quality medical care. The maximum
927 administrative cost for a Florida Healthy Kids Corporation
928 contract shall be 15 percent. For all health care contracts, the

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929 minimum medical loss ratio is for a Florida Healthy Kids
 930 ~~Corporation contract shall be~~ 85 percent. The calculations must
 931 use uniform financial data collected from all plans in a format
 932 established by the corporation and shall be computed for each
 933 insurer on a statewide basis. Funds shall be classified in a
 934 manner consistent with 45 C.F.R. part 158 ~~For dental contracts,~~
 935 ~~the remaining compensation to be paid to the authorized insurer~~
 936 ~~or provider under a Florida Healthy Kids Corporation contract~~
 937 ~~shall be no less than an amount which is 85 percent of premium,~~
 938 ~~to the extent any contract provision does not provide for this~~
 939 ~~minimum compensation, this section shall prevail.~~

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

943 11. Establish disenrollment criteria in the event local
 944 matching funds are insufficient to cover enrollments.

945 12. Develop and implement a plan to publicize the Florida
 946 Kidcare program and Healthy Florida, the eligibility
 947 requirements of the programs program, and the procedures for
 948 enrollment in the program and to maintain public awareness of
 949 the corporation and the programs program.

950 13. Secure staff necessary to properly administer the
 951 corporation. Staff costs shall be funded from state and local
 952 matching funds and such other private or public funds as become
 953 available. The board of directors shall determine the number of
 954 staff members necessary to administer the corporation.

955 14. In consultation with the partner agencies, annually
 956 provide a report on the Florida Kidcare program ~~annually~~ to the
 957 Governor, the Chief Financial Officer, the Commissioner of

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958 Education, the President of the Senate, the Speaker of the House
 959 of Representatives, and the Minority Leaders of the Senate and
 960 the House of Representatives.

961 15. Provide information on a quarterly basis to the
 962 Legislature and the Governor which compares the costs and
 963 utilization of the full-pay enrolled population and the Title
 964 XXI-subsidized enrolled population in the Florida Kidcare
 965 program. The information, at a minimum, must include:

966 a. The monthly enrollment and expenditure for full-pay
 967 enrollees in the Medikids and Florida Healthy Kids programs
 968 compared to the Title XXI-subsidized enrolled population; and

969 b. The costs and utilization by service of the full-pay
 970 enrollees in the Medikids and Florida Healthy Kids programs and
 971 the Title XXI-subsidized enrolled population. This subparagraph
 972 is repealed effective December 31, 2013.

973
 974 ~~By February 1, 2010, the Florida Healthy Kids Corporation shall~~
 975 ~~provide a study to the Legislature and the Governor on premium~~
 976 ~~impacts to the subsidized portion of the program from the~~
 977 ~~inclusion of the full pay program, which shall include~~
 978 ~~recommendations on how to eliminate or mitigate possible impacts~~
 979 ~~to the subsidized premiums.~~

980 16. By August 15, 2013, the corporation shall notify all
 981 current full-pay enrollees of the availability of the exchange,
 982 as defined in the federal Patient Protection and Affordable Care
 983 Act, and how to access other insurance affordability options.
 984 New applications for full-pay coverage may not be accepted after
 985 September 30, 2013.

986 ~~17.16.~~ Establish benefit packages that conform to the

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987 provisions of the Florida Kidcare program, as created in ss.
988 409.810-409.821.

989 (c) Coverage under the corporation's program is secondary
990 to any other available private coverage held by, or applicable
991 to, the participant ~~child~~ or family member. Insurers under
992 contract with the corporation are the payors of last resort and
993 must coordinate benefits with any other third-party payor that
994 may be liable for the participant's medical care.

995 (d) The Florida Healthy Kids Corporation shall be a private
996 corporation not for profit, registered, incorporated, and
997 organized pursuant to chapter 617, and shall have all powers
998 necessary to carry out the purposes of this act, including, but
999 not limited to, the power to receive and accept grants, loans,
1000 or advances of funds from any public or private agency and to
1001 receive and accept from any source contributions of money,
1002 property, labor, or any other thing of value, to be held, used,
1003 and applied for the purposes of this act. The corporation and
1004 any committees it forms shall act in compliance with part III of
1005 chapter 112, and chapters 119 and 286.

1006 (6) BOARD OF DIRECTORS AND MANAGEMENT SUPERVISION.—

1007 (a) The Florida Healthy Kids Corporation shall operate
1008 subject to the supervision and approval of a board of directors
1009 chaired by an appointee designated by the Governor ~~Chief~~
1010 ~~Financial Officer or her or his designee,~~ and composed of 12
1011 other members. The Senate shall confirm the designated chair and
1012 other board appointees selected for 3-year terms of office as
1013 follows:

1014 ~~1. The Secretary of Health Care Administration, or his or~~
1015 ~~her designee.~~

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1016 ~~2. One member appointed by the Commissioner of Education~~
1017 ~~from the Office of School Health Programs of the Florida~~
1018 ~~Department of Education.~~

1019 ~~3. One member appointed by the Chief Financial Officer from~~
1020 ~~among three members nominated by the Florida Pediatric Society.~~

1021 ~~4. One member, appointed by the Governor, who represents~~
1022 ~~the Children's Medical Services Program.~~

1023 ~~5. One member appointed by the Chief Financial Officer from~~
1024 ~~among three members nominated by the Florida Hospital~~
1025 ~~Association.~~

1026 ~~6. One member, appointed by the Governor, who is an expert~~
1027 ~~on child health policy.~~

1028 ~~7. One member, appointed by the Chief Financial Officer,~~
1029 ~~from among three members nominated by the Florida Academy of~~
1030 ~~Family Physicians.~~

1031 ~~8. One member, appointed by the Governor, who represents~~
1032 ~~the state Medicaid program.~~

1033 ~~9. One member, appointed by the Chief Financial Officer,~~
1034 ~~from among three members nominated by the Florida Association of~~
1035 ~~Counties.~~

1036 ~~10. The State Health Officer or her or his designee.~~

1037 ~~11. The Secretary of Children and Family Services, or his~~
1038 ~~or her designee.~~

1039 ~~12. One member, appointed by the Governor, from among three~~
1040 ~~members nominated by the Florida Dental Association.~~

1041 (b) A member of the board of directors serves at the
1042 pleasure of the Governor ~~may be removed by the official who~~
1043 ~~appointed that member.~~ The board shall appoint an executive
1044 director, who is responsible for other staff authorized by the

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1045 board.

1046 (c) Board members are entitled to receive, from funds of

1047 the corporation, reimbursement for per diem and travel expenses

1048 as provided by s. 112.061.

1049 (d) There shall be no liability on the part of, and no

1050 cause of action shall arise against, any member of the board of

1051 directors, or its employees or agents, for any action they take

1052 in the performance of their powers and duties under this act.

1053 (e) Board members who are serving on or before the date of

1054 enactment of this act or similar legislation may remain until

1055 July 1, 2013.

1056 (f) An executive steering committee is created to provide

1057 management direction and support and to make recommendations to

1058 the board on the programs. The steering committee is composed of

1059 the Secretary of Health Care Administration, the Secretary of

1060 Children and Families, and the State Surgeon General. Committee

1061 members may not delegate their membership or attendance.

1062 (7) LICENSING NOT REQUIRED; FISCAL OPERATION.—

1063 (a) The corporation shall not be deemed an insurer. The

1064 officers, directors, and employees of the corporation shall not

1065 be deemed to be agents of an insurer. Neither the corporation

1066 nor any officer, director, or employee of the corporation is

1067 subject to the licensing requirements of the insurance code or

1068 the rules of the Department of Financial Services or Office of

1069 Insurance Regulation. However, any marketing representative

1070 utilized and compensated by the corporation must be appointed as

1071 a representative of the insurers or health services providers

1072 with which the corporation contracts.

1073 (b) The board has complete fiscal control over the

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1074 corporation and is responsible for all corporate operations.

1075 (c) The Department of Financial Services shall supervise

1076 any liquidation or dissolution of the corporation and shall

1077 have, with respect to such liquidation or dissolution, all power

1078 granted to it pursuant to the insurance code.

1079 Section 14. Section 624.915, Florida Statutes, is repealed.

1080 Section 15. Section 624.917, Florida Statutes, is created

1081 to read:

1082 624.917 Healthy Florida program.—

1083 (1) PROGRAM CREATION.—There is created Healthy Florida, a

1084 health care program for lower income, uninsured adults who meet

1085 the eligibility guidelines established under s. 624.91. The

1086 Florida Healthy Kids Corporation shall administer the program

1087 under its existing corporate governance and structure.

1088 (2) DEFINITIONS.—As used in this section, the term:

1089 (a) "Actuarially equivalent" means:

1090 1. The aggregate value of the benefits included in health

1091 benefits coverage is equal to the value of the benefits in the

1092 child benchmark benefit plan as defined in s. 409.811; and

1093 2. The benefits included in health benefits coverage are

1094 substantially similar to the benefits included in the child

1095 benchmark benefit plan, except that preventive health services

1096 do not include dental services.

1097 (b) "Agency" means the Agency for Health Care

1098 Administration.

1099 (c) "Applicant" means the individual who applies for

1100 determination of eligibility for health benefits coverage under

1101 this section.

1102 (d) "Child benchmark benefit plan" means the form and level

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 1103 of health benefits coverage established in s. 409.815.
 1104 (e) "Child" means any person younger than 19 years of age.
 1105 (f) "Corporation" means the Florida Healthy Kids
 1106 Corporation.
 1107 (g) "Enrollee" means an individual who has been determined
 1108 eligible for and is receiving coverage under this section.
 1109 (h) "Florida Kidcare program" or "Kidcare program," means
 1110 the health benefits program administered through ss. 409.810-
 1111 409.821.
 1112 (i) "Health benefits coverage" means protection that
 1113 provides payment of benefits for covered health care services or
 1114 that otherwise provides, either directly or through arrangements
 1115 with other persons, covered health care services on a prepaid
 1116 per capita basis or on a prepaid aggregate fixed-sum basis.
 1117 (j) "Healthy Florida" means the program created by this
 1118 section which is administered by the Florida Healthy Kids
 1119 Corporation.
 1120 (k) "Healthy Kids" means the Florida Kidcare program
 1121 component created under s. 624.91 for children who are 5 through
 1122 18 years of age.
 1123 (l) "Household income" means the group or the individual
 1124 whose income is considered in determining eligibility for the
 1125 Healthy Florida program. The term "household" has the same
 1126 meaning as provided in s. 36B(d)(2) of the Internal Revenue Code
 1127 of 1986.
 1128 (m) "Medicaid" means the medical assistance program
 1129 authorized by Title XIX of the Social Security Act, and
 1130 regulations thereunder, and ss. 409.901-409.920, as administered
 1131 in this state by the agency.

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 1132 (n) "Medically necessary" means the use of any medical
 1133 treatment, service, equipment, or supply necessary to palliate
 1134 the effects of a terminal condition, or to prevent, diagnose,
 1135 correct, cure, alleviate, or preclude deterioration of a
 1136 condition that threatens life, causes pain or suffering, or
 1137 results in illness or infirmity and which is:
 1138 1. Consistent with the symptom, diagnosis, and treatment of
 1139 the enrollee's condition;
 1140 2. Provided in accordance with generally accepted standards
 1141 of medical practice;
 1142 3. Not primarily intended for the convenience of the
 1143 enrollee, the enrollee's family, or the health care provider;
 1144 4. The most appropriate level of supply or service for the
 1145 diagnosis and treatment of the enrollee's condition; and
 1146 5. Approved by the appropriate medical body or health care
 1147 specialty involved as effective, appropriate, and essential for
 1148 the care and treatment of the enrollee's condition.
 1149 (o) "Modified adjusted gross income" means the individual
 1150 or household's annual adjusted gross income as defined in s.
 1151 36B(d)(2) of the Internal Revenue Code of 1986 which is used to
 1152 determine eligibility under the Florida Kidcare program.
 1153 (p) "Patient Protection and Affordable Care Act" or "Act"
 1154 means the federal law enacted as Pub. L. No. 111-148, as further
 1155 amended by the federal Health Care and Education Reconciliation
 1156 Act of 2010, Pub. L. No. 111-152, and any amendments,
 1157 regulations or guidance thereunder, issued under those acts.
 1158 (q) "Premium" means the entire cost of a health insurance
 1159 plan, including the administration fee or the risk assumption
 1160 charge.

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- 1161 (r) "Premium assistance payment" means the monthly
 1162 consideration paid by the agency per enrollee in the Florida
 1163 Kidcare program towards health insurance premiums.
 1164 (s) "Qualified alien" means an alien as defined in 8 U.S.C.
 1165 s. 1641(b) and (c).
 1166 (t) "Resident" means a United States citizen or qualified
 1167 alien who is domiciled in this state.
 1168 (3) ELIGIBILITY.—To be eligible and remain eligible for the
 1169 Healthy Florida program, an individual must be a resident of
 1170 this state and meet the following additional criteria:
 1171 (a) Be identified as newly eligible, as defined in s.
 1172 1902(a)(10)(A)(i)(VIII) of the Social Security Act or s. 2001 of
 1173 the federal Patient Protection and Affordable Care Act, and as
 1174 may be further defined by federal regulation.
 1175 (b) Maintain eligibility with the corporation and meet all
 1176 renewal requirements as established by the corporation.
 1177 (c) Renew eligibility on at least an annual basis.
 1178 (4) ENROLLMENT.—The corporation may begin the enrollment of
 1179 applicants in the Healthy Florida program on October 1, 2013.
 1180 Enrollment may occur directly, through the services of a third-
 1181 party administrator, referrals from the Department of Children
 1182 and Families, and the exchange as defined by the federal Patient
 1183 Protection and Affordable Care Act. As an enrollee disenrolls,
 1184 the corporation must also provide the enrollee with information
 1185 about other insurance affordability programs and electronically
 1186 refer the enrollee to the exchange or other programs, as
 1187 appropriate. The earliest coverage effective date under the
 1188 program shall be January 1, 2014.
 1189 (5) DELIVERY OF SERVICES.—The corporation shall contract

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- 1190 with authorized insurers licensed under chapter 627 and managed
 1191 care organizations under chapter 641 which meet standards
 1192 established by the corporation to provide comprehensive health
 1193 care services to enrollees who qualify for services under this
 1194 section. The corporation may contract for such services on a
 1195 statewide or regional basis.
 1196 (a) The corporation shall establish access and network
 1197 standards for such contracts and ensure that contracted
 1198 providers have sufficient providers to meet enrollee needs.
 1199 Quality standards must be developed by the corporation, specific
 1200 to the adult population, which take into consideration
 1201 recommendations from the National Committee on Quality
 1202 Assurance, stakeholders, and other existing performance
 1203 indicators from both public and commercial populations.
 1204 (b) The corporation shall provide an enrollee a choice of
 1205 plans. The corporation may select a plan if no selection has
 1206 been received before the coverage start date. Once enrolled, an
 1207 enrollee has an initial 90-day, free-look period before a lock-
 1208 in period of not more than 12 months is applied. Exceptions to
 1209 the lock-in period must be offered to an enrollee for reasons
 1210 based upon good cause or qualifying events.
 1211 (c) The corporation may consider contracts that provide
 1212 family plans that would allow members from multiple state and
 1213 federally funded programs to remain together under the same
 1214 plan.
 1215 (d) All contracts must meet the medical loss ratio
 1216 requirements under s. 624.91.
 1217 (6) BENEFITS.—The corporation shall establish a benefits
 1218 package that is actuarially equivalent to the benchmark benefit

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1219 plan offered under s. 409.815(2), excluding dental, and meets
 1220 the alternative benefits package requirements under s. 1937 of
 1221 the Social Security Act. Benefits must be offered as an
 1222 integrated, single package.

1223 (a) In addition to benchmark benefits, health reimbursement
 1224 accounts or a comparable health savings account for each
 1225 enrollee must be established through the corporation or the
 1226 contracts managed by the corporation. Enrollees must be rewarded
 1227 for healthy behaviors, wellness program adherence, and other
 1228 activities established by the corporation which demonstrate
 1229 compliance with preventive care or disease management
 1230 guidelines. Funds deposited into these accounts may be used to
 1231 pay cost-sharing obligations or to purchase over-the-counter
 1232 health-related items to the extent allowed under federal law or
 1233 regulation.

1234 (b) Enhanced services may be offered if the cost of such
 1235 additional services provides savings to the overall plan.

1236 (c) The corporation shall establish a process for the
 1237 payment of wrap-around services not covered by the benchmark
 1238 benefit plan through a separate subcapitation process to its
 1239 contracted providers if it is determined that such services are
 1240 required by federal law. Such services would be covered when
 1241 deemed medically necessary on an individual basis. The
 1242 subcapitation pool is subject to a separate reconciliation
 1243 process under the medical loss ratio provisions in s. 624.91.

1244 (d) A prior authorization process and other utilization
 1245 controls may be established by the plan for any benefit if
 1246 approved by the corporation.

1247 (7) COST SHARING.—The corporation may collect premiums and

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1248 copayments from enrollees in accordance with federal law.

1249 Amounts to be collected for the Healthy Florida program must be
 1250 established annually in the General Appropriations Act.

1251 (a) Payment of a monthly premium may be required before the
 1252 establishment of an enrollee's coverage start date and to retain
 1253 monthly coverage.

1254 (b) An enrollee may be required to make copayments as a
 1255 condition of receiving a health care service.

1256 (c) A provider is responsible for the collection of point-
 1257 of-service cost-sharing obligations. The enrollee's cost-sharing
 1258 contribution is considered part of the provider's total
 1259 reimbursement. Failure to collect an enrollee's cost sharing
 1260 reduces the provider's share of the reimbursement.

1261 (8) PROGRAM MANAGEMENT.—The corporation is responsible for
 1262 the oversight of the Healthy Florida program. The agency shall
 1263 seek a state plan amendment or other appropriate federal
 1264 approval to implement the Healthy Florida program. The agency
 1265 shall consult with the corporation in the amendment's
 1266 development and submit by June 14, 2013, the state plan
 1267 amendment to the federal Department of Health and Human
 1268 Services. The agency shall contract with the corporation for the
 1269 administration of the Healthy Florida program and for the timely
 1270 release of federal and state funds. The agency retains its
 1271 authorities as provided in ss. 409.902 and 409.963.

1272 (a) The corporation shall establish a process by which
 1273 grievances can be resolved and Healthy Florida recipients can be
 1274 informed of their rights under the Medicaid Fair Hearing
 1275 Process, as appropriate, or any alternative resolution process
 1276 adopted by the corporation.

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1277 (b) The corporation shall establish a program integrity
 1278 process to ensure compliance with program guidelines. At a
 1279 minimum, the corporation shall withhold benefits from an
 1280 applicant or enrollee if the corporation obtains evidence that
 1281 the applicant or enrollee is no longer eligible, submitted
 1282 incorrect or fraudulent information in order to establish
 1283 eligibility, or failed to provide verification of eligibility.
 1284 The corporation shall notify the applicant or enrollee that,
 1285 because of such evidence, program benefits must be withheld
 1286 unless the applicant or enrollee contacts a designated
 1287 representative of the corporation by a specified date, which
 1288 must be within 10 working days after the date of notice, to
 1289 discuss and resolve the matter. The corporation shall make every
 1290 effort to resolve the matter within a timeframe that will not
 1291 cause benefits to be withheld from an eligible enrollee. The
 1292 following individuals may be subject to specific prosecution in
 1293 accordance with s. 414.39:

1294 1. An applicant who obtains or attempts to obtain benefits
 1295 for a potential enrollee under the Healthy Florida program when
 1296 the applicant knows or should have known that the potential
 1297 enrollee does not qualify for the Healthy Florida program.

1298 2. An individual who assists an applicant in obtaining or
 1299 attempting to obtain benefits for a potential enrollee under the
 1300 Healthy Florida program when the individual knows or should have
 1301 known that the potential enrollee does not qualify for the
 1302 Healthy Florida program.

1303 (9) APPLICABILITY OF LAWS RELATING TO MEDICAID.—The
 1304 provisions of ss. 409.902, 409.9128, and 409.920 apply to the
 1305 administration of the Healthy Florida program.

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

576-02875-13

20131816__

1306 (10) PROGRAM EVALUATION.—The corporation shall collect both
 1307 eligibility and enrollment data from program applicants and
 1308 enrollees as well as encounter and utilization data from all
 1309 contracted entities during the program term. The corporation
 1310 shall submit monthly enrollment reports to the President of the
 1311 Senate, the Speaker of the House of Representative, and the
 1312 Minority Leaders of the Senate and the House of Representatives.
 1313 The corporation shall submit an interim independent evaluation
 1314 of the Healthy Florida program to the presiding officers no
 1315 later than July 1, 2015, with annual evaluations due July 1 each
 1316 year thereafter. The evaluations must address, at a minimum,
 1317 application and enrollment trends and issues, utilization and
 1318 cost data, and customer satisfaction.

1319 (11) PROGRAM EXPIRATION.—The Healthy Florida program shall
 1320 expire at the end of the state fiscal year in which any of these
 1321 conditions occur, whichever occurs first:

1322 (a) The federal match contribution falls below 90 percent.

1323 (b) The federal match contribution falls below the
 1324 increased FMAP for medical assistance for newly eligible
 1325 mandatory individuals as specified in the federal Patient
 1326 Protection and Affordable Care Act, Pub. L. No. 111-148, as
 1327 amended by the federal Health Care and Education Reconciliation
 1328 Act of 2010, Pub. L. No. 111-152.

1329 (c) The federal match for the Healthy Florida program and
 1330 the Medicaid program are blended under federal law or regulation
 1331 in such a way that causes the overall federal contribution to
 1332 diminish when compared to separate, nonblended federal
 1333 contributions.

1334 Section 16. The Florida Healthy Kids Corporation may make

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

576-02875-13 20131816__

1335 changes to comply with the objections of the federal Department
1336 of Health and Human Services to gain approval of the Healthy
1337 Florida program in compliance with the federal Patient
1338 Protection and Affordable Care Act, upon giving notice to the
1339 Senate and the House of Representatives of the proposed changes.
1340 If there is a conflict between a provision in this section and
1341 the federal Patient Protection and Affordable Care Act, Pub. L.
1342 No. 111-148, as amended by the federal Health Care and Education
1343 Reconciliation Act of 2010, Pub. L. No. 111-152, the provision
1344 must be interpreted and applied so as to comply with the
1345 requirement of the federal law.

1346 Section 17. This act shall take effect upon becoming a law.



393192

LEGISLATIVE ACTION

Senate

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House

Appropriations Subcommittee on Health and Human Services (Bean)
recommended the following:

Senate Amendment

Delete line 318
and insert:
bundled services, prepaid health clinic plans, or other prepaid
health care coverage.



496256

LEGISLATIVE ACTION

Senate	.	House
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Appropriations Subcommittee on Health and Human Services (Bean)
recommended the following:

Senate Amendment (with title amendment)

Between lines 359 and 360
insert:

Section 3. The sum of \$15,275,000 from the General Revenue Fund is appropriated to the Agency for Health Care Administration beginning in the 2013-2014 fiscal year to provide funding for the Health Choice Plus Program within Florida Health Choices, Inc., and to fund the corporation's administrative costs necessary for implementing and operating the program.

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



13 And the title is amended as follows:
14 Delete line 29
15 and insert:
16 review and repeal date; providing an appropriation;
17 providing an effective date.



806166

LEGISLATIVE ACTION

Senate	.	House
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Appropriations Subcommittee on Health and Human Services (Bean)
recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause
and insert:

Section 1. Paragraphs (a), (b), (e), and (f) of subsection
(4) and paragraph (b) of subsection (7) of section 408.910,
Florida Statutes, are amended, and paragraph (c) is added to
subsection (10) of that section, to read

408.910 Florida Health Choices Program.—

(4) ELIGIBILITY AND PARTICIPATION.—Participation in the
program is voluntary and shall be available to employers,
individuals, vendors, and health insurance agents as specified



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13 in this subsection.

14 (a) Employers eligible to enroll in the program include
15 those employers:

16 ~~1. Employers that meet criteria established by the~~
17 ~~corporation and elect to make their employees eligible through~~
18 ~~the program.~~

19 ~~2. Fiscally constrained counties described in s. 218.67.~~

20 ~~3. Municipalities having populations of fewer than 50,000~~
21 ~~residents.~~

22 ~~4. School districts in fiscally constrained counties.~~

23 ~~5. Statutory rural hospitals.~~

24 (b) Individuals eligible to participate in the program
25 include:

26 1. Individual employees of enrolled employers.

27 2. Other individuals that meet criteria established by the
28 corporation ~~State employees not eligible for state employee~~
29 ~~health benefits.~~

30 ~~3. State retirees.~~

31 ~~4. Medicaid participants who opt out.~~

32 (e) Eligible individuals may participate in the program
33 ~~voluntarily continue participation in the program regardless of~~
34 ~~subsequent changes in job status or Medicaid eligibility.~~

35 Individuals who join the program may participate by complying
36 with the procedures established by the corporation. These
37 procedures must include, but are not limited to:

38 1. Submission of required information.

39 2. Authorization for payroll deduction.

40 3. Compliance with federal tax requirements.

41 4. Arrangements for payment ~~in the event of job changes.~~



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42 5. Selection of products and services.

43 (f) Vendors who choose to participate in the program may
44 enroll by complying with the procedures established by the
45 corporation. These procedures may include, but are not limited
46 to:

47 1. Submission of required information, including a complete
48 description of the coverage, services, provider network, payment
49 restrictions, and other requirements of each product offered
50 through the program.

51 2. Execution of an agreement to comply with requirements
52 established by the corporation.

53 3. Execution of an agreement that prohibits refusal to sell
54 any offered ~~non-risk-bearing~~ product or service to a participant
55 who elects to buy it.

56 4. Establishment of product prices based on applicable
57 criteria ~~age, gender, and location of the individual~~
58 ~~participant, which may include medical underwriting.~~

59 5. Arrangements for receiving payment for enrolled
60 participants.

61 6. Participation in ongoing reporting processes established
62 by the corporation.

63 7. Compliance with grievance procedures established by the
64 corporation.

65 (7) THE MARKETPLACE PROCESS.—The program shall provide a
66 single, centralized market for purchase of health insurance,
67 health maintenance contracts, and other health products and
68 services. Purchases may be made by participating individuals
69 over the Internet or through the services of a participating
70 health insurance agent. Information about each product and



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71 service available through the program shall be made available
72 through printed material and an interactive Internet website. A
73 participant needing personal assistance to select products and
74 services shall be referred to a participating agent in his or
75 her area.

76 (b) Initial selection of products and services must be made
77 by an individual participant within the applicable open
78 enrollment period ~~60 days after the date the individual's~~
79 ~~employer qualified for participation. An individual who fails to~~
80 ~~enroll in products and services by the end of this period is~~
81 ~~limited to participation in flexible spending account services~~
82 ~~until the next annual enrollment period.~~

83 (10) EXEMPTIONS.-

84 (c) Any standard forms, website design, or marketing
85 communication developed by the corporation and used by the
86 corporation, or any vendor that meets the requirements of s.
87 408.910(4)(f) is not subject to the Florida Insurance Code, as
88 established in s. 624.01.

89 Section 2. Section 408.9105, Florida Statutes, is created
90 to read:

91 408.9105 Health Choice Plus Program.-

92 (1) LEGISLATIVE INTENT.-The Legislature recognizes that
93 there are more than 600,000 uninsured residents in this state
94 who have incomes at or below 100 percent of the federal poverty
95 level. Many insurance options are not affordable, and the
96 Legislature intends to provide a benefit program to those
97 individuals who seek assistance with coverage and who assume
98 individual responsibility for their own health care needs. It is
99 therefore the intent of the Legislature to expand the services



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100 provided by the Florida Health Choices Program and begin the
101 phase-in of the Health Choice Plus Program starting July 1,
102 2013. The Health Choice Plus Program shall:

103 (a) Use the existing infrastructure and governance of
104 Florida Health Choices, Inc., to manage the program described in
105 this section.

106 (b) Offer goods and services to individuals who are between
107 19 to 64 years of age, inclusive.

108 (c) Establish guidelines for financial participation in the
109 program which allow for enrollees and others to contribute
110 toward a health benefits account.

111 1. An enrollee shall contribute at least \$20 per month
112 toward the health benefits account. This contribution amount may
113 be adjusted annually in the General Appropriations Act.

114 2. The level of benefit paid into an enrollee's account
115 using state funds is determined by the corporation based upon
116 the availability of state, local, and federal funds. The amount
117 may not exceed \$10 per individual per month. This amount may be
118 adjusted annually in the General Appropriations Act.

119 (d) Implement an employer-based contribution option.

120 (e) Develop and maintain an education and public outreach
121 campaign for the Health Choice Plus Program.

122 (f) Provide a secure website to facilitate the purchase of
123 goods and services and to provide public information about the
124 program. The website must also provide information about the
125 availability of insurance affordability programs targeted at
126 this population.

127 (g) Establish an incentive program that rewards enrollees
128 for achievements in reaching healthy living goals.



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

130 (a) "CHIP" means Children's Health Insurance Program as
131 authorized under Title XXI of the Social Security Act.

132 (b) "Corporation" means Florida Health Choices, Inc., as
133 established under s. 408.910.

134 (c) "Corporation's marketplace" means the single,
135 centralized market established by the corporation which
136 facilitates the purchase of products made available in the
137 marketplace.

138 (d) "Enrollee" means an individual who participates in or
139 receives benefits under the Health Choice Plus Program.

140 (e) "Goods and services" means the individual products
141 offered for sale to an enrollee on the corporation's marketplace
142 or other health care-related items that may be purchased by an
143 enrollee in the private market. An enrollee may purchase these
144 products using funds accumulated in his or her health benefits
145 account.

146 (f) "Health benefits account" means the account established
147 for an enrollee at the corporation into which funds may be
148 deposited by the state, the enrollee, other individuals, or
149 organizations for the purchase of health care goods and services
150 on the enrollee's behalf.

151 (g) "Lawful permanent resident" means a non-United States
152 citizen who resides in the United States under legally
153 recognized and lawfully recorded permanent residence as an
154 immigrant. This individual may also be known as a permanent
155 resident alien.

156 (h) "Parent" or "caretaker relative" means an individual
157 who is a relative that has primary custody or legal guardianship



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158 of a dependent child and provides the primary care and
159 supervision of that dependent child in the same household. A
160 caretaker relative must be related to the dependent child by
161 blood, marriage, or adoption within the fifth degree of kinship.

162 (i) "Patient Protection and Affordable Care Act" or "PPACA"
163 means the federal law enacted as Pub. L. No. 111-148, as further
164 amended by the federal Health Care and Education Reconciliation
165 Act of 2010, Pub. L. No. 111-152, and any amendments.

166 (j) "Program" means the Health Choice Plus Program
167 established under this section.

168 (k) "Vendor" means an entity that meets the requirements
169 under s. 408.910(4) (d) and is accepted by the corporation.

170 (3) ELIGIBILITY.—

171 (a) To be eligible for the Health Choice Plus Program, an
172 individual must be a resident of this state and meet all of the
173 following criteria:

174 1. Be between 19 and 64 years of age, inclusive.

175 2. Have a modified adjusted gross income that does not
176 exceed 100 percent of the federal poverty level based on the
177 individual's most recent federal tax return, or if the
178 individual did not file a tax return, the individual's most
179 recent monthly income.

180 3. Be a United States citizen or a lawful permanent
181 resident.

182 4. Be ineligible for Medicaid.

183 5. Be ineligible for employer-sponsored insurance coverage.

184 If the enrollee is eligible for employer-sponsored coverage but
185 the cost of that coverage for the enrollee's share for
186 individual coverage would exceed 5 percent of the enrollee's



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187 total modified adjusted gross household income or the enrollee's
188 share of family coverage would exceed 5 percent of enrollee's
189 total modified adjusted gross household income, the enrollee is
190 not considered eligible for employer-sponsored coverage for
191 purposes of this section.

192 6. Not be enrolled in other coverage that meets the
193 definition of essential benefits coverage under PPACA.

194 (b) In addition to the requirements in paragraph (a), an
195 enrollee must meet the following categorical requirements in
196 order to maintain enrollment in the program:

197 1. For an enrollee who is also a parent or a caretaker
198 relative, the enrollee must do all of the following:

199 a. Maintain enrollment in Medicaid or CHIP for any
200 dependent child in the household who is eligible for Medicaid or
201 CHIP and who must be enrolled in Medicaid or CHIP throughout the
202 enrollee's participation in the Health Choice Plus Program.

203 b. Complete a health assessment within the first 3 months
204 after enrollment at a county health department, federally
205 qualified health center, or other approved health care provider.

206 c. Schedule and keep at least one preventive visit with a
207 primary care provider within 6 months after enrollment and
208 repeat the preventive visit at least once every 18 months
209 thereafter.

210 d. Provide proof of employment for at least 20 hours a week
211 or proof of efforts made to seek employment. In lieu of
212 employment, the enrollee may provide proof of volunteering for
213 at least 10 hours a month at a school or at a nonprofit
214 organization or enrollment as a full-time student at an
215 accredited educational institution. Exceptions to this



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216 requirement may be made on a case-by-case basis for medical
217 conditions for an enrollee or if the enrollee is the primary
218 caretaker for a family member who has a chronic and severe
219 medical condition that requires a minimum of 40 hours a week of
220 care.

221 2. For an enrollee who is also a childless adult, the
222 enrollee must do all of the following:

223 a. Provide proof of employment for at least 20 hours a week
224 or proof of efforts made to seek employment. In lieu of
225 employment, the enrollee may provide proof of volunteering for
226 at least 20 hours a month at a school or at a nonprofit
227 organization or enrollment as a full-time student at an
228 accredited educational institution. Exceptions to this
229 requirement may be made on a case-by-case basis for medical
230 conditions for the enrollee or if the enrollee is the primary
231 caretaker for a family member who has a chronic and severe
232 medical condition that requires a minimum of 40 hours a week of
233 care.

234 b. Complete a health assessment within the first 3 months
235 after enrollment at a county health department, federally
236 qualified health center, or other approved health care provider.

237 c. Schedule and keep at least one preventive visit with a
238 primary care provider within the first 6 months after enrollment
239 and repeat the preventive visit at least once every 18 months
240 thereafter.

241
242 If the enrollee fails to meet the requirements specified in this
243 subsection, the enrollee is disenrolled from the program at the
244 end of the month in which the enrollee fails to meet the



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245 requirements. The enrollee may receive one 30-day extension to
246 comply before cancellation of coverage. If an enrollee's
247 coverage is canceled, the enrollee may not reapply for coverage
248 until the next open enrollment period or 90 days after
249 cancellation of coverage occurs, whichever occurs later. The
250 individual's reenrollment is subject to available funding.

251 (4) ENROLLMENT.—

252 (a) Enrollment in the Health Choice Plus Program may occur
253 through the portal of the Florida Health Choices Program, a
254 referral process from the Department of Children and Families,
255 the Florida Healthy Kids Corporation, or the exchange as defined
256 by the federal Patient Protection and Affordable Care Act.

257 (b) Subject to available funding, the corporation shall
258 establish at least one open enrollment period each year. When
259 the program is full based on available funding, enrollment must
260 cease.

261 (c) Eligibility is determined by using electronic means to
262 the fullest extent practicable before requesting any written
263 documentation from an applicant.

264 (5) HEALTH BENEFITS ACCOUNT.—

265 (a) A health benefits account is established for each
266 enrollee upon confirmation of eligibility in the program. The
267 corporation shall determine the deposit amount and frequency of
268 deposits based on the availability of funds, the number of
269 enrollees, and other factors.

270 (b) An enrollee shall make a financial contribution toward
271 his or her own health benefits account in order to maintain
272 enrollment in accordance with paragraph (1)(c).

273 1. The corporation shall establish disenrollment criteria



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274 for failure to pay the required minimum contribution.

275 2. The disenrollment criteria must include waiting periods
276 of not more than 1 month before reinstatement to the program if
277 the enrollee is still eligible and has paid all required
278 financial obligations.

279 3. The enrollee's employer may contribute toward an
280 employee's health benefits account under the program, including
281 making the enrollee's required contribution, in whole or in
282 part, to the enrollee's health benefits account at any time.

283 (c) Subject to appropriations available for this specific
284 purpose, the corporation shall establish a procedure for the
285 deposit of supplemental or bonus funds into an enrollee's health
286 benefits account if certain healthy living performance goals are
287 achieved. These goals must be established no later than July 1
288 in each fiscal year and distributed to all enrollees, published
289 on the corporation's website, and distributed to new enrollees
290 within 30 calendar days after enrollment. For the 2014 calendar
291 year, the goals must be established no later than October 1,
292 2013.

293 1. An enrollee may use funds deposited in a health benefits
294 account to offset other health care costs or to purchase other
295 products and services offered by the marketplace, subject to
296 guidelines established by the corporation and in accordance with
297 federal law.

298 2. Bonus funds may accumulate in the enrollee's health
299 benefits account for the duration of the program and must
300 automatically expire and return to the corporation upon the
301 termination of the program.

302 (d) The marketplace is encouraged to use existing community



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303 programs and partnerships to deliver services and to include
304 traditional safety net providers for the delivery of services to
305 enrollees, including, but not limited to, rural health clinics,
306 federally qualified health centers, county health departments,
307 emergency room diversion programs, and community mental health
308 centers. A health care entity that receives state funding must
309 participate in the Health Choice Plus Program and offer services
310 or products through the marketplace or to enrollees, as
311 appropriate. An enrollee may be required to make nominal
312 copayments to providers for nonpreventive services. The
313 corporation may establish the amount of the copayments when
314 applicable.

315 (e) Except for supplemental funds described under paragraph
316 (c), funds deposited in a health benefits account belong to the
317 enrollee when deposited and are available for health-care-
318 related expenditures, including, but not limited to, physician's
319 fees, hospital costs, prescriptions, insurance premium payments,
320 copayments, and coinsurance. The corporation shall establish a
321 process or contract with another entity for the management of
322 the funds. The process must ensure the timely distribution and
323 the appropriate expenditure of the state's contributions.

324 (f) The corporation shall establish a refund process for an
325 enrollee who requests the closure of a health benefits account
326 and the return of any unspent individual contributions. The
327 enrollee may be refunded only those funds that the enrollee or
328 employer has contributed to his or her health benefits account.
329 All other state funds in the enrollee's health benefits account
330 revert to the corporation.

331 (6) FUNDING.-



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332 (a) The corporation may accept funds from an employer to
333 deposit into an enrollee's health benefits account to supplement
334 funds if such a deposit is not in conflict with other provisions
335 of this section.

336 (b) The corporation may accept state and federal funds to
337 further subsidize the costs of coverage and to administer the
338 program.

339 (c) The corporation shall seek other grants and donations
340 to support the program.

341 (d) An assessment on vendors that participate in the
342 marketplace may be used to fund the administration of the
343 program.

344 (7) SERVICES.—The corporation shall manage the health
345 benefits accounts and provide a marketplace of options from
346 which an enrollee may also use his or her health benefits
347 account to purchase individual services and products, including,
348 but not limited to, discount medical plans, limited benefit
349 plans, health flex plans, individual health insurance plans,
350 prepaid health clinic plans, bundled services, or other prepaid
351 health care coverage.

352 (8) HEALTHY LIVING PERFORMANCE GOALS AND PAYMENT.—

353 (a) To the extent that funds are made available for this
354 purpose, an enrollee is rewarded for achieving a healthy
355 lifestyle and using preventive health care services
356 appropriately.

357 (b) The program shall post on its website, by July 1 of
358 each fiscal year, a list of optional healthy living performance
359 goals and the proposed incentives for achievement of each goal.
360 The corporation shall establish a procedure for the



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361 documentation of such goals, timeframes for achievement of the
362 optional goals, and the payment of supplemental amounts into an
363 enrollee's health benefits account, subject to available
364 funding.

365 (c) Bonus payments for achieving a healthy living
366 performance goal shall be paid into an enrollee's health
367 benefits account at the end of the quarter in which the goal is
368 achieved. The amount of the payment is based upon the schedule
369 posted by the program on July 1 of that fiscal year.

370 (9) LIABILITY.—Coverage under the Health Choice Plus
371 Program is not an entitlement, and a cause of action does not
372 arise against the state, a local governmental entity, any other
373 political subdivision of the state, or the corporation or its
374 board of directors for failure to make coverage under this
375 section available to an eligible person or for discontinuation
376 of any coverage.

377 (10) PROGRAM EVALUATION.—The corporation shall include
378 information about the Health Choice Plus Program in its annual
379 report under s. 408.910. The corporation shall complete and
380 submit by January 1, 2016, a separate independent evaluation of
381 the effectiveness of the Health Choice Plus Program to the
382 Governor, the President of the Senate, and the Speaker of the
383 House of Representatives.

384 (11) PROGRAM REVIEW.—The Health Choice Plus Program is
385 subject to repeal on July 1, 2016, unless reviewed and saved
386 from repeal through reenactment by the Legislature.

387 Section 3. The sum of \$15,275,000 from the General Revenue
388 Fund is appropriated to the Agency for Health Care
389 Administration beginning in the 2013-2014 fiscal year to provide



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390 funding for the Health Choice Plus Program within Florida Health
391 Choices, Inc., and to fund the corporation's administrative
392 costs necessary for implementing and operating the program.

393 Section 4. This act shall take effect July 1, 2013.

394

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

396 And the title is amended as follows:

397 Delete everything before the enacting clause
398 and insert:

399 A bill to be entitled
400 An act relating to the Health Choice Plus Program;
401 amending s. 408.910, F.S.; conforming provisions to
402 changes made by the act; providing that the Florida
403 Insurance Code is not applicable in certain
404 circumstances; creating s. 408.9105, F.S.; creating
405 the Health Choice Plus Program; providing legislative
406 intent; providing requirements of the program;
407 providing definitions; providing eligibility
408 requirements; providing for enrollment in the program;
409 providing requirements and procedures for the deposit
410 and use of funds in a health benefits account;
411 providing that the marketplace is encouraged to use
412 existing community programs and partnerships to
413 deliver services and to include traditional safety net
414 providers for the delivery of services to enrollees;
415 requiring Florida Health Choices, Inc., to establish a
416 refund process; authorizing the corporation to accept
417 funds from various sources to deposit into health
418 benefits accounts, subsidize the costs of coverage,



419 and administer and support the program; requiring the
420 corporation to manage the health benefits accounts and
421 provide the marketplace of options which an enrollee
422 in the program may use; providing for payment for
423 achieving healthy living performance goals; requiring
424 the program to post on its website a list of optional
425 healthy living performance goals and to establish a
426 procedure for documentation, achievement, and payment
427 regarding the healthy living performance goals;
428 providing that coverage under the program is not an
429 entitlement; prohibiting a cause of action against
430 certain entities under certain circumstances;
431 requiring the corporation to submit to the Governor
432 and the Legislature information about the program in
433 its annual report and an evaluation of the
434 effectiveness of the program; providing for a program
435 review and repeal date; providing an appropriation;
436 providing an effective date.

The Florida Senate
BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Appropriations Subcommittee on Health and Human Services

BILL: SB 1844

INTRODUCER: Health Policy

SUBJECT: Health Choice Plus Program

DATE: April 15, 2013 REVISED: _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Brown	Pigott	AHS	Pre-meeting
2.	_____	_____	AP	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____

I. Summary:

SB 1844 creates a new health care services program, the Health Choice Plus (HCP) program within the Florida Health Choices Corporation (FHCC). The FHCC will phase-in the HCP program and be responsible for its ongoing oversight, including the delivery of services, management of contracts, and collection of enrollee or employer contributions.

The HCP is created as an alternative health benefits program for uninsured, low income Floridians with incomes at or below 100 percent of the federal poverty level (FPL) who meet other designated eligibility criteria. Enrollees and the state will jointly fund health benefits accounts, to be managed by the FHCC, to the extent funds are appropriated annually in the General Appropriations Act (GAA). Enrollees may utilize funds in those accounts to purchase a range of health care products from the FHCC’s marketplace or to offset other out of pocket health care costs. Enrollees must contribute at least \$20 per month and the state will contribute no more than \$10 per month. These amounts may be adjusted annually in the GAA.

The bill has an estimated fiscal impact of \$15,275,000 general revenue (GR) for Fiscal Year 2013-2014.

Continued enrollment in HCP is contingent upon several factors, including but not limited to, an enrollee health assessment within the first three months of enrollment, continued payment of the monthly contribution requirement, and the enrollee’s employment or full-time school enrollment. Exceptions to full-time employment may be made for an enrollee’s medical condition or where the enrollee is the primary caregiver for a relative with a chronic medical condition that requires at least 40 hours of care per week. Supplemental payments may also be deposited to an enrollee’s health benefits account for successful achievement of optional healthy living goals,

subject to a specific appropriation for this purpose. Total enrollment in the program is limited based on the availability of funds.

The program is subject to automatic repeal on July 1, 2016, unless reenacted by the Legislature.

The bill has and effective date of July 1, 2013.

The bill substantially amends section 408.910 of the Florida Statutes.

The bill creates section 408.9105 of the Florida Statutes.

II. Present Situation:

Florida provides health insurance coverage options to low income Floridians through a variety of programs utilizing state and federal funds. As of February 28, 2013, more than 3.2 million individuals received coverage through the Medicaid program.¹ Enrollment in the Florida Kidcare program's non-Medicaid funded components for the same time period was an additional 256,721 children.²

Florida's Medicaid program is expected to spend \$21 billion for Fiscal Year 2012-2013, making it fifth largest in the nation for expenditures.³ The Medicaid program is jointly funded between the state and federal governments; 52.73 percent of the costs for health care services are paid by federal funds and 42.27 percent is state share in the current fiscal year. Funding for the Florida Kidcare program's Title XXI components has an enhanced federal match of 70.66 percent for the 2012-2013 federal fiscal year.⁴

According to the most recent data from the American Community Survey (ACS) of the federal Census Bureau, an estimated four million Floridians are uninsured.⁵ Of that number, according to the ACS data, 594,000 are children.⁶ More than 1.9 million uninsured adults are under 139 percent of the FPL, according to statistics for 2010-2011.⁷ Lower income adults – those below 100 percent of the FPL – number at 1.1 million for that same time period.⁸

¹ Agency for Health Care Administration, *Report of Medicaid Eligibles*, http://ahca.myflorida.com/Medicaid/about/pdf/age_assistance_category_130228.pdf (last visited Mar. 17, 2013).

² Agency for Health Care Administration, *Florida KidCare Enrollment Report – February 2013*, (copy on file with the Senate Health Policy Committee).

³ Agency for Health Care Administration, Presentation to House Health and Human Services Committee, *Florida Medicaid: An Overview - December 5, 2012*, [http://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=2714&Session=2013&DocumentType=Meeting Packets&FileName=HHSC_Mtg_12-5-12_ONLINE.pdf](http://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=2714&Session=2013&DocumentType=Meeting%20Packets&FileName=HHSC_Mtg_12-5-12_ONLINE.pdf) (last visited Mar. 17, 2013).

⁴ Florida KidCare Coordinating Council, *2013 Annual Report and Recommendations*, p. 5, (January 2013), http://www.floridakidcare.org/council/reports/2013_KCC_Report.pdf (last visited Mar. 17, 2013).

⁵ Office of Economic and Demographic Research, Florida Legislature, *Economic Analysis of PPACA and Medicaid Expansion*, Presentation to Senate Select Committee on Patient Protection and Affordable Care Act (Mar. 4, 2013), http://www.floridakidcare.org/council/reports/2013_Recommendations.pdf (last visited Mar. 17, 2013).

⁶ Id.

⁷ Kaiser Family Foundation, statehealthfacts.org, *Health Insurance Coverage of the Non-Elderly (0-64) with Incomes up to 139% of FPL (2010-2011)*, <http://www.statehealthfacts.org/profileind.jsp?ind=849&cat=3&rgn=11&cmprgn=1> (last visited Mar. 17, 2013).

⁸ Id.

Eligibility for the current Medicaid program is based on a number of factors, including age, household or individual income, and assets. The Department of Children and Families (DCF) determines eligibility for Medicaid but the Agency for Health Care Administration (AHCA) is the single state Medicaid agency under s. 409.963, F.S., and has the lead responsibility for the overall program.⁹

Recipients in the Medicaid program receive their benefits through several different delivery systems depending on their individual situation. Delivery systems currently include fee-for-service providers and various managed care organizations, including provider service networks (PSNs), health maintenance organizations (HMOs), and prepaid limited health service organizations. In July 2006, the AHCA implemented the Medicaid Managed Care Pilot Program as directed by the 2005 Legislature through s. 409.91211, F.S. The pilot program operates under an 1115 Research and Demonstration Waiver approved by the federal Centers for Medicare and Medicaid Services (CMS). The pilot program was initially authorized for Broward and Duval counties with expansion to Baker, Clay and Nassau the following year.

Under the current pilot program, most Medicaid recipients in the five pilot counties (Baker, Broward, Clay, Duval, and Nassau counties) are required to receive their benefits through either HMOs, PSNs, or a specialty plan. In addition to the minimum benefits package, plans may provide enhanced services such as over-the-counter benefits, preventive dental care for adults, and health and wellness benefits.

Medicaid Statewide Managed Medical Care Program

In 2011, the Legislature passed HB 7107, creating the Statewide Medicaid Managed Care (SMMC) Program as ch. 409, part IV, F.S. SMMC requires the AHCA to create an integrated managed care program for Medicaid enrollees that incorporates all of the minimum benefits, for the delivery of primary and acute care as well as long-term care services. SMMC has two components: the Long Term Care (LTC) Managed Care component and the Managed Medical Assistance (MMA) component.

To implement SMMC and receive federal Medicaid funding, the AHCA was required to seek federal authorization through two different Medicaid waivers from CMS. The first component authorized was the LTC Managed Care component's 1915(b) and (c) waiver. Approval was granted on February 1, 2013.

The LTC Managed Care component will serve Medicaid-eligible recipients who are also determined to require a nursing facility level of care. Medicaid recipients who qualify will receive all of their long-term care services from the long-term care managed care plan.

Implementation of the LTC Managed Care component started July 1, 2012, with completion expected by October 1, 2013. The AHCA released an Invitation to Negotiate (ITN) on June 29, 2012, and on January 15, 2013, notices of contract awards to managed care plans under that ITN were announced.

⁹ Agency for Health Care Administration, *Welcome to Medicaid!*, <http://ahca.myflorida.com/Medicaid/index.shtml> (last visited Mar. 17, 2013).

For the MMA component, the AHCA sought to modify the existing Medicaid Reform 1115 Demonstration waiver to expand the program statewide. The AHCA initiated the SMMC project in January 2012 and released a separate ITN to competitively procure managed care plans on a statewide basis on December 28, 2012. Bids were due to the AHCA on March 29, 2013, and awards are expected to be announced on September 16, 2013.

Plans can supplement the minimum benefits in their bids and offer enhanced options. The number of plans to be selected by region is prescribed under s. 409.974, F.S. Specialty plans that serve specific, targeted populations based on age, medical condition, and diagnosis are also included under SMMC. Under s. 409.967, F.S., accountability provisions for the managed care plans specify several conditions or requirements, including emergency care and physician reimbursement standards, access and credentialing requirements, encounter data submission guidelines, and grievance and resolutions.

Statewide implementation of SMMC is expected to be completed by October 1, 2014. Final approval of the necessary Medicaid waiver by the federal government has not yet been received; however, on February 20, 2013, the AHCA and the CMS reached an “Agreement in Principle” on the proposed plan.

Under SMMC, all persons meeting applicable eligibility requirements of Title XIX of the Social Security Act must be enrolled in a managed care plan. Medicaid recipients who (a) have other creditable care coverage, excluding Medicare, (b) reside in residential commitment facilities operated through the Department of Juvenile Justice, group care facilities operated by the DCF, and treatment facilities funded through DCF Substance Abuse and Mental Health Program; (c) are eligible for refugee assistance; or (d) are residents of a developmental disability center, may voluntarily enroll in the SMMC program. If they elect not to enroll, they will be served through the Medicaid fee-for-service system.

Cover Florida and Florida Health Choices

In 2008, the Florida Legislature created two programs simultaneously to address the issue of Florida’s uninsured: the Cover Florida Health Access Program and the Florida Health Choices Program.¹⁰ The two programs offered two unique methods of addressing Florida’s uninsured population.

Cover Florida Health Access Program

Cover Florida is designed to provide affordable health care options for uninsured residents between the ages of 19 and 64 and who met other criteria under s. 408.9091, F.S. The AHCA and the Office of Insurance Regulation (OIR) have joint responsibility for the program and were directed to issue an Invitation to Negotiate (ITN) to secure plans for the delivery of services by July 1 2008. An ITN was released July 2, 2008, and as a result of that ITN, two-year contracts were executed with two statewide plans and four regional plans.¹¹

¹⁰ See Chapter Law 2008-32.

¹¹ Agency for Health Care Administration, *Cover Florida Health Care Access Program Annual Report (March 2013)*, p. 1, http://ahca.myflorida.com/MCHO/Managed_Health_Care/CHMO/docs/CoverFLReport-Mar2013.pdf (last visited Mar. 22, 2013).

The Cover Florida plans are not subject to the Florida Insurance Code and ch. 641, F.S., relating to HMOs. Two plan options were required for development: plans with catastrophic coverage and plans without catastrophic coverage. Plans without catastrophic coverage are required to include other benefit options such as:¹²

- Incentives for routine preventive care;
- Office visits for diagnosis and treatment of illness or injury;
- Behavioral health services;
- Durable medical equipment and prosthetics; and,
- Diabetic supplies.

Plans that did include catastrophic coverage are required to include all of the benefits above, plus have options for these additional benefits:¹³

- Inpatient hospital stays;
- Hospital emergency care services;
- Urgent care services; and,
- Outpatient facility services, outpatient surgery, and outpatient diagnostic services.

All plans are guarantee-issue policies and are required to include prescription drug benefits. Plans can also place limits on services and cap benefits and copayments.

To be eligible, the enrollee must be:

- A resident of Florida;
- Between 19 and 64 years old;
- Not covered by private insurance or eligible for public insurance, unless eligibility for coverage lapses due to no longer meeting income or categorical requirements; and,
- Uninsured for at least the prior six months, with exceptions for persons who lose coverage within the past six months under certain conditions.

As of December 17, 2010, no insurers or HMOs offered any new policies under Cover Florida.¹⁴ The six insurers selected by the state in 2009 to participate in Cover Florida ceased enrollment in 2011 due to lack of participation by both insurers and participants.¹⁵ Currently, 1,997 enrollees participate in two plans and both plans will terminate those policies in 2014.¹⁶

¹² See s. 409.9091(4)(6)(a).

¹³ See s. 409.9091(4)(a)(7).

¹⁴ Department of Financial Services, *Cover Florida Health Care Access Program Defined*, http://www.myfloridacfo.com/consumers/insurancelibrary/insurance/l_and_h/cover_florida/cover_florida_-_defined.htm (last visited Mar. 22, 2013).

¹⁵ South Florida Business Journal, Brian Bandell, <http://www.bizjournals.com/southflorida/print-edition/2011/03/25/cover-florida-health-plan-program.html?s=print>, Mar. 25, 2011, (last visited Mar. 22, 2013).

¹⁶ *Supra* note 11, at 2.

Florida Health Choices Program (FHCP)

The FHCP is a private, non-profit, corporation under s. 408.917, F.S., and is led by a 15-member board of directors. The FHCP is designed as a single, centralized marketplace for the purchase of health products including, but not limited to, health insurance plans, HMO plans, prepaid services, and flexible spending accounts. Policies sold as part of the program are exempt from regulation under the Insurance Code and laws governing HMOs. The following entities are authorized to be eligible vendors:

- Insurers authorized under ch. 624, F.S.;
- HMOs authorized under ch. 641, F.S.;
- Prepaid health clinics licensed under ch. 641, part II, F.S.;
- Health care providers, including hospitals and other licensed health facilities, health care clinics, pharmacies, and other licensed health care providers;
- Provider organizations, including service networks, group practices, and professional associations; and,
- Corporate entities providing specific health services.

The FHCP is authorized to collect premiums and other payments from employers. The law further specifies who may participate as either an employer or an individual. Employers eligible to enroll include:¹⁷

- Employers that meet criteria established by the FHCP and elect to make their employees eligible;
- Fiscally constrained counties described in s. 218.67, F.S.;
- Municipalities having populations of fewer than 50,000 residents;
- School districts in fiscally constrained counties; or,
- Statutory rural hospitals.

Individuals eligible to participate include:¹⁸

- Individual employees of enrolled employers;
- State employees not eligible for state employee health benefits;
- State retirees; or,
- Medicaid participants who opt-out.

For phase one of Florida Health Choices' launch in 2013, the Marketplace will serve small businesses with 2 to 50 employees.¹⁹ The initial list of vendors will include plans from Florida Blue, Florida Health Care Plans, Argus Dental, and Liberty Dental.²⁰ The pilot will last six months and then the FHCP will evaluate adding other services.²¹

¹⁷ See s. 408.910(4)(a), F.S.

¹⁸ See s. 408.910(4)(b), F.S.

¹⁹ Florida Health Choices, *2012 Annual Report*, p. 4, http://myfloridachchoices.org/wp-content/uploads/2011/03/FHC-AnnualReport-2012_v4a.pdf (last visited Mar. 22, 2013).

²⁰ Florida Health Choices, *Florida Health Choices Announces Initial Offerings*, (Feb. 22, 2013) <http://myfloridachchoices.org/florida-health-choices-announces-initial-offerings/> (last visited Mar. 25, 2013).

²¹ *Supra* Note 19 at 3.

The Patient Protection and Affordable Care Act (PPACA)

In March 2010, the Congress passed the PPACA.²² One of the PPACA's key components requires states to expand Medicaid to a minimum eligibility threshold of 133 percent of the FPL, or as it is sometimes expressed, 138 percent of the FPL when considering the automatic five-percent income disregard, effective January 1, 2014.²³ While the costs for the newly eligible under this expansion would be initially funded at 100 percent federal funds for the first three calendar years, states would gradually be required to pay a share of the costs, starting at five percent in calendar year 2017 before leveling off at 10 percent in 2020.²⁴ Under the PPACA as enacted, states refusing to expand to the new eligibility threshold faced the loss of *all* of their federal Medicaid funding.²⁵

Florida, along with 25 other states challenged the constitutionality of the law. In *NFIB v. Sebelius*, the U.S. Supreme Court found the enforcement provisions of the Medicaid expansion unconstitutional.²⁶ As a result, states could voluntarily expand their Medicaid populations to 138 percent of the FPL and receive the enhanced federal match, but could not be required to do so for the population defined as newly eligible in the law, which was interpreted by the federal Department of Health and Human Services (HHS) to be only the adult population (childless adults aged 19 - 64).²⁷ States are unable to receive the enhanced federal matching funds for partial Medicaid expansions.²⁸

While finding the adult expansion of Medicaid optional, subsequent federal guidance has also emphasized state flexibility in how states expand coverage to those defined as newly eligible. In a letter to the National Governors Association January 14, 2013, HHS Secretary Kathleen Sebelius reminded states of their ability to design flexible benefit packages without the need for waivers.²⁹ This letter had been preceded by an HHS document entitled "Frequently Asked Questions on Exchange, Market Reforms and Medicaid" on December 10, 2012, that discussed promotion of personal responsibility, wellness benefits, and state flexibility to design benefits.³⁰

A state Medicaid director letter on November 20, 2012 (ACA #21), further addressed state options for the adult Medicaid expansion group and the alternative benefit plans available under Section 1937 of the Social Security Act.³¹ Under Section 1937, state Medicaid programs have the

²² Pub. Law No. 111-148, H.R. 3590, 111th Cong. (Mar. 23, 2010).

²³ 42 U.S.C. s. 1396a(10).

²⁴ 42 U.S.C. s. 1396d(y)(1).

²⁵ 42 U.S.C. s. a1396c

²⁶ See *supra* note 1.

²⁷ Department of Health and Human Services, *Secretary Sebelius Letter to Governors, July 10, 2012*, <http://capsules.kaiserhealthnews.org/wp-content/uploads/2012/07/Secretary-Sebelius-Letter-to-the-Governors-071012.pdf> (last visited Mar. 16, 2013).

²⁸ Centers for Medicare and Medicaid Services, *Frequently Asked Questions on Exchanges, Market Reforms and Medicaid (December 10, 2012)*, p.12, <http://medicaid.gov/State-Resource-Center/Frequently-Asked-Questions/Downloads/Governor-FAQs-12-10-12.pdf> (last visited April 1, 2013).

²⁹ *Letter to National Governor's Association from Secretary Sebelius*, January 14, 2013 (copy on file with Senate Health Policy Committee).

³⁰ See *Supra* note 28, at 15-16.

³¹ Centers for Medicare and Medicaid Services, *State Medicaid Director Letter: Essential Health Benefits in the Medicaid Program* (November 20, 2012), <http://www.medicicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-003.pdf> (last visited Mar. 17, 2013).

option of providing certain groups with benchmark or benchmark-equivalent coverage based on four products: (1) the standard Blue Cross/Blue Shield Preferred Provider option offered to federal employees; (2) state employee coverage that is generally offered to all state employees; (3) the commercial HMO with the largest insured, non-Medicaid enrollment in the state or (4) coverage approved by the HHS secretary.³² For children under the age of 21, the coverage must include the Early and Periodic Screening, Diagnostic and Treatment Service (EPSDT). Other aspects of the essential health benefit requirements of the PPACA, as discussed further below, may also be applicable, depending on the benefit package utilized.

In addition to the Medicaid expansion component, the PPACA imposes a mandate on individuals to buy insurance, or pay a penalty, which was interpreted by the U.S. Supreme Court as a tax. Currently, many uninsured individuals are eligible for Medicaid or Kidcare coverage but are not enrolled. The existence of the federal mandate to purchase insurance may result in some indeterminate number of current eligibles coming forward and enrolling in Medicaid who had previously not enrolled. Their participation will result in increased costs and would not likely have occurred without the catalyst of the federal legislation.

To obtain insurance coverage, the PPACA authorized the state-based American Health Benefit exchanges and Small Business Health Options Program (SHOP) exchanges. These exchanges are to be administered by governmental agencies or non-profit organizations and be ready to accept applications for coverage beginning October 1, 2013, for January 1, 2014, coverage dates. The exchanges, at a minimum, must:³³

- Certify, re-certify and de-certify plans participating on the exchange;
- Operate a toll-free hotline;
- Maintain a website;
- Provide plan information and plan benefit options;
- Interact with the state's Medicaid and CHIP programs and provide information on eligibility and determination of eligibility for these programs;
- Certify individuals who gain exemptions from the individual responsibility requirement; and
- Establish a navigator program.

The initial guidance from the HHS in November 2010 set forward a number of principles and priorities for the exchanges. Further guidance was issued on May 16, 2012, detailing the proposed operations of federally facilitated exchanges for those states that elected not to implement a state-based exchange. On November 16, 2012, Florida Governor Rick Scott notified HHS that Florida had too many unanswered questions to commit to a state-based exchange under the PPACA for the first enrollment period on January 1, 2014.³⁴

³² See *supra* note 31, at 2.

³³ Centers for Medicare and Medicaid Services, Initial Guidance to States on Exchanges, November 18, 2010, http://cciio.cms.gov/resources/files/guidance_to_states_on_exchanges.html (last visited Mar. 16, 2013).

³⁴ Letter from Governor Rick Scott to Health and Human Services Secretary Kathleen Sebelius, November 16, 2012 <http://www.flgov.com/2012/11/16/letter-from-governor-rick-scott-to-u-s-secretary-of-health-and-human-services-kathleen-sebelius/> (last visited Mar. 16, 2013).

The PPACA also includes a tax penalty for those individuals that do not have qualifying health insurance coverage beginning January 1, 2014. The penalty is the greater of \$695 per year, up to a maximum of three times that amount per family or 2.5% of household income. The penalty, however, is phased-in and exemptions apply.

The following persons are exempt from the PPACA's requirement to maintain coverage:³⁵

- Individuals with a religious objection;
- Individuals not lawfully present; and
- Incarcerated individuals.

The following persons are exempt from the PPACA's penalty for failure to maintain coverage:³⁶

- Individuals who cannot afford coverage, i.e. those whose required premium contributions exceed eight percent of household income;
- Individuals with income below the income tax filing threshold;
- American Indians;
- Individuals without coverage for less than three months; and
- Individuals determined by the HHS secretary to have suffered a hardship with respect to the capability to obtain coverage under a qualified plan.

Qualifying coverage may be obtained through an employer, the federal or state exchanges created under PPACA, or private individual or group coverage meeting the minimum essential benefits coverage standard.

Employers with more than 50 full time employees also share a financial responsibility under PPACA. Employers with more than 50 full-time employees that do not offer coverage meeting the essential benefits coverage standard and who have at least one employee receive a premium tax credit will be assessed a fee of \$2,000 per full time employee, after the 30th employee.³⁷ If an employer does offer coverage and an employee receives a premium tax credit, the employer is assessed the lesser of \$3,000 per employee receiving the credit or \$2,000 per each employee after the 30th employee.³⁸

Premium credits and other cost sharing subsidies are available to United States citizens and legal immigrants within certain income limits for coverage purchased through the exchanges. Legal immigrants with incomes at or below 100 percent of the FPL who are not eligible for Medicaid during their first five years are eligible for premium credits.³⁹ Premium credits are set on a

³⁵ See Sec. 5000A(d), Internal Revenue Code of 1986, as created or amended by the Patient Protection and Affordable Care Act of 2010 and/or the Health Care and Education Reconciliation Act of 2010.

³⁶ See Sec. 5000A(e), Internal Revenue Code of 1986, as created or amended by the Patient Protection and Affordable Care Act of 2010 and/or the Health Care and Education Reconciliation Act of 2010.

³⁷ Kaiser Family Foundation, *Summary of New Health Reform Law*, Last Modified April 15, 2011, <http://www.kff.org/healthreform/upload/8061.pdf> (last viewed Mar. 16, 2013).

³⁸ Kaiser Family Foundation, *Summary of New Health Reform Law*, Last Modified April 15, 2011, <http://www.kff.org/healthreform/upload/8061.pdf> (last viewed Mar. 16, 2013).

³⁹ 26 U.S.C. s. 36B(c).

sliding scale based on the percent of FPL for the household and reduce the out-of-pocket costs incurred by individuals and families.

The amount for premium tax credits, as a percentage of income, are set in section 36B of the Internal Revenue Code follows⁴⁰:

Premium Tax Credits	
Income Range	Premium Percentage Range (% of income)
Up to 133% FPL	2%
133% to 150%	3% - 4%
150% to 200%	4% - 6.3%
200% to 250%	6.3% - 8.05%
250% to 300%	8.05% - 9.5%
300% to 400%	9.5%

Subsidies for cost sharing are also applicable for those between 100 percent of the FPL and 400 percent of the FPL.⁴¹ For 2013, 100 percent of the FPL equates to the following by family size:⁴²

2013 Federal Poverty Guidelines – 100% FPL	
Family Size	Maximum Annual Income
1	\$11,490
2	\$15,510
3	\$19,530
4	\$23,550

The cost sharing credits reduce the out-of-pocket amounts incurred by individuals on essential health benefits and will also impact the actuarial value of a health plan. Actuarial value reflects the average share of covered benefits paid by the insurer or health plan.⁴³ For example, if the actuarial value of a plan is 90 percent, the health plan is paying 90 percent of the costs and the enrollee 10 percent. Under the PPACA, the maximum amount of cost sharing under this component range from 94 percent for those between 100 percent to 150 percent of the FPL, to 70 percent for those between 250 percent and 400 percent of the FPL.⁴⁴

⁴⁰ 26 U.S.C. s. 36B(c).

⁴¹ Kaiser Family Foundation, *Summary of New Health Reform Law*, Last Modified April 15, 2011, <http://www.kff.org/healthreform/upload/8061.pdf> (last viewed Mar. 16, 2013).

⁴² See Annual Update of the HHS Poverty Guidelines, 78 Fed. Reg. 5182, 5183 (January 24, 2013) <https://www.federalregister.gov/articles/2013/01/24/2013-01422/annual-update-of-the-hhs-poverty-guidelines#t-1> (last visited Mar. 29, 2013).

⁴³ Lisa Bowen Garrett, et al., The Urban Institute, *Premium and Cost Sharing Subsidies under Health Reform: Implications for Coverage, Costs and Affordability* (December 2009), http://www.urban.org/UploadedPDF/411992_health_reform.pdf (last visited Mar. 16, 2013).

⁴⁴ Kaiser Family Foundation, *Summary of New Health Reform Law*, Last Modified April 15, 2011, <http://www.kff.org/healthreform/upload/8061.pdf> (last viewed Mar. 16, 2013).

Select Committee on Patient Protection and Affordable Care Act

In December 2012, Florida Senate President Don Gaetz formed the Select Committee on the PPACA to launch a comprehensive assessment on the impact of the law on Florida, evaluate the state's options under the law, and to make recommendations to the full Senate membership on any actions necessary to mitigate cost increases, preserve a competitive insurance market, and protect Florida's consumers.⁴⁵ The Select Committee received public testimony, expert presentations, and staff reports over nine meetings before it developed three specific recommendations relating to the development of a health care exchange, coverage for certain state employees, and the expansion of Medicaid. On Medicaid, the Select Committee voted 7-4 to recommend to the full Senate to not expand Medicaid under the current state plan or pending waivers.⁴⁶ Following that vote, two alternative proposals for coverage of the population under 138 percent of the FPL that utilize the private insurance market were put forward for further discussion and debate.⁴⁷

III. Effect of Proposed Changes:

Section 1 revises the legislative intent for the Florida Health Choices program to recognize the Health Choice Plus Program (HCP).

Section 2 creates s. 408.9105, F.S., and a new program called Health Choice Plus (HCP). The HCP program is managed by the FHCC under its existing infrastructure and governance and provides a benefit program to uninsured Floridians under 100 percent of the FPL. The bill establishes health benefit accounts for enrollees with financial contributions from the enrollee, the state (subject to funding in the GAA), and other sources such as the enrollee's employer; and provides a marketplace for enrollees to purchase health care goods and services utilizing funds from health benefits account. Examples of products that may be purchased include, but are not limited to, discount medical plans, limited benefit plans, health flex plans, individual health insurance plans, bundled services, or other prepaid health care coverage.

The bill provides specific criteria for initial eligibility for HCP and conditions for continued enrollment. The bill requires that an enrolled individual meet the following conditions:

- Be a resident of Florida;
- Be between the ages of 19 and 64;
- Have a modified adjusted gross income of less than 100 percent of the FPL based on the individual's last tax return or other documentation;
- Be a United States citizen or a lawful permanent resident;
- Not be eligible for Medicaid;
- Not be eligible for employer sponsored coverage (with some exceptions); and,

⁴⁵ See Florida Senate, *Patient Protection and Affordable Care Act*, <http://www.flsenate.gov/topics/ppaca> (last visited: April 1, 2013).

⁴⁶ Florida Senate Select Committee on Patient Protection and Affordable Care Act, *Letter to Senate President Don Gaetz on Medicaid Recommendation* <http://www.flsenate.gov/usercontent/topics/ppaca/03-12-13MedicaidRecommendation.pdf> (last visited: April 1, 2013).

⁴⁷ Id.

- Meet criteria based on whether the enrollee meets the definition of a childless adult or parent/relative caretaker.

The bill requires HCP to establish guidelines for financial participation by enrollees. At a minimum, an enrollee is required to contribute \$20 per month towards his or her health benefit account. The enrollee contribution amount may be adjusted annually through the GAA. The amount paid into the account by the state will be determined by the FHCC based on the availability of state, local, or federal funding. The bill provides that the state contribution may not exceed \$10 per enrollee per month; however, this amount may be adjusted annually in the GAA. HCP is also directed to implement an employer based contribution option. An employer may contribute towards an employee's health benefits account, including making the entire payment amount, at any time.

The bill directs HCP to develop and maintain an education and public outreach campaign and to provide a secure website that provides information and facilitates the purchase of goods and services. Information must also be provided about other insurance affordability programs.

The bill requires that HCP must hold at least one open enrollment period per year, subject to available funding. Eligibility must be determined utilizing electronic means to the fullest extent possible. Once the program reaches its capacity, enrollment will cease. Enrollment may occur through the Florida Health Choices portal, a referral from the DCF, the Florida Healthy Kids Corporation, or an exchange as defined under the PPACA.

Once eligibility is confirmed, the bill directs the FHCC to determine the amount of funds that will be deposited into each enrollee's account based upon the availability of funds and other factors. Enrollees must make a financial contribution to their health benefits account in order to maintain enrollment and the FHCC is required to establish disenrollment criteria for non-payment of those minimum contributions. A maximum waiting period of one month prior to reinstatement to HCP for non-payment of any required payment may be imposed.

The bill requires the establishment of an optional incentives program for the achievement of healthy living goals. The program will establish annual healthy living goals and provide supplemental payments into an enrollee's health benefits account for meeting those goals, subject to the availability of funds.

The FHCC must establish the healthy living goals each fiscal year and publish the goals, procedures, and timeframes for the achievement of the goals by July 1 and distribute to new enrollees within 30 calendar days after enrollment. The bill directs HCP to publish goals for the 2014 calendar year by October 1, 2013. Bonus funds may accumulate in an enrollee's account until program termination.

The bill provides that continued enrollment in HCP and receipt of state contributions on the enrollee's behalf are contingent upon the enrollee obtaining a health assessment from a county health department, federally qualified health center, or other approved health care provider within the first three months of enrollment.

The following additional criteria apply based on the enrollee's category of eligibility:

Criteria	Childless Adult	Parent\Relative Caretaker
Any dependent child in the household must be enrolled in Medicaid or CHIP, if eligible		X
Proof of 20 hours of employment or effort to seek employment; or, in lieu of employment volunteer hours at school or non-profit or enrollment as full-time student	X Volunteer hours - 20	X Volunteer hours – 10
Health Assessment in first 3 months	X	X
One preventive visit in first 6 months, repeat every 18 months thereafter	X	X

Failure to meet the ongoing eligibility criteria will result in the enrollee’s disenrollment. One 30-day extension may be granted by HCP to comply. If disenrolled, the enrollee may not re-apply for coverage until the next open enrollment period or 90 days, whichever occurs later.

Funds deposited into an enrollee’s health benefits account may be used by the enrollee to offset health care costs or to purchase other health care services offered in the marketplace. Except for certain supplemental funds, funds deposited in an enrollee’s account belong to the enrollee and are available for health care related expenditures. The bill provides that the optional bonus payments will be paid into the enrollee’s account at the end of the quarter in which the goal was completed.

The bill requires the FHCC to establish a refund process for enrollees who request the closure of their health benefits accounts and the return of any unspent individual contributions. Enrollees may only be refunded funds that the enrollee or employer has contributed to their health benefits account. All other state funds revert to the FHCC.

HCP is authorized to accept funds from employers to deposit into their employees’ health benefits accounts, when not in conflict with any other provisions of the bill. The FHCC is also permitted to accept state and federal funds or to seek other grants to help administer HCP. An assessment on vendors may be utilized to fund administration.

The bill specifically excludes HCP from the Florida Insurance Code and affirms that coverage under HCP is not insurance. The bill designates the coverage as a non-entitlement and affirms that a cause of action does not arise against the state, a local governmental entity, any other political subdivision of the state, or the FHCC or its board of directors, for failure to make coverage available to eligible persons or for the discontinuation of any coverage under HCP.

The bill requires the FHCC to include information about the program into its regular annual report. A separate evaluation of HCP is also required and is due to the governor and Legislature by January 1, 2016.

A program sunset clause is provided to repeal the program effective July 1, 2016, unless saved from repeal through re-enactment by the Legislature.

Section 3 provides an effective date of July 1, 2013.

Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

IV. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill contemplates the FHCC contracting with private providers of health care services and products to deliver health care benefits to an additional population of currently uninsured individuals who may or may not be seeking health care services now. Physicians, hospitals, and other health care providers may be impacted by additional individuals seeking health care coverage and there may be a higher demand for such services once implemented.

Additionally, those safety net and other providers who serve this same population and are not receiving compensation or are receiving reduced compensation for those services may have an additional avenue for revenue.

C. Government Sector Impact:

The bill requires enrollees to receive certain health assessments from county health departments, federally qualified health centers, or other approved health care providers as a condition of continued enrollment. For those county health departments with primary care services, there could be an increased demand for services as individuals seek to comply with this requirement.

In addition to the increased demand for services, the program includes state contributions to the health benefit accounts on a monthly basis and incentives for achievement on optional healthy living performance goals based on an initial enrollment of 60,000 members for 12 months. No federal funds are expected for this program.

The following is the estimated state fiscal impact for 60,000 members over 12 months:

		PMPM Enrollee	PMPM State	Annual State PMPM	TOTAL
Health Benefits Account Funds		\$20.00	\$10.00	\$120.00	\$7,200,000
Incentives					
\$25 Each Healthy Living Goal					
100% Achieve 2	\$3,000,000				\$3,000,000
25% Achieve 3	\$1,125,000				\$1,125,000
5% Achieve 4	\$300,000				\$300,000
2% Achieve 5	\$150,000				\$150,000
Administration (FHC)	\$1,500,000				\$1,500,000
Direct Services (Community and safety net provider supplement for HBAs)	\$2,000,000				\$2,000,000
Grand Total:					\$15,275,000

V. Technical Deficiencies:

None.

VI. Related Issues:

The FHCC will be receiving and reviewing medical records and personal health information of enrollees in the HCP. The exemption from public records under s. 408.910(14) F.S., only applies to the FHCC and enrollees and participants of the Florida Health Choices program. An exemption for the HCP would be appropriate to ensure that medical records and personal information of enrollees and applicants to the program would remain confidential and exempt from s. 119.07(1), F.S. and s. 24(a), Art. 1 of the State Constitution.

VII. Additional Information:

A. **Committee Substitute – Statement of Substantial Changes:**
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. **Amendments:**

None.

By the Committee on Health Policy

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1 A bill to be entitled
 2 An act relating to the Health Choice Plus Program;
 3 amending s. 408.910, F.S.; conforming provisions to
 4 changes made by the act; creating s. 408.9105, F.S.;
 5 creating the Health Choice Plus Program; providing
 6 legislative intent; providing definitions; providing
 7 eligibility requirements; providing exceptions in
 8 specific situations; providing for enrollment in the
 9 program; providing for disenrollment in specific
 10 situations; providing for reenrollment in specific
 11 situations; providing requirements and procedures for
 12 use of funds in a health benefits account; authorizing
 13 the Florida Health Choices, Inc., to accept funds from
 14 various sources to deposit into health benefits
 15 accounts, subsidize the costs of coverage, and
 16 administer and support the program; requiring the
 17 corporation to manage the health benefits accounts and
 18 provide the marketplace of options that an enrollee in
 19 the program may use; providing for payment for
 20 achieving health living performance goals; providing
 21 that the Florida Insurance Code is not applicable to
 22 the program; providing that coverage under the program
 23 is not an entitlement; prohibiting a cause of action
 24 against certain entities under certain circumstances;
 25 requiring the corporation to submit to the Governor
 26 and the Legislature information about the program in
 27 its annual report and an evaluation of the
 28 effectiveness of the program; providing for a program
 29 review and repeal date; providing an effective date.

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

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30
 31 Be It Enacted by the Legislature of the State of Florida:
 32
 33 Section 1. Subsection (1) of section 408.910, Florida
 34 Statutes, is amended to read:
 35 408.910 Florida Health Choices Program.—
 36 (1) LEGISLATIVE INTENT.—The Legislature finds that a
 37 significant number of the residents of this state do not have
 38 adequate access to affordable, quality health care. The
 39 Legislature further finds that increasing access to affordable,
 40 quality health care can be best accomplished by establishing ~~a~~
 41 competitive markets ~~market~~ for purchasing health insurance and
 42 health services. It is therefore the intent of the Legislature
 43 to create the Florida Health Choices Program and the Health
 44 Choice Plus Program to:
 45 (a) Expand opportunities for Floridians to purchase
 46 affordable health insurance and health services.
 47 (b) Preserve the benefits of employment-sponsored insurance
 48 while easing the administrative burden for employers who offer
 49 these benefits.
 50 (c) Enable individual choice in both the manner and amount
 51 of health care purchased.
 52 (d) Provide for the purchase of individual, portable health
 53 care coverage.
 54 (e) Disseminate information to consumers on the price and
 55 quality of health services.
 56 (f) Sponsor ~~a~~ competitive markets ~~market~~ that stimulate
 57 ~~stimulates~~ product innovation, quality improvement, and
 58 efficiency in the production and delivery of health services.

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59 Section 2. Section 408.9105, Florida Statutes, is created
60 to read:

61 408.9105 Health Choice Plus Program.-

62 (1) LEGISLATIVE INTENT.-The Legislature recognizes that
63 there are more than 600,000 uninsured residents in this state
64 who have incomes at or below 100 percent of the federal poverty
65 level. Many insurance options are not affordable, and the
66 Legislature intends to provide a benefit program to those
67 individuals who seek assistance with coverage and who assume
68 individual responsibility for their own health care needs. It is
69 therefore the intent of the Legislature to expand the services
70 provided by the Florida Health Choices Program and begin the
71 phase-in of the Health Choice Plus Program starting July 1,
72 2013. The Health Choice Plus Program must:

73 (a) Use the existing Florida Health Choices Corporation's
74 infrastructure and governance to manage the program described in
75 this section.

76 (b) Offer goods and services to individuals who are between
77 19 to 64 years of age, inclusive.

78 (c) Establish guidelines for financial participation in the
79 program which allows for enrollees and others to contribute
80 toward a health benefits account.

81 1. An enrollee shall contribute at least \$20 per month
82 toward the health benefits account. This amount may be adjusted
83 annually in the General Appropriations Act.

84 2. The level of benefit paid into an enrollee's account
85 using state funds is to be determined by the corporation based
86 upon the availability of state, local, and federal funding. The
87 amount may not exceed \$10 per individual per month. This amount

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88 may be adjusted annually in the General Appropriations Act.

89 (d) Implement an employer-based contribution option.

90 (e) Develop and maintain an education and public outreach
91 campaign for the Health Choice Plus Program.

92 (f) Provide a secure website to facilitate the purchase of
93 goods and services and to provide public information about the
94 program. The website must also provide information about the
95 availability of insurance affordability programs targeted at
96 this population.

97 (g) Establish an incentive program that rewards enrollees
98 for achievements in reaching healthy living goals.

99 (2) DEFINITIONS.-For the Health Choice Plus Program, the
100 following terms are applicable:

101 (a) "CHIP" means Children's Health Insurance Program as
102 authorized under Title XXI of the Social Security Act.

103 (b) "Corporation" means Florida Health Choices, Inc., as
104 established under s. 408.910.

105 (c) "Corporation's marketplace" means the single,
106 centralized market established by the corporation which
107 facilitates the purchase of products made available in the
108 marketplace.

109 (d) "Enrollee" means an individual who participates in or
110 receives benefits under the Health Choice Plus Program.

111 (e) "Program" means the Health Choice Plus Program
112 established under this section.

113 (f) "Vendor" means an entity that meets the requirements
114 under s. 408.910(4)(d) and is accepted by the corporation.

115 (g) "Health benefits account" means the account established
116 for an enrollee at the corporation into which funds may be

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117 deposited by the state, the enrollee, other individuals, or
 118 organizations for the purchase of health care goods and services
 119 on the enrollee's behalf.

120 (h) "Parent" or "caretaker relative" means an individual
 121 who is a relative that has primary custody or legal guardianship
 122 of a dependent child and provides the primary care and
 123 supervision to that dependent child in the same household. A
 124 caretaker relative must be related to the dependent child by
 125 blood, marriage, or adoption within the fifth degree of kinship.

126 (i) "Goods and services" means the individual products
 127 offered for sale to an enrollee on the corporation's marketplace
 128 or other health care-related items that may be purchased by an
 129 enrollee in the private market. An enrollee may purchase these
 130 products using funds accumulated in his or her health benefits
 131 account.

132 (j) "Lawful permanent resident" means a non-United States
 133 citizen who resides in the United States under legally
 134 recognized and lawfully recorded permanent residence as an
 135 immigrant. This individual may also be known as a permanent
 136 resident alien.

137 (k) "Patient Protection and Affordable Care Act" or "PPACA"
 138 means the federal law enacted as Pub. L. No. 111-148, as further
 139 amended by the federal Health Care and Education Reconciliation
 140 Act of 2010, Pub. L. No. 111-152, and any amendments.

141 (3) ELIGIBILITY.—

142 (a) To be eligible for the Health Choice Plus Program, an
 143 individual must be a resident of this state and meet all of the
 144 following criteria:

145 1. Be between 19 and 64 years of age, inclusive.

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146 2. Have a modified adjusted gross income that does not
 147 exceed 100 percent of the federal poverty level based on the
 148 individual's most recent federal tax return, or if the
 149 individual did not file a tax return, the individual's most
 150 recent monthly income.

151 3. Be a United States citizen or a lawful permanent
 152 resident.

153 4. Not be eligible for Medicaid.

154 5. Not be eligible for employer-sponsored insurance
 155 coverage. If the enrollee is eligible for employer-sponsored
 156 coverage but the cost of that coverage for the enrollee's share
 157 for individual coverage would exceed 5 percent of the enrollee's
 158 total modified adjusted gross household income or the enrollee's
 159 share of family coverage would exceed 5 percent of enrollee's
 160 total modified adjusted gross household income, the enrollee is
 161 not eligible for employer-sponsored coverage under this section.

162 6. Not be enrolled in other coverage that meets the
 163 definition of essential benefits coverage under PPACA.

164 (b) In addition to the requirements in paragraph (a), an
 165 enrollee must meet the following categorical requirements in
 166 order to maintain enrollment in the program:

167 1. For an enrollee who is also a parent or a caretaker
 168 relative, the enrollee must do all of the following:

169 a. Maintain enrollment in Medicaid or CHIP for any
 170 dependent child in the household who is eligible for Medicaid or
 171 CHIP and who must be enrolled in Medicaid or CHIP throughout the
 172 enrollee's participation in the Health Choice Plus program.

173 b. Complete a health assessment within the first 3 months
 174 after enrollment at a county health department, federally

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175 qualified health center, or other approved health care provider.

176 c. Schedule and keep at least one preventive visit with a
 177 primary care provider within 6 months after enrollment and
 178 repeat the preventive visit at least once every 18 months
 179 thereafter.

180 d. Provide proof of employment for at least 20 hours a week
 181 or of efforts made to seek employment. In lieu of employment,
 182 the enrollee may provide proof of volunteering for at least 10
 183 hours a month at a school or at a nonprofit organization or
 184 enrollment as a full-time student at an accredited educational
 185 institution. Exceptions to this requirement may be made on a
 186 case-by-case basis for medical conditions for the enrollee or if
 187 the enrollee is the primary caretaker for a family member who
 188 has a chronic and severe medical condition that requires a
 189 minimum of 40 hours a week of care.

190 2. For an enrollee who is also a childless adult, the
 191 enrollee must do all of the following:

192 a. Provide proof of employment for at least 20 hours a week
 193 or of efforts made to seek employment. In lieu of employment,
 194 the enrollee may provide proof of volunteering for at least 20
 195 hours a month at a school or at a nonprofit organization or
 196 enrollment as a full-time student at an accredited educational
 197 institution. Exceptions to this requirement may be made on a
 198 case-by-case basis for medical conditions for the enrollee or if
 199 the enrollee is the primary caretaker for a family member who
 200 has a chronic and severe medical condition that requires a
 201 minimum of 40 hours a week of care.

202 b. Complete a health assessment within the first 3 months
 203 after enrollment at a county health department, federally

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204 qualified health center, or other approved health care provider;

205 c. Schedule and keep at least one preventive visit with a
 206 primary care provider within the first 6 months after enrollment
 207 and repeat the preventive visit at least once every 18 months
 208 thereafter.

209
 210 If the enrollee fails to meet the requirements specified in this
 211 subsection, the enrollee is disenrolled from the program at the
 212 end of the month in which the enrollee has not met the
 213 requirements. The enrollee may receive one 30-day extension to
 214 comply before cancellation of coverage. If an enrollee's
 215 coverage is canceled, the enrollee may not reapply for coverage
 216 until the next open enrollment period or 90 days after
 217 cancellation of coverage occurs, whichever occurs later. The
 218 individual's reenrollment is subject to available funding.

219 (4) ENROLLMENT.—

220 (a) Enrollment in the Health Choice Plus Program may occur
 221 through the portal of the Florida Health Choices Program, a
 222 referral process from the Department of Children and Families,
 223 the Florida Healthy Kids Corporation, or the exchange as defined
 224 by the federal Patient Protection and Affordable Care Act.

225 (b) Subject to available funding, the corporation shall
 226 establish at least one open enrollment period each year. When
 227 the program is full based on available funding, enrollment must
 228 cease.

229 (c) Eligibility is determined by using electronic means to
 230 the fullest extent practicable before requesting any written
 231 documentation from an applicant.

232 (5) HEALTH BENEFITS ACCOUNT.—

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233 (a) A health benefits account is established for each
 234 enrollee upon confirmation of eligibility in the program. The
 235 corporation shall determine the deposit amount and frequency of
 236 deposits based on the availability of funds, the number of
 237 enrollees, and other factors.

238 (b) An enrollee shall make a financial contribution toward
 239 his or her own health benefits account in order to maintain
 240 enrollment in accordance with paragraph (1)(c).

241 1. The corporation shall establish disenrollment criteria
 242 for failure to pay the required minimum contribution.

243 2. The disenrollment criteria must include waiting periods
 244 of not more than 1 month before reinstatement to the program if
 245 the enrollee is still eligible and has paid all required
 246 financial obligations.

247 3. The enrollee's employer may contribute toward an
 248 employee's health benefits account under the program, including
 249 making the enrollee's required contribution, in whole or in
 250 part, to the enrollee's health benefits account at any time.

251 (c) Subject to appropriations available for this specific
 252 purpose, the corporation shall establish a procedure for the
 253 deposit of supplemental or bonus funds into an enrollee's health
 254 benefits account if certain healthy living performance goals are
 255 achieved. These goals must be established no later than July 1
 256 in each fiscal year and distributed to all enrollees, published
 257 on the corporation's website, and distributed to new enrollees
 258 within 30 calendar days after enrollment. For calendar year
 259 2014, the goals must be established no later than October 1,
 260 2013.

261 1. An enrollee may use funds deposited in a health benefits

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262 account to offset other health care costs or to purchase other
 263 products and services offered by the marketplace, subject to
 264 guidelines established by the corporation and in accordance with
 265 federal law.

266 2. Bonus funds may accumulate in the enrollee's health
 267 benefits account for the duration of the program and must
 268 automatically expire and return to the corporation upon the
 269 termination of the program.

270 (d) The marketplace is encouraged to use existing community
 271 programs and partnerships to deliver services and to include
 272 traditional safety net providers for the delivery of services to
 273 enrollees, including, but not limited to, rural health clinics,
 274 federally qualified health centers, county health departments,
 275 emergency room diversion programs, and community mental health
 276 centers. A health care entity that receives state funding must
 277 participate in the Health Choice Plus Program and offer services
 278 or products through the marketplace or to enrollees, as
 279 appropriate. An enrollee may be required to make nominal
 280 copayments to providers for any nonpreventive services. The
 281 corporation may establish the amount of the copayments when
 282 applicable.

283 (e) Except for supplemental funds described under paragraph
 284 (c), funds deposited in a health benefits account belong to the
 285 enrollee when deposited and are available for health-care-
 286 related expenditures, including, but not limited to, physician's
 287 fees, hospital costs, prescriptions, insurance premium payments,
 288 copayments, and coinsurance. The corporation shall establish a
 289 process or contract with another entity for the management of
 290 the funds. The process must ensure the timely distribution and

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291 the appropriate expenditure of the state's contributions.
 292 (f) The corporation shall establish a refund process for an
 293 enrollee who requests the closure of a health benefits account
 294 and the return of any unspent individual contributions. The
 295 enrollee may be refunded only those funds that the enrollee or
 296 employer has contributed to his or her health benefits account.
 297 All other state funds in the enrollee's health benefits account
 298 revert to the corporation.
 299 (6) FUNDING.—
 300 (a) The corporation may accept funds from an employer to
 301 deposit in an enrollee's health benefits account to supplement
 302 funds if such a deposit is not in conflict with other provisions
 303 of this section.
 304 (b) The corporation may accept state and federal funds to
 305 further subsidize the costs of coverage and to administer the
 306 program.
 307 (c) The corporation shall seek other grants and donations
 308 to support the program.
 309 (d) An assessment on vendors that participate in the
 310 marketplace may be used to fund the administration of the
 311 program.
 312 (7) SERVICES.—The corporation shall manage the health
 313 benefits accounts and provide a marketplace of options from
 314 which an enrollee may also use his or her health benefits
 315 account to purchase individual services and products, including,
 316 but not limited to, discount medical plans, limited benefit
 317 plans, health flex plans, individual health insurance plans,
 318 bundled services, or other prepaid health care coverage.
 319 (8) HEALTHY LIVING PERFORMANCE GOALS AND PAYMENT.—

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320 (a) To the extent that funds are made available for this
 321 purpose, an enrollee is rewarded for achieving a healthy
 322 lifestyle and using preventive health care services
 323 appropriately.
 324 (b) The program shall post on its website, by July 1 of
 325 each fiscal year, a list of optional healthy living performance
 326 goals and the proposed incentives for achievement of each goal.
 327 The corporation shall establish a procedure for the
 328 documentation of such goals, timeframes for achievement of the
 329 optional goals, and the payment of supplemental amounts into an
 330 enrollee's health benefits account, subject to available
 331 funding.
 332 (c) Bonus payments for achieving a healthy living
 333 performance goal shall be paid into an enrollee's health
 334 benefits account at the end of the quarter in which the goal is
 335 achieved. The amount of the payment is based upon the schedule
 336 posted by the program on July 1 of that fiscal year.
 337 (9) APPLICABILITY OF INSURANCE CODE.—Coverage offered under
 338 this program is not insurance. Any standard forms, website
 339 design, or marketing communication developed by the corporation
 340 and used by the corporation or any vendor that meets the
 341 requirements of s. 408.910(4)(f) is not subject to the Florida
 342 Insurance Code.
 343 (10) LIABILITY.—Coverage under the Health Choice Plus
 344 Program is not an entitlement, and a cause of action does not
 345 arise against the state, a local governmental entity, any other
 346 political subdivision of the state, or the corporation or its
 347 board of directors for failure to make coverage under this
 348 section available to an eligible person or for discontinuation

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349 of any coverage.

350 (11) PROGRAM EVALUATION.—The corporation shall include
351 information about the Health Choice Plus Program in its annual
352 report under s. 408.910. The corporation shall complete and
353 submit by January 1, 2016, a separate independent evaluation of
354 the effectiveness of the Health Choice Plus Program to the
355 Governor, the President of the Senate, and the Speaker of the
356 House of Representatives.

357 (12) PROGRAM REVIEW.—The Health Choice Plus Program is
358 subject to repeal on July 1, 2016, unless reviewed and saved
359 from repeal through reenactment by the Legislature.

360 Section 3. This act shall take effect July 1, 2013.