By the Committee on Health, Aging and Long-Term Care; and Senator Saunders

317-1993A-00

A bill to be entitled

An act relating to health care; amending s. 409.212, F.S.; providing for periodic increase in the optional state supplementation rate; amending s. 409.901, F.S.; amending definitions of terms used in ss. 409.910-409.920, F.S.; amending s. 409.902, F.S.; providing that the Department of Children and Family Services is responsible for Medicaid eligibility determinations; amending s. 409.903, F.S.; providing responsibility for determinations of eligibility for payments for medical assistance and related services; amending s. 409.905, F.S.; increasing the maximum amount that may be paid under Medicaid for hospital outpatient services; amending s. 409.906, F.S.; allowing the Department of Children and Family Services to transfer funds to the Agency for Health Care Administration to cover state match requirements as specified; amending s. 409.907, F.S.; revising requirements relating to the minimum amount of the surety bond which each provider is required to maintain; specifying grounds on which provider applications may be denied; amending s. 409.908, F.S.; increasing the maximum amount of reimbursement allowable to Medicaid providers for hospital inpatient care; creating s. 409.9119, F.S.; creating a disproportionate share program for children's hospitals; providing formulas governing payments made to hospitals under the program;

providing for withholding payments from a hospital that is not complying with agency rules; amending s. 409.912, F.S.; providing for the transfer of certain unexpended Medicaid funds from the Department of Elderly Affairs to the Agency for Health Care Administration; providing for the adoption and the transfer of certain rules relating to the determination of Medicaid eligibility; authorizing developmental research schools to participate in Medicaid certified school match program; providing for the Agency for Health Care Administration to seek a federal waiver allowing the agency to undertake a pilot project that involves contracting with skilled nursing facilities for the provision of rehabilitation services to adult ventilator dependent patients; providing for evaluation of the pilot program; repealing s. 409.912(4)(b), F.S., relating to the authorization of the agency to contract with certain prepaid health care services providers; providing an effective date.

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

Section 1. Present subsection (6) of section 409.212, Florida Statutes, is redesignated as subsection (7), and a new subsection (6) is added to that subsection, to read:

409.212 Optional supplementation.--

(6) The optional state supplementation rate shall be increased by the cost-of-living adjustment to the federal

benefits rate provided that the average state optional supplementation contribution does not increase as a result.

Section 2. Subsections (3), (15), and (18) of section 409.901, Florida Statutes, are amended to read:

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

(3) "Applicant" means an individual whose written application for medical assistance provided by Medicaid under ss. 409.903-409.906 has been submitted to the Department of Children and Family Services ~~agency~~, or to the Social Security Administration if the application is for Supplemental Security Income, but has not received final action. This term includes an individual, who need not be alive at the time of application, whose application is submitted through a representative or a person acting for the individual.

(15) "Medicaid program" means the program authorized under Title XIX of the federal Social Security Act which provides for payments for medical items or services, or both, on behalf of any person who is determined by the Department of Children and Family Services, or, for Supplemental Security Income, by the Social Security Administration, to be eligible on the date of service for Medicaid assistance.

(18) "Medicaid recipient" or "recipient" means an individual whom the Department of Children and Family Services, or, for Supplemental Security Income, the Social Security Administration, determines is eligible, pursuant to federal and state law, to receive medical assistance and related services for which the agency may make payments under the Medicaid program. For the purposes of determining third-party liability, the term includes an individual formerly determined to be eligible for Medicaid, an individual

who has received medical assistance under the Medicaid program, or an individual on whose behalf Medicaid has become obligated.

Section 3. Section 409.902, Florida Statutes, is amended to read:

409.902 Designated single state agency; payment requirements; program title.--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 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 Family Services is responsible for Medicaid eligibility determinations, including policy, rules, 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.

Section 4. Section 409.903, Florida Statutes, is amended to read:

409.903 Mandatory payments for eligible persons.--The agency shall make payments for medical assistance and related services on behalf of the following persons who the department, or the Social Security Administration by contract with the Department of Children and Family Services, ~~agency~~

determines to be eligible, subject to the income, assets, and categorical eligibility tests set forth in federal and state law. Payment on behalf of these Medicaid eligible persons is subject to the availability of moneys and any limitations established by the General Appropriations Act or chapter 216.

(1) Low-income families with children are eligible for Medicaid provided they meet the following requirements:

(a) The family includes a dependent child who is living with a caretaker relative.

(b) The family's income does not exceed the gross income test limit.

(c) The family's countable income and resources do not exceed the applicable Aid to Families with Dependent Children (AFDC) income and resource standards under the AFDC state plan in effect in July 1996, except as amended in the Medicaid state plan to conform as closely as possible to the requirements of the WAGES Program as created in s. 414.015, to the extent permitted by federal law.

(2) A person who receives payments from, who is determined eligible for, or who was eligible for but lost cash benefits from the federal program known as the Supplemental Security Income program (SSI). This category includes a low-income person age 65 or over and a low-income person under age 65 considered to be permanently and totally disabled.

(3) A child under age 21 living in a low-income, two-parent family, and a child under age 7 living with a nonrelative, if the income and assets of the family or child, as applicable, do not exceed the resource limits under the WAGES Program.

(4) A child who is eligible under Title IV-E of the Social Security Act for subsidized board payments, foster

care, or adoption subsidies, and a child for whom the state has assumed temporary or permanent responsibility and who does not qualify for Title IV-E assistance but is in foster care, shelter or emergency shelter care, or subsidized adoption.

(5) A pregnant woman for the duration of her pregnancy and for the post partum period as defined in federal law and rule, or a child under age 1, if either is living in a family that has an income which is at or below 150 percent of the most current federal poverty level, or, effective January 1, 1992, that has an income which is at or below 185 percent of the most current federal poverty level. Such a person is not subject to an assets test. Further, a pregnant woman who applies for eligibility for the Medicaid program through a qualified Medicaid provider must be offered the opportunity, subject to federal rules, to be made presumptively eligible for the Medicaid program.

(6) A child born after September 30, 1983, living in a family that has an income which is at or below 100 percent of the current federal poverty level, who has attained the age of 6, but has not attained the age of 19. In determining the eligibility of such a child, an assets test is not required.

(7) A child living in a family that has an income which is at or below 133 percent of the current federal poverty level, who has attained the age of 1, but has not attained the age of 6. In determining the eligibility of such a child, an assets test is not required.

(8) A person who is age 65 or over or is determined by the agency to be disabled, whose income is at or below 100 percent of the most current federal poverty level and whose assets do not exceed limitations established by the agency. However, the agency may only pay for premiums, coinsurance,

and deductibles, as required by federal law, unless additional coverage is provided for any or all members of this group by s. 409.904(1).

Section 5. Subsection (6) of section 409.905, Florida Statutes, is amended to read:

409.905 Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, number of services, or any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216.

(6) HOSPITAL OUTPATIENT SERVICES.--The agency shall pay for preventive, diagnostic, therapeutic, or palliative care and other services provided to a recipient in the outpatient portion of a hospital licensed under part I of chapter 395, and provided under the direction of a licensed physician or licensed dentist, except that payment for such care and services is limited to$1,500~~$1,000~~ per state fiscal year per recipient, unless an exception has been made by the agency, and with the exception of a Medicaid recipient under age 21, in which case the only limitation is medical necessity.

Section 6. Subsection (5) of section 409.906, Florida Statutes, is amended to read:

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

(5) CASE MANAGEMENT SERVICES.--The agency may pay for primary care case management services rendered to a recipient pursuant to a federally approved waiver, and targeted case management services for specific groups of targeted recipients, for which funding has been provided and which are rendered pursuant to federal guidelines. The agency is authorized to limit reimbursement for targeted case management services in order to comply with any limitations or directions provided for in the General Appropriations Act. Notwithstanding s. 216.292, the Department of Children and

Family Services may transfer general funds to the Agency for Health Care Administration to cover state matching requirements exceeding the amount specified in the General Appropriations Act for targeted case management services.

Section 7. Subsections (7), (9), and (10) of section 409.907, Florida Statutes, 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 services or supplying goods in accordance with federal, state, and local law, and who agrees that no person shall, on the grounds of handicap, race, color, or national origin, or for any other reason, be subjected to discrimination under any program or activity for which the provider receives payment from the agency.

(7) The agency may require, as a condition of participating in the Medicaid program and before entering into the provider agreement, that the provider submit information concerning the professional, business, and personal background of the provider and permit an onsite inspection of the provider's service location by agency staff or other personnel designated by the agency to perform ~~assist in~~ this function. Before entering into the provider agreement, or as a condition of continuing participation in the Medicaid program, the agency ~~and~~ may also require that Medicaid providers reimbursed on a fee-for-services basis or fee schedule basis which is not cost-based, post a surety bond ~~from the provider~~ not to exceed $50,000 or the total amount billed by the provider to the program during the current or most recent calendar year, whichever is greater. For new providers, the amount of the

surety bond shall be determined by the agency based on the provider's estimate of its first year's billing. If the provider's billing during the first year exceeds the bond amount, the agency may require the provider to acquire an additional bond equal to the actual billing level of the provider. A provider's bond shall not exceed $50,000 if a physician or group of physicians licensed under chapter 458, chapter 459, or chapter 460 has a 50 percent or greater ownership interest in the provider or if the provider is an assisted living facility licensed under part III of chapter 400. The bonds permitted by this section are in addition to the bonds referenced in s. 400.179(4)(d).If the provider is a corporation, partnership, association, or other entity, the agency may require the provider to submit information concerning the background of that entity and of any principal of the entity, including any partner or shareholder having an ownership interest in the entity equal to 5 percent or greater, and any treating provider who participates in or intends to participate in Medicaid through the entity. The information must include:

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

(b) Information concerning any prior violation, fine, suspension, termination, or other administrative action taken under the Medicaid laws, rules, or regulations of this state or of any other state or the Federal Government; any prior violation of the laws, rules, or regulations relating to the Medicare program; any prior violation of the rules or regulations of any other public or private insurer; and any

prior violation of the laws, rules, or regulations of any regulatory body of this or any other state.

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

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

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

(a) Enroll the applicant as a Medicaid provider; or

(b) Deny the application if the agency determines that~~, based on the grounds listed in subsection (10),~~ it is in the best interest of the Medicaid program to do so, specifying the reasons for denial. The agency may consider the factors listed in subsection (10), as well as any other factor that could affect the effective and efficient administration of the program, including, but not limited to, the current availability of medical care, services, or supplies to recipients, taking into account geographic location and reasonable travel time.

(10) The agency may consider whether ~~deny enrollment in the Medicaid program to a provider if~~ the provider, or any officer, director, agent, managing employee, or affiliated person, or any partner or shareholder having an ownership interest equal to 5 percent or greater in the provider if the

provider is a corporation, partnership, or other business entity, has:

(a) Made a false representation or omission of any material fact in making the application, including the submission of an application that conceals the controlling or ownership interest of any officer, director, agent, managing employee, affiliated person, or partner or shareholder who may not be eligible to participate;

(b) Been or is currently excluded, suspended, terminated from, or has involuntarily withdrawn from participation in, Florida's Medicaid program or any other state's Medicaid program, or from participation in any other governmental or private health care or health insurance program;

(c) Been 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;

(d) Been convicted under federal or state law of a criminal offense related to the neglect or abuse of a patient in connection with the delivery of any health care goods or services;

(e) Been convicted under federal or state law of a criminal offense relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance;

(f) Been convicted of any criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct;

(g) Been convicted under federal or state law of a crime punishable by imprisonment of a year or more which involves moral turpitude;

(h) Been convicted in connection with the interference or obstruction of any investigation into any criminal offense listed in this subsection;

(i) Been found to have violated federal or state laws, rules, or regulations governing Florida's Medicaid program or any other state's Medicaid program, the Medicare program, or any other publicly funded federal or state health care or health insurance program, and been sanctioned accordingly;

(j) Been previously found by a licensing, certifying, or professional standards board or agency to have violated the standards or conditions relating to licensure or certification or the quality of services provided; or

(k) Failed to pay any fine or overpayment properly assessed under the Medicaid program in which no appeal is pending or after resolution of the proceeding by stipulation or agreement, unless the agency has issued a specific letter of forgiveness or has approved a repayment schedule to which the provider agrees to adhere.

Section 8. Paragraph (a) of subsection (1) of section 409.908, Florida Statutes, is amended to read:

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

and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

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

(a) Reimbursement for inpatient care is limited as provided for in s. 409.905(5). Reimbursement for hospital outpatient care is limited to $1,500~~$1,000~~ per state fiscal year per recipient, except for:

1. Such care provided to a Medicaid recipient under age 21, in which case the only limitation is medical necessity;

2. Renal dialysis services; and

3. Other exceptions made by the agency.

(b) Hospitals that provide services to a disproportionate share of low-income Medicaid recipients, or that participate in the regional perinatal intensive care center program under chapter 383, or that participate in the statutory teaching hospital disproportionate share program, or that participate in the extraordinary disproportionate share

program, may receive additional reimbursement. The total amount of payment for disproportionate share hospitals shall be fixed by the General Appropriations Act. The computation of these payments must be made in compliance with all federal regulations and the methodologies described in ss. 409.911, 409.9112, and 409.9113.

(c) The agency is authorized to limit inflationary increases for outpatient hospital services as directed by the General Appropriations Act.

Section 9. Section 409.9119, Florida Statutes, is created to read:

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

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

TAE = DSR x BMPD x MD

Where:

TAE = total amount earned by a children's hospital.

DSR = disproportionate share rate.

BMPD = base Medicaid per diem.

MD = Medicaid days.

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

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

Where:

TAP = total additional payment for a children's hospital.

TAE = total amount earned by a children's hospital.

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

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

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

Section 10. Subsection (9) of section 409.912, Florida Statutes, is amended to read:

409.912 Cost-effective purchasing of health care.--The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with

the delivery of quality medical care. The agency shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services.

(9) The agency, after notifying the Legislature, may apply for waivers of applicable federal laws and regulations as necessary to implement more appropriate systems of health care for Medicaid recipients and reduce the cost of the Medicaid program to the state and federal governments and shall implement such programs, after legislative approval, within a reasonable period of time after federal approval. These programs must be designed primarily to reduce the need for inpatient care, custodial care and other long-term or institutional care, and other high-cost services.

(a) Before ~~Prior to~~ seeking legislative approval of such a waiver as authorized by this subsection, the agency must ~~shall~~ provide notice and an opportunity for public comment. Notice must ~~shall~~ be provided to all persons who have made requests of the agency for advance notice and must ~~shall~~ be published in the Florida Administrative Weekly not less than 28 days before ~~prior to~~ the intended action.

(b) Notwithstanding s. 216.292, funds that are appropriated to the Department of Elderly Affairs for the Assisted Living for the Elderly Medicaid waiver and are not

expended must be transferred to the agency to fund Medicaid-reimbursed nursing home care.

Section 11. Section 409.919, Florida Statutes, is amended to read:

409.919 Rules.--The agency shall adopt any rules necessary to comply with or administer ss. 409.901-409.920 and all rules necessary to comply with federal requirements. In addition, the Department of Children and Family Services shall adopt and accept transfer of any rules necessary to carry out its responsibilities for receiving and processing Medicaid applications and determining Medicaid eligibility, and for assuring compliance with and administering ss. 409.901-409.906 and any other provisions related to responsibility for the determination of Medicaid eligibility.

Section 12. Notwithstanding the provisions of sections 236.0812, 409.9071, and 409.908(21), Florida Statutes, developmental research schools, as authorized under section 228.053, Florida Statutes, shall be authorized to participate in the Medicaid certified school match program subject to the provisions of sections 236.0812, 409.9071, and 409.908(21), Florida Statutes.

Section 13. (1) The Agency for Health Care Administration is directed to submit to the Health Care Financing Administration a request for a waiver that will allow the agency to undertake a pilot project that would implement a coordinated system of care for adult ventilator dependent patients. Under this pilot program, the agency shall identify a network of skilled nursing facilities that have respiratory departments geared towards intensive treatment and rehabilitation of adult ventilator patients and will contract with such a network for respiratory or other services. The

pilot project must allow the agency to evaluate a coordinated and focused system of care for adult ventilator dependent patients to determine the overall cost-effectiveness and improved outcomes for participants.

(2) The agency must submit the waiver by September 1, 2000. The agency must forward a preliminary report of the pilot project's findings to the Governor, the Speaker of the House of Representatives, and the President of the Senate six months after project implementation. The agency must submit a final report of the pilot project's findings to these same recipients no later than February 15, 2002.

Section 14. Paragraph (b) of subsection (4) of section 409.912, Florida Statutes, is repealed.

Section 15. This act shall take effect July 1, 2000.

STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN COMMITTEE SUBSTITUTE FOR Senate Bill 2242

The Committee Substitute requires that the optional state supplementation rate increase by the cost-of-living adjustment to the federal benefits rate; limits provider types who can be required to post a surety bond in excess of $50,000 to those providers which are reimbursed on a fee-for-service basis or fee schedule basis which is not cost based, excluding providers in which physicians or physician groups licensed under chapters 458, 458, or 460 have greater that 50 percent ownership interest or if the provider is an assisted living facility licensed under chapter 400, Part III; authorizes university laboratory schools to participate in Medicaid certified school match funding; and repeals paragraph (b) of subsection (4) of 409.912, F.S., relating to exemption from the HMO licensure requirements of part 1 of chapter 641, F.S., for entities providing only Medicaid services on a prepaid basis.