STORAGE NAME: h2329z.hcs ****AS PASSED BY THE LEGISLATURE****
DATE: June 28, 2000 **CHAPTER #:2000-163, Laws of Florida**

HOUSE OF REPRESENTATIVES
AS REVISED BY THE COMMITTEE ON
HEALTH CARE SERVICES
FINAL ANALYSIS

BILL #: HB 2329 (PCB HCS 00-06) (Includes HB's 1633, 1905, 1945, and 2047)

RELATING TO: Health Care

SPONSOR(S): Committee on Health Care Services, Rep. Peaden

TIED BILL(S):

ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE:
(1) HEALTH CARE SERVICES YEAS 17 NAYS 0
(2) HEALTH AND HUMAN SERVICES APPROPRIATIONS YEAS 10 NAYS 0

I. SUMMARY:

HB 2329 addresses a variety of health care related subjects and issues as follows:
Medicaid: Increases the annual adult hospital outpatient services cap from $1,000 to $1,500; initiates a Disproportionate Share Program for specialty hospitals for children; authorizes the transfer of specified funds to the Agency for Health Care Administration (AHCA) relating to targeted case management services and the Assisted Living for the Elderly Medicaid waiver; includes Medicaid fraud issues relating to additional provider surety bond requirements based on volume of Medicaid business for certain provider types, and additional authority for denial of Medicaid provider applications; includes nursing home liability insurance costs in the calculation of nursing home interim rate adjustments on a limited basis; clarifies provisions relating to Medicaid physician reimbursement for services rendered to dually eligible Medicare and Medicaid patients; authorizes renewal of the AHCA contract or contracts for fiscal intermediary services; authorizes university laboratory schools to participate in Medicaid certified school match funding; authorizes AHCA to seek a federal demonstration project waiver for a system of care for adult ventilator-dependent patients; repeals AHCA's ability to contract for prepaid health care services with certain entities; provides specific rule-making authority for the Department of Children and Family Services specific to Medicaid eligibility determination (HB 1633); and Medicaid Fraud Control Unit issues relating to exemptions from several confidential medical records provisions contained in Florida Statutes, power to subpoena medical records relating to Medicaid recipients, authority for investigators to serve process; and provision of otherwise confidential Department of Health records upon request.
Graduate Medical Education (HB 1905): Amends "The Community Hospital Education Act," addressing the focus of training, eligibility for funding, creation of slots, and accreditation status; authorizes the seeking of federal matching funds; specifies primary care specialties; provides for a Program for Graduate Medical Education Innovation; specifies periodic certification of hospitals eligible for matching funds; and specifies the committee on graduate medical education; amends the definition of "teaching hospital" specific to *Florida* hospitals and medical schools, accreditation, resident slots, and determination of such hospitals; revises Medicaid limitations for hospital inpatient services specific to: graduate medical education costs, receipt of funds, and an exception from county contributions.
Other Issues: Provides, in statute, for the ongoing adjustment in Optional State Supplementation based on the federal benefits rate; authorizes the Department of Elderly Affairs (DOEA) to contract, on a prepaid basis, with certain "other qualified providers" (as specifically defined) to provide long-term care within community diversion pilot project areas (HB 1945); and designates February 6th of each year as Florida Alzheimer's Disease Day.

The bill's effective date is July 1, 2000.

The fiscal impact of the bill is $256.3 million (derived as follows: 56.47% federal; 37.68% local government transfers; and 5.85% state).

II. SUBSTANTIVE ANALYSIS:

A. DOES THE BILL SUPPORT THE FOLLOWING PRINCIPLES:

1.	Less Government	Yes []	No [x]	N/A []
2.	Lower Taxes	Yes []	No []	N/A [x]
3.	Individual Freedom	Yes []	No []	N/A [x]
4.	Personal Responsibility	Yes []	No []	N/A [x]
5.	Family Empowerment	Yes []	No []	N/A [x]

For any principle that received a "no" above, please explain:
The bill creates more government in several ways: directing the Agency for Health Care Administration (AHCA) to compile data on nursing home liability costs; directing AHCA to seek a federal demonstration waiver for ventilator-dependent adults; and the creation of the Program for Graduate Medical Education Innovation and the Committee on Graduate Medical Education.

B. PRESENT SITUATION:

Medicaid

Medicaid is a medical assistance program that pays for health care for the poor and disabled. The program is jointly funded by the federal government, the state, and the counties. The federal government, through law and regulations, has established extensive requirements for the Medicaid Program. The Agency for Health Care Administration is the single state agency responsible for administering the Florida Medicaid Program. The statutory provisions for the Medicaid Program appear in ss. 409.901 through 409.9205, F.S. The state budget for the program for fiscal year 1999-2000 is $7,416,045,061, and the program anticipates serving 1,607,144 clients this year.

Medicaid Inpatient Hospital Services

In the 1980s and early 1990s, Medicaid expenditures were increasing at double-digit rates. One attempt by the Legislature to slow down the growth was to limit target rate reimbursements on facility-specific Medicaid hospital per diem rates. Medicaid reimburses hospitals according to separate plans for inpatient and outpatient services. The Agency for Health Care Administration uses the plans to authorize per diem rates for each facility according to its cost report. Medicaid payment is considered payment in full for covered services.

The Medicaid hospital reimbursement plans limit growth in reimbursement rates based on specific target rates and ceilings. An inpatient variable cost-based reimbursement ceiling is established for each county. General hospitals are subject to the limitation, but statutorily defined teaching hospitals, specialty hospitals, and rural hospitals are exempt from the inpatient variable cost-based ceiling.

In 1993 a target rate system for hospital outpatient rates was established. The target ceiling is used to limit the growth in the cost-based county ceiling and facility specific rates

between rate semesters. The target ceilings are adjusted each January and July based on the prior rate semester's county ceilings and facility specific rates multiplied by the allowable rate of increase.

Florida's hospitals have undergone major changes in reimbursement policies. Changes in federal Medicare reimbursement policies, limitations on disproportionate share hospital payments, and the trend toward increased managed care have increased the concerns of hospitals over lowered fees and resulting revenues. Florida's high number of uninsured persons also increases hospitals' financial vulnerability.

Medicaid Adult Outpatient Hospital Services Cap

Section 409.905(6), F.S., requires AHCA to pay for preventive, diagnostic, therapeutic, or palliative care and other services provided to a Medicaid recipient in the outpatient portion of a hospital. Payment is limited to $1,000 per state fiscal year per adult recipient.

Section 409.908(1)(a), F.S., limits Medicaid reimbursement for hospital outpatient services to $1,000 per fiscal year per adult recipient except for renal dialysis services and for other exceptions made by AHCA. The exceptions are for services that can be safely performed in the hospital outpatient setting and are more cost-effective when done in the outpatient setting rather than in the inpatient setting.

The agency indicated that the last increase in the cap for hospital outpatient services occurred in 1987. Over the past thirteen years, the cost of medical care has risen substantially, while the level of reimbursement cap for hospitals providing outpatient care to adults who are eligible under Medicaid has not changed. The cap of $1,000 is often inadequate to provide appropriate reimbursement to a hospital serving a Medicaid recipient requiring outpatient care. The average Medicaid hospital outpatient claim is $164, according to AHCA.

Medicaid Reimbursement for Nursing Home Services

Medicaid mandatory services include skilled nursing facility services, as specified in s. 409.905(8), F.S. Paragraph (b) of subsection (2) of s. 409.908, F.S., stipulates that AHCA establish and implement a Florida Title XIX (Medicaid) Long-Term Care Reimbursement Plan. Under the plan, a prospective case mix reimbursement rate is calculated for each nursing home based on the facility’s costs of rendering care, with specific accounting for the costs of patient care, operating costs, and property costs. These factors combine to serve as the basis for a facility’s per diem rate of reimbursement. These rates are subject to specific regional and county ceilings, and are fixed on the semi-annual semester basis by AHCA using actual audited data reported to AHCA by nursing homes. The only exception to this is an allowance for interim rate adjustments, on the basis of outstanding factors that impact the cost of doing business. These interim rate adjustments have, up to this point, been limited to costs associated with revisions in federal or state requirements that have a direct impact on the cost of nursing home care to Medicaid recipients. The costs of liability insurance for nursing homes is built into the rate setting process for each rate semester. Given the increasing cost of liability insurance for nursing homes, there is some concern about the nursing home industry’s ability to recover these costs as part of Medicaid reimbursement methodology.

A widely recognized issue is the fiscal impact on the nursing home industry of the increasing costs of general and professional liability insurance. A specific aspect of this issue raised by the nursing home industry is the extent to which such costs are captured

and recovered as part of the Medicaid nursing home reimbursement methodology. A specific review of this issue has not been done to date.

Medicaid Reimbursement for Services Rendered to Dually-Eligible Patients

Medicaid mandatory services include physician services, as specified in s. 409.905(9), F.S. Reimbursement for physician services generally are as specified in subsection (12) of s. 409.908, F.S. Subsection (13) of this same section specifies physician reimbursement for services rendered to dually eligible patients, those eligible for both Medicare and Medicaid. There has been a lack of clarity in this provision of statute and its implementation since the creation of this provision in the Florida Statute in 1991. As part of the Balanced Budget Act of 1997, the U.S. Congress also addressed some of the uncertainty relating to this topic. State legislative clarification of this provision as contained in ch. 98-191, Laws of Florida, still leaves some doubt as to the reimbursement rates that should have historically been paid to physicians for services rendered to the dually eligible. There are several current and pending lawsuits regarding this issue, which have a potentially large fiscal impact on the state.

Disproportionate Share Program

Currently under the Florida Medicaid program, there are seven separate programs specifically designed to provide enhanced Medicaid reimbursement for certain classes of hospitals rendering services to Medicaid recipients and indigent clients. These programs, their respective authorization, and fiscal year 1999-2000 total funding (in millions) are as follows:

Statute	Program	Funding
s. 409.911	Regular hospitals	$153.4
s. 409.9112	Regional Perinatal Intensive Care Centers	$6.9
s. 409.9113	Teaching hospitals	$19.8
s. 409.9115	Mental health hospitals	$147.8
s. 409.9116	Rural hospitals	$9.8
s. 409.9117	Primary care hospitals	$6.5
s. 409.9118	Specialty (tuberculosis) hospital	$4.3
	TOTAL	$348.5

While the federal government, via the Balanced Budget Act of 1997, has imposed limits on the total amount of each state's Medicaid budget that can flow through the disproportionate share program and specific limits on mental health disproportionate share, each state has the flexibility to array these expenditures as the state sees fit. One of the Governor's budget recommendations for fiscal year 2000-2001 is the creation of a children's hospital disproportionate share program, targeting specifically All Children's (Pinellas) and Miami Children's (Miami-Dade) hospitals.

Chapter 91-282, Laws of Florida, created the extraordinary DSH program under section 409.9114, F.S. Chapter 93-129, Laws of Florida, repealed this section of statute. However, the reference to the extraordinary DSH program was not deleted from s. 409.908, F.S., relating to reimbursement of Medicaid providers.

Medicaid Prepaid Health Care Services

Section 409.912(2), F.S., authorizes AHCA to enter comprehensive risk contracts serving the general Medicaid population with entities certified by the Department of Insurance (DOI) under part I of ch. 641, F.S. By contrast, s. 409.912(4)(b), F.S., authorizes AHCA to contract with entities that only serve Medicaid members, and which entities are exempt from regulation by DOI under the provisions of part I of ch. 641, F.S. This exemption dates back to early attempts by Medicaid to contract with any entity willing to provide prepaid plan services to Medicaid recipients, and more recent Medicaid attempts to contract with specific publicly-funded entities for such services, namely a consortium of federally-funded community health centers. In the recent past, AHCA has concluded that Medicaid recipients should have the benefit of the protections afforded every other citizen of Florida under part I of ch. 641, F.S., regardless of whether their health plan of choice offers commercial products or not.

Part I, ch. 641, F.S., encompasses a number of requirements which AHCA regards as critical to any sound and responsible risk-based contractor. These requirements include surplus requirements to promote fiscally sound plans, and requirements for subcontractors and regulations on marketers and marketing practices (historically a source of many complaints from Medicaid members).

The Department of Insurance is also tasked, through part I, ch. 641, F.S., with specific responsibilities in the event a health plan becomes insolvent. Those responsibilities include the provision of administrative supervision, rehabilitation, and, potentially, liquidation of an insolvent health plan. The Department of Insurance has the expertise and resources for these activities; AHCA does not. Dealing with insolvent contractors has presented problems for AHCA in the past since AHCA does not have the staff or experience necessary to competently administer the post-closure affairs of an insolvent plan.

Prior to the adoption of the requirements of s. 409.912(2), F.S., AHCA contracted with a number of Medicaid prepaid health plans that were not certified under part I, ch. 641, F.S. AHCA had two difficult experiences where AHCA was forced to terminate the contract due to the inability of the contractor to meet its current financial obligations. There were several other instances where only “last minute” mergers or acquisitions prevented the similar demise of health plans. Since AHCA began dealing only with DOI certified plans, AHCA has not had the frequency of this phenomenon, and with the cooperative working relationship between AHCA and DOI, AHCA has been much better able to deal with the consequences of the financial failure of contracted plans.

Long-Term Care Community Diversion Pilot Projects

In 1997, the Florida Legislature enacted the Long-Term Care Community Diversion Pilot Project Act (ss. 430.701 - 430.710, F.S.), providing authority and guidance for the implementation of the pilot projects. The pilot projects provide acute care services covered by Medicaid, home and community-based long-term care services, and when necessary, nursing home care through managed care organizations. Pilot project enrollees are dually eligible for Medicare and Medicaid and are an especially vulnerable population. Dually eligible beneficiaries rely on Medicare as their primary payer for medical acute and chronic care, and on Medicaid as a "Medigap" policy to pay pharmacy and cost-sharing expenses and as the payer of long-term care services. Section 430.705, F.S., requires pilot projects to integrate acute and long-term care services, and the funding sources for such services, as feasible, and provides for the Department of Elderly Affairs to select pilot project areas based on a variety of factors. The Palm Beach (Palm Beach, Indian River, Okeechobee, Martin and St. Lucie) and Orange County (Orange, Seminole, Brevard, and Osceola) areas

were selected as the initial sites for the pilot projects, and 3 pilot contracts are operational in these areas.

The department selects and contracts with managed care organizations to provide long-term care within pilot project areas. Section 430.703(6), F.S., defines "managed care organization" to mean an entity that meets the requirements of the Department of Insurance for operation as an HMO and meets the qualifications for participation as a managed care organization established by the Agency for Health Care Administration and the Department of Elderly Affairs. In addition, the Medicaid waiver from the federal Health Care Financing Administration requires managed care organizations to have, or have applied for, a health care provider certificate from the agency and a certificate of authority from the Department of Insurance (HMO licensure). The department relies on the HMO licensure process and standards to ensure financial soundness and minimum quality of care standards.

Under s. 430.707, F.S., the department contracts with managed care organizations, and may contract with entities which have submitted an application as a community nursing home diversion project to provide benefits pursuant to the "Program of All-Inclusive Care for the Elderly" as established in Pub. L. No. 105-33. These latter entities are exempt from the requirements of ch. 641, F.S., if the entity is a private, nonprofit, superior-rated nursing home with at least 50 percent of its residents eligible for Medicaid. It should also be noted that the federal PACE regulations, which govern the operations of PACE, contain detailed financial and quality assurance standards.

Implementation of the pilot projects has been delayed by a lack of actuarial data HMOs depend on to measure financial risk and by concerns with Medicare capitated payment rates. Experience with managing and taking risk for long-term care is limited, and this has meant the time-line for typical new business development activities has been extended. The Medicare rate for persons who are chronically ill and very frail also has been a major problem for HMOs from the beginning of the department's efforts to implement the pilot projects. As of March, 2000, there were approximately 500 individuals enrolled in the diversion project throughout the Orlando and Palm Beach areas. Based on current enrollment projections, it is expected that by July 1, 2000, approximately 750 individuals will be enrolled in the pilot projects.

Budget Transfer Authority

Under s. 216.292, F.S., agencies may, following executive and legislative review and approval processes, transfer specific budgeted funds. This is a regular and ongoing process during any state fiscal year. On an ongoing basis, the Agency for Health Care Administration must seek such authority with sister agencies in order to meet certain programmatic and budget expectations. For example, the agency works very closely with the Department of Children and Family Services in ensuring adequate funding for targeted case management services rendered to those with mental health conditions. The agency reimburses for Medicaid targeted case management services to clients served by the Office of Alcohol, Drug Abuse and Mental Health in the Department of Children and Family Services and Children’s Medical Services in the Department of Health. Case management is defined as activities associated with ensuring access to necessary medical, social, educational, and other services required by the individual. The Medicaid appropriation for targeted case management for adults served by the Mental Health program is funded by federal funds, matching state general revenue funds appropriated directly to Medicaid, and by general revenue funds transferred from the Department of Children and Family Services if the state match requirement exceeds the general revenue appropriated in Medicaid. In

prior years, the General Appropriations Acts have included proviso permitting the transfer of general revenue funds from the Department of Children and Family Services.

The same is true with regard to the Assisted Living for the Elderly Medicaid waiver in conjunction with the Department of Elderly Affairs. The Assisted Living for the Elderly (ALE) Waiver is a home and community-based services program that was implemented statewide on February 1, 1995, for recipients who reside in qualified Assisted Living Facilities (ALFs). The Department of Elderly Affairs operates the waiver, and Medicaid provides federal matching funds. The waiver includes case management and assisted living services. Assisted living services include: attendant call system, attendant care, behavior management, chore, companion services, homemaker, incontinence supplies, intermittent nursing, medication administration, occupational therapy, personal care, physical therapy, specialized medical equipment and supplies, speech therapy, and therapeutic social and recreational services. The Medicaid appropriation for the waiver is funded by federal funds and matching state general revenue funds appropriated directly to the Department of Elderly Affairs. Medicaid pays the waiver claims, and bills the Department of Elderly Affairs for the state share.

One of the revisions sought as part of the Governor's budget recommendations for the 2000 session is authority for these type recurring transfers to take place apart from the s. 216.292, F.S., review process.

Medicaid Eligibility Determination

During the 1999 Legislative Session, a Reviser's Bill replaced the word "department," which referred to the Department of Children and Family Services (DCF), with the word "Agency," which referred to the Agency for Health Care Administration (AHCA), in certain sections of ch. 409, F.S. Specifically, s. 409.919, F.S., provides statutory authority for rulemaking in the Medicaid program. DCF performs Medicaid eligibility determinations through an interagency agreement with AHCA. Prior to the 1999 amendment to s. 409.919, F.S., DCF had rulemaking authority to adopt rules under which it would conduct Medicaid eligibility determinations. The result of the amendment to this section was to remove DCF's rulemaking authority to adopt rules under which to conduct Medicaid eligibility determinations.

The Department of Children and Family Services is currently involved in litigation in federal court regarding Medicaid-related disability determinations and it is anticipated that any settlement would necessitate adopting additional rules or revisions to existing rules to implement.

Medicaid School Health Services Certified Match Program and Developmental Research Schools

Sections 236.0812, 409.9071, and 409.908(21), F.S., authorize school districts to certify to the Florida Medicaid program their expenditures for school health services rendered to Medicaid eligible students; AHCA in turn certifies these amounts to the Health Care Financing Administration; and HCFA provides federal matching funds for these expenditures. As established annually as part of the General Appropriations Act, there is an annual expenditure cap of $50 million on such certifications under this program. For the current fiscal year, the Social Services Estimating Conference meeting of February 18, 2000, projected an expenditure of $37.8 million under this program.

Developmental research schools, as authorized under s. 228.053, F.S., may be established by a state university to serve as a vehicle for the conduct of research, demonstration, and evaluation regarding management, teaching, and learning as part of the participating university's curriculum. Currently, developmental research schools exist at Florida Agricultural and Mechanical University (FAMU), Florida State University (FSU), Florida Atlantic University (FAU), and University of Florida (UF). The number of students in attendance ranges from around 500 students at FAMU and FAU, to over 1,000 students at FSU and UF.

Because the requirements for the certified school match program target school districts, and because developmental research schools are organizationally part of the universities with which they are affiliated and not part of the respective school district, the developmental research schools have not been part of the Medicaid certified match program for school health services.

Medicaid Fiscal Agent Contract

Traditionally, federal Medicaid regulations have required each state's Medicaid program to put out for bid the state's Medicaid fiscal intermediary, or fiscal agent, services every five years. Because of the volume of this undertaking, the process requires multiple full-time equivalents working over a multi-year period to accomplish this recurring task. Given the uncertainty of the Year 2000 (Y2K) impact on state's Medicaid Management Information Systems, the federal government relinquished its stance on recurrent re-bidding of these crucial services. This provides as opportunity for a state to decide to renew a contract for fiscal intermediary services one or more times as the state may decide, at the state's discretion, not to exceed a total period longer than the term of the initial contract. This will provide considerable administrative cost savings to Medicaid.

Care for Adult Ventilator Dependent Individuals

There is currently no statutory authorization for reimbursement for respiratory services for adult Medicaid recipients. Although respiratory equipment and supplies were made available to adult Medicaid recipients, effective October 1999, the professional services were not part of the authorization. Hospitals cannot discharge ventilator dependent adults who live alone or who cannot access professional respiratory care. Placements in skilled nursing facilities have been difficult, because no supplemental reimbursement is available to these facilities for this extra care. Hospitals are forced to keep these patients for 2 to 3 years, and sometimes for the rest of their lives. As a result, hospitals are absorbing costs in excess of $1 million annually for each ventilator dependent person. At times, hospitals are able to establish an agreement with a nursing facility that allows the hospital to assist the nursing facility in the support of these patients. Some patients are relocated to other states, including Virginia, Maryland, and North Carolina, which becomes a hardship on families living in Florida. A recent survey, conducted by the Division of Vocational Rehabilitation, revealed that only 28 of 257 nursing facilities in Florida provide ventilator care.

Optional State Supplementation (OSS) Program

Optional State Supplementation is a means-tested General Revenue funded public assistance program which supplements the federal Supplemental Security Income (SSI) of indigent elderly and disabled Floridians. This supplement increases the recipients' income to assist in paying for supportive living arrangements in the community in order to prevent unnecessary institutionalization (nursing home or mental hospital). To qualify for this

program, applicants must: (1) be over age 65 or disabled; and (2) have a monthly income below $697 and total assets under $2,000.

According to the Department of Children and Family Services, the average annual cost to the state for an OSS-qualified person to reside in a nursing home is $18,456. The annual cost to the State of Florida for the same individual to reside in an ALF is approximately $2,544 -- a savings of over $15,000 a year.

The two long term care environments used by OSS recipients are assisted living facilities (ALFs) and adult family care homes (AFCHs). To date, approximately 8,868 OSS recipients are cared for in assisted living facilities, and 372 are cared for in adult family care homes. Many ALF providers will not accept OSS clients because the reimbursement rate is lower than the actual cost to provide the care. The actual cost of care for these recipients, as determined by the Department of Children and Family Services and the OSS workgroup (established by the 1998 Legislature) is approximately $850 a month.

Each year the federal government provides a cost of living allowance (COLA) increase to Social Security recipients. Prior to 1994, the State of Florida, in effect, took this increase away from OSS recipients, by reducing the state's contribution in the amount of the COLA increase. Beginning in 1995, the Legislature set a new precedent and allowed the pass-through of this increase to the recipient, without reducing the state contribution. This pass-through is continued each year by placing proviso language in the General Appropriations Act.

Medicaid Fraud and Abuse

The Legislature, the Attorney General's Office, and specifically the Medicaid Fraud Control Unit under the Attorney General, the Agency for Health Care Administration, the Office of Statewide Prosecutor, and the federal government have taken numerous steps over the past several years to combat fraud and abuse within the Florida Medicaid program. Past initiatives have included: claims payment analyses and controls, provider surety bonds and financial background checks, on-site provider visits, Level I and Level II criminal background checks, additional Medicaid Management Information System edits, and improved interagency coordination. Current initiatives include: pharmacy audits, including on-site audits and audits specific to overpayments, an explanation of medical benefits mailing to some recipients; pharmacy lock-in, whereby a federal waiver has been obtained to permit the state to lock-in an abusive Medicaid recipient to a single pharmacy; recipient fingerprinting demonstration project, at approximately 200 pharmacies to ensure that only the eligible recipient or an authorized representative is picking up prescribed drugs; enhanced claims analysis and automated fraud and abuse detection capabilities; additional pharmacy fraud and abuse controls, including surety bonds and on-site inspections prior to entering provider agreements; fraud detection system enhancements to identify patterns of fraud; and physician practice pattern review, including drug usage evaluation, prescribing profiles, physician education, and outcomes analysis.

As part of its fraud and abuse efforts, the agency has made two recommendations for the 2000 legislative session for revisions to s. 409.907, F.S., relating to Medicaid provider agreements, to aid in the prevention of fraud and abuse in the Medicaid program. The agency proposed that, instead of a surety bond fixed at a flat amount of $50,000, the surety bond should be based on the amount of Medicaid billings submitted or anticipated to be submitted by a Medicaid provider, where appropriate. The agency currently requires a $50,000 surety bond from specific provider types, including durable medical equipment (DME) providers, home health agencies, home and community based providers who

provide DME, physician groups and clinics where 50 percent or more of the practice is owned by non-physicians, specified transportation providers, and independent laboratories.

The agency is currently authorized to deny potential applicants based on 11 specific criteria, primarily related to being convicted of criminal offenses under either federal or state law. The agency requested additional authority to deny Medicaid provider applications. This revision is designed to allow the agency the ability to make a determination regarding a provider applicant with whom the agency may have had prior experience, but for whom there may not necessarily be a criminal record, for instance.

Section 409.920(2)(a-f), F.S., makes it unlawful to engage in certain activities the purpose of which is to falsely procure Medicaid benefits. The prohibited activities range from knowingly making false statements in claims submitted for payment to knowingly receiving any remuneration in return for referring an individual to a person for services for which payment may be made under the Medicaid program. A person who engages in any of the prohibited activities commits a third degree felony.

Attorney General's Medicaid Fraud Control Unit

Section 409.920(7), F.S., requires the Attorney General to conduct a statewide program of Medicaid fraud control. This section directs the Attorney General to:

- Investigate possible criminal violations of any applicable state law pertaining to fraud in the administration of the Medicaid program;
- Investigate the alleged abuse or neglect of patients, and misappropriation of patients' private funds, in health care facilities receiving payments under the Medicaid program;
- Refer to the Office of Statewide Prosecution or the appropriate state attorney all violations indicating a substantial potential for criminal prosecution;
- Refer to the Agency for Health Care Administration (agency) all suspected abusive activities not of a criminal nature;
- Refer to the agency for collection each instance of overpayment; and
- Safeguard the privacy rights of all individuals and provide safeguards to prevent the use of patient medical records for any reason beyond the scope of a specific investigation for fraud or abuse.

Section 409.920(8), F.S., authorizes the Attorney General to enter upon the premises of any health care provider, excluding a physician, participating in the Medicaid program to examine all accounts and records that may be relevant in determining:

- The existence of fraud;
- Abuse or neglect of patients; or
- Misappropriation of patients' private funds.

The Attorney General also may subpoena witnesses or materials within or outside the state, administer oaths and affirmations, and collect evidence for possible use in either civil or criminal judicial proceedings. Additionally, this section allows the Attorney General to request and receive the assistance of any state attorney or law enforcement agency in the investigation and prosecution of any violation of s. 409.920, F.S.

Section 409.920(8)(b), F.S., requires a participating physician to make available any accounts or records that may be relevant in determining the existence of fraud in the Medicaid program. However, the accounts or records of a non-Medicaid patient may not be reviewed by, or turned over to, the Attorney General without the patient's written consent.

Section 409.9205, F.S., provides that all investigators employed by the Medicaid Fraud Control Unit who have been certified under s. 943.1395, F.S., are law enforcement officers of the state. Such investigators have the authority to conduct criminal investigations, bear arms, make arrests, and apply for, serve, and execute search warrants, arrest warrants, and capias (to order law enforcement to take a person, generally a child/juvenile, into custody) throughout the state as it pertains to Medicaid fraud. The Attorney General is required to provide notice of criminal investigations to, and coordinate those investigations with, the sheriffs of the respective counties.

Confidential Patient Records

Generally, medical records kept by health care providers in connection with the examination or treatment of patients may not be furnished to, and the medical condition of the patient may not be discussed with, any person other than the patient or the patient's legal representative, except upon written authorization of the patient. Likewise, patient records maintained by a hospital or similar licensed health care facility are also confidential. Some of the statutes providing for confidentiality of medical records, and accompanying exceptions thereto, include the following:

- Clinical records for patients receiving treatment pursuant to the Baker Act pursuant to s. 394.4615, F.S.;
- Records for patients in hospitals, ambulatory surgical centers, and mobile surgical centers pursuant to s. 395.3025, F.S.;
- Nursing home or long-term care facility patient records, as well as complaint records about those facilities, in the possession of the state or district ombudsman council pursuant to s. 400.0077, F.S.;
- Information about patients received by persons employed by, or providing services to, a home health agency pursuant to s. 400.494, F.S.;
- Patient records maintained by school districts enrolled as Medicaid providers pursuant to s. 409.9071, F.S.;
- Patient records of home health care providers pursuant to s. 430.608, F.S.; and
- Patient records obtained by the Department of Health which are used in health care practitioner disciplinary proceedings pursuant to s. 455.667, F.S.

Community Hospital Education Program

The 1971 Legislature created s. 381.0403, F.S., the Community Hospital Education Program (CHEP). This program is the only source of direct state funding for primary care graduate medical education in Florida. The objective of the CHEP is to increase the number of primary care physicians practicing in Florida by assisting Florida hospitals to defray the high costs of these programs. Annual appropriations are distributed to Florida internship and residency programs based on policies enacted by an 11 member Community Hospital Education Program Council (CHEC), appointed by the Governor. The statute requires highest priority for family practice residencies. The CHEC has historically limited eligibility for funding to "primary care" specialties, defined as general internal medicine, general pediatrics, obstetrics/gynecology, emergency medicine, psychiatry, and combined internal medicine/pediatrics, as well as family practice.

The FY 1999-2000 CHEP appropriation of $8.5 million was used to support approximately 1,543 interns and residents in 58 programs sponsored by 28 teaching hospitals. Family practice residents are being supported at $11,500 per capita, while all other CHEP-supported specialities are receiving $2,650 per capita. CHEP annual appropriations have traditionally been made in the Board of Regents' General Office Budget, because the

board has statutory responsibility to provide administrative support to the Community Hospital Education Council.

The CHEC has a policy not to provide funding to any internship or residency program with fewer than three participants, unless the appropriate accrediting entity for the speciality allows for fewer participants.

CHEP funding is not eligible to match federal programs such as Medicaid because it is administered by the Board of Regents rather than the Agency for Health Care Administration.

Committee on Graduate Medical Education

Proviso language accompanying Specific Appropriation #191 of the FY 1999-2000 General Appropriations Act established a committee to study graduate medical education in Florida. The committee membership included the four medical school deans, hospital administrators, and the president of the Florida Medical Association. The committee provided a report on December 1, 1999, recommending that the state seek federal matching funds for CHEP funding and establish a new fund for programs to assist the state to meet medical workforce needs.

Graduate Medical Innovations

The state does not have a program to provide incentive funding to hospitals or medical schools to promote state health manpower objectives such as more physicians in under-served areas, more geriatricians, and more ethnic diversity among physicians. Such a program was recommended by the Committee on Graduate Medical Education.

Teaching Hospitals

Section 409.908(44), F.S., defines the term "teaching hospital" to include any hospital with at least 100 residents and seven separate residency programs. The statute does not give any specific agency the authority to certify that a hospital meets this definition, nor does it state whether the 100 resident minimum refers to headcount or full-time-equivalent residents. Six hospitals meet this definition:

Shands Hospital, Gainesville
Shands Hospital, Jacksonville
Tampa General Hospital
Jackson Memorial Hospital, Miami
Mt. Sinai Medical Center, Miami Beach
Orlando Regional Healthcare

Among the principal reasons for being designated as a "teaching hospital" is the ability to receive funding under the Medicaid Teaching Hospital Disproportionate Share Program, s. 409.9113, F.S.

Alzheimer’s Disease

Alzheimer’s disease is a progressively degenerative neurological disorder, and is the most common cause of dementia--the loss of intellectual function (thinking, remembering, and reasoning)--severe enough to interfere with everyday life. Although the disease does strike young people (some as young as age 40), Alzheimer’s is closely associated with advancing

age. Ten percent of people over age 65 and nearly 50 percent of those age 85 and older are affected. It is estimated that in excess of 4 million people in the United States, and just under one-half million people in Florida have Alzheimer's disease. With Florida's aged population, and the aging of the baby boomers, the numbers of Alzheimer's patients are expected to continue to grow.

While being heavily researched, there is as yet no preventive or cure for Alzheimer's disease, nor a way to halt the progression of the disease. Because it is a progressive disease, every person who gets the disease will need different levels of care during the course of the disease, and will ultimately need total care. Such care can be provided in a variety of settings.

The total annual cost of care for those with Alzheimer's disease today is at least $100 billion. The average lifetime cost or care of such persons is estimated at $174,000. Alzheimer's disease costs American business an estimated $33 billion annually, with most of that in lost work of employees who are care givers. Medicare spent an average of $7,682 in 1995 on beneficiaries with Alzheimer's disease, or 70 percent more than the average spent on beneficiaries without a cognitive impairment.

C. EFFECT OF PROPOSED CHANGES:

The bill addresses: a number of substantive and budget issues relating to the Florida Medicaid program, and the Attorney General's Medicaid Fraud Control Unit; graduate medical education substantive and budget issues; and other issues. See the SECTION-BY-SECTION ANALYSIS which follows for additional details.

D. SECTION-BY-SECTION ANALYSIS:

Section 1. Adds a new subsection (6) to s. 394.4615, F.S., and redesignates other subsections relating to confidentiality of mental health and health care clinical records, to provide that clinical records relating to a Medicaid recipient must be furnished to the Medicaid Fraud Control Unit, upon request.

Section 2. Adds a new paragraph (k) to subsection (4) of s. 395.3025, F.S., relating to copies and examinations of patient and personnel records, of hospitals, ambulatory surgical centers, and mobile surgical centers, to authorize the release of patient records without consent of the patient to the Medicaid Fraud Control Unit.

Section 3. Adds a new subsection (6) to s. 400.0077, F.S., relating to confidentiality, to provide that the confidentiality attached to nursing home or long-term care facility patient records in the possession of the state or district long-term care ombudsman does not limit the subpoena power granted the Attorney General under s. 409.920(8)(b), F.S., relating to Medicaid provider fraud.

Section 4. Adds a new subsection (2) to s. 400.494, F.S., relating to confidentiality of records about home health agency patients, to provide that this section does not apply to information lawfully requested by the Medicaid Fraud Control Unit.

Section 5. Adds a new subsection (7) to s. 409.9071, F.S., relating to Medicaid provider agreements for school districts certifying state match, to provide that the agency's and school districts' confidentiality is waived and that they must provide any information or documents relating to the Medicaid provider agreement to the Medicaid Fraud Control Unit, upon request.

Section 6. Amends s. 409.920(8)(b), F.S., relating to Medicaid provider fraud, to provide authorization for the Attorney General to subpoena medical records relating to Medicaid recipients.

Section 7. Amends s. 409.9205, F.S., relating to the Medicaid Fraud Control Unit, to authorize the investigators to apply for, serve, and execute other processes throughout the state pertaining to Medicaid fraud as authorized by ch. 409, F.S. [NOTE: *Black's Law Dictionary* (7th Ed. 1999), defines "process" as "[a] summons or writ, esp. to appear or respond in court..."]

Section 8. Amends s. 430.608, F.S., relating to confidentiality of information relating to persons served under the home care for the elderly program of the Department of Elderly Affairs, to provide that this section does not limit the subpoena authority of the Medicaid Fraud Control Unit.

Section 9. Adds a new paragraph (b) to subsection (8) of s. 455.667, F.S., relating to ownership and control of patient records, to provide that patient records obtained by the Department of Health in health care practitioner disciplinary proceedings which relate to a current or former Medicaid recipient must be provided to the Medicaid Fraud Control Unit, upon request.

Section 10. Amends s. 409.212, F.S., to add as a new subsection (6) authorization for the ongoing adjustment in the optional state supplementation rate based on the cost of living adjustment to the federal benefits rates. [NOTE: This authorization is typically a part of the General Appropriations Act; this provision puts into statute what is a recurring budget proviso item.]

Section 11. Amends subsections (3), (15), and (18) of s. 409.901, F.S., relating to Medicaid definitions, to substitute "department" for "agency" for purposes of submission of applications for medical assistance under Medicaid and add Social Security Administration for purposes of submission of applications for Supplemental Security Income.

Section 12. Amends s. 409.902, F.S., relating to the designation of a single state agency for purposes of the Medicaid program to designate that the Department of Children and Family Services is responsible for Medicaid eligibility determinations, including policies, rules, and the agreement with the Social Security Administration for Medicaid eligibility determinations for Supplemental Security Income recipients.

Section 13. Amends s. 409.903, F.S., relating to mandatory payments for Medicaid eligible persons, to incorporate conforming references to the Department of Children and Family Services and Social Security Administration.

Section 14. Amends subsection (6) of s. 409.905, F.S., relating to the hospital outpatient services requirements as part of mandatory Medicaid services, to increase the annual adult outpatient services cap from $1,000 to $1,500.

Section 15. Amends subsection (5) of s. 409.906, F.S., relating to case management services as an optional Medicaid service, to specifically authorize the Department of Children and Family Services to transfer general funds to the Agency for Health Care Administration to cover state match requirements exceeding the amount specified in the General Appropriations Act for targeted case management services, notwithstanding the provisions of s. 216.292, F.S., relating to the non-transferability of appropriated funds by state agencies.

Section 16. Amends subsections (7), (9), and (10) of s. 409.907, F.S., relating to Medicaid provider agreements. The provisions of subsection (7) are amended to incorporate a series of revisions relating to provider surety bond requirements. The current requirement is that providers seeking to enter provider agreements have a surety bond not to exceed $50,000. This requirement is expanded such that, before entering into a provider agreement, or as a condition of continuing participation in the Medicaid program, the agency may require the Medicaid providers reimbursed on a fee-for-services basis or a fee schedule basis which is not cost based to post a surety bond 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 is to be determined by the agency based on the provider's estimate of its first year's billing, with provision for an upward adjustment based on actual billing. A provider's bond shall not exceed $50,000 if a physician or group of physicians licensed under ch. 458, ch. 459, or ch. 460, F.S., 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 ch. 400, F.S. Bonds under this section are in addition to bonds referenced in s. 400.179(4)(d), F.S., relating to nursing home lease bond requirements. [NOTE: It appears that the cross-reference should be to s. 400.179(5)(d), F.S.]

Subsection (9) is amended to authorize the agency to deny a provider agreement if the agency determines that such denial is in the best interest of the agency, and in so doing deletes the limitation that such denials be based solely on the grounds contained in subsection (10) of this section, but instead can also be based on, but not limited to, current availability of medical care, services, or supplies, taking into account geographic location and reasonable travel time.

Subsection (10) is amended to specify that the factors listed be used in *considering*, rather than *denying*, provider participation in Medicaid.

Section 17. Amends s. 409.908, F.S., relating to reimbursement of Medicaid providers. Paragraph (a) of subsection (1), relating to hospital reimbursement, is amended to increase the annual adult hospital outpatient services reimbursement cap from $1,000 to $1,500.

Paragraph (b) of subsection (2), relating to nursing home reimbursement, is amended to specify that nursing home interim rate adjustments shall not be granted to reflect increases in the cost of general or professional liability insurance for nursing homes unless the following criteria are met: the nursing home must have at least a 65 percent Medicaid utilization in the most recent cost report submitted to the agency, and the increase in general or professional liability costs to the facility for the most recent policy period affects total Medicaid per diem by at least 5 percent. This rate adjustment shall not result in the per diem exceeding the class ceiling. This provision shall only apply to fiscal year 2000-2001, and shall be implemented to the extent existing appropriations are available.

The language goes on to direct the agency to report to the Governor and legislative leadership by December 31, 2000, on the cost of liability insurance for Florida nursing homes for fiscal years 1999 and 2000, and the extent to which these costs are not being compensated by the Medicaid program. Medicaid participating nursing homes are required to report to the agency data necessary to compile this report.

Subsection (13), relating to Medicaid reimbursement for services rendered to patients who are dually eligible for Medicare and Medicaid, is amended to add legislative findings and clarification relating to physician reimbursement. The added language specifies that it was never the intent of the Legislature to provide payment in excess of the payment amount

provided for under the State Medicaid Plan for such services. The language also indicates that this expression of the Legislature is in clarification of existing law and shall apply to payment for, and with respect to provider agreements with respect to, items or services furnished on or after the effective date of this act, and apply to payment by Medicaid for items furnished before the effective date of this act if such payment is the subject of a lawsuit that is based on the provisions of s. 409.908, F.S., that is pending as of, or is initiated after, the effective date of this act.

Section 18. Creates s. 409.9119, F.S., to provide for a disproportionate share program for specialty hospitals for children. Specifically included are: guidelines and requirements for creation of this program; an exemption from contributions from counties under Medicaid matching fund requirements; factors to be used in determining amounts to be earned by specialty hospitals for children and additional amounts to be paid to such hospitals; and compliance requirements for receipt of funds.

Section 19. Amends s. 409.912, F.S., relating to cost-effective purchasing of health care under Medicaid. Subsection (9), relating to waivers, is amended to direct the Department of Elderly Affairs to transfer to the Agency for Health Care Administration any unexpended funds for the Assisted Living for the Elderly Medicaid waiver, notwithstanding the provisions of s. 216.292, F.S., relating to the nontransferability of appropriated funds by state agencies. Such funds must, in turn, be used by the agency to fund Medicaid-reimbursed nursing home care.

A new subsection (37) is added to this section to authorize the agency, at its discretion, to renew a contract for fiscal intermediary services one or more times as the agency may decide, not to exceed a total period longer than the term of the initial contract, notwithstanding the provisions of ch. 287, F.S., relating to state contracting provisions.

Section 20. Amends s. 409.919, F.S., relating to Medicaid rules, to require the Department of Children and Family Services to adopt rules to comply with sections 409.901-409.906, F.S., and other provisions necessary for Medicaid eligibility determination.

Section 21. Authorizes developmental research schools to participate in the Medicaid certified school match program, notwithstanding the provisions that limit such participation to school districts.

Section 22. Directs the Agency for Health Care Administration to submit to the Health Care Financing Administration a waiver request for a pilot project to implement a coordinated system of care for adult ventilator dependent patients. The pilot will use a network of skilled nursing facilities that agree to participate on a capitated basis. Evaluation must focus on overall cost-effectiveness and participant outcomes. Waiver submission and preliminary and final report timeframes are specified.

Section 23. Amends s. 430.703, F.S., relating to the definitions of terms applicable to community long term care pilot projects. A new subsection (7) is added to define “other qualified provider” to mean an entity licensed under ch. 400, F.S., that demonstrates a long-term care continuum, posts a $500,000 performance bond, and meets all the financial and quality assurance requirements for a provider service network as specified in s. 409.912, F.S., and all requirements pursuant to an interagency agreement between the agency and the Department of Elderly Affairs.

Section 24. Amends subsection (1) of s. 430.707, F.S., relating to selection of managed care organizations for participation in long term care community diversion pilot projects, to

specify that the Department of Elderly Affairs, in consultation with the agency, select and contract, on a prepaid basis, with other qualified providers as defined in s. 430.703(7), F.S., in addition to contracting with managed care organizations for such services. The agency is directed to evaluate and report quarterly to the department the compliance by other qualified providers with all the financial and quality assurance requirements of the contract.

Section 25. Designates February 6th of each year as Florida Alzheimer's Disease Day.

Section 26. Repeals paragraph (b) of subsection (4) of s. 409.912, F.S., relating to Medicaid's authority to contract for prepaid health care services with entities that provide only Medicaid services on a prepaid basis, and which are exempt from part I of ch. 641, F.S.

Section 27. Amends s. 381.0403, F.S., relating to the Community Hospital Education Act, to: emphasize primary care training as opposed to family practice program training; provide additional detail as to eligibility for funding based on training slots; provide a means to seek available federal matching funds for graduate medical education purposes; define primary care specialties; provide for a Program for Graduate Medical Education Innovations, to the extent funded; specify that the Board of Regents certify to the Agency for Health Care Administration those hospitals eligible for certain funds; and provide for the Committee on Graduate Medical Education with specific study topics and annual report requirements.

Section 28. Amends s. 408.07(44), F.S., which defines "teaching hospital," to make the definition specific to *Florida* hospitals and medical schools, specify the accreditation entity, base resident slots on full-time equivalent positions, and specify that AHCA determine the hospitals that meet the definition.

Section 29. Amends subsection (6) of s. 409.905, F.S., relating to the hospital outpatient services requirements as part of mandatory Medicaid services, to increase the annual adult outpatient services cap from $1,000 to $1,500. [NOTE: This section duplicates section 14 of the bill.]

Section 30. Amends s. 409.908, F.S., relating to reimbursement of Medicaid providers. Paragraph (a) of subsection (1), relating to reimbursement for inpatient care, is amended to provide exceptions for the limitations on reimbursement for hospital inpatient services specific to the raising of rate reimbursement caps, excluding rural hospitals, the recognition of costs of graduate medical education, and other methodologies that are recognized in the General Appropriations Act. Added language goes on to specify that during years funds are transferred from the Board of Regents, any reimbursement supported by such funds shall be subject to certification by the Board of Regents that the hospital has complied with s. 381.0403, F.S., the Community Hospital Education Act. New language authorizes AHCA to receive funds from state entities, including but limited to the Board of Regents, local governments, and other political subdivisions for the purpose of making special exception payments, including federal matching funds, through the hospital inpatient reimbursement methodologies. Such funds must be separately accounted for and not commingled with other state and local funds in any manner. Counties are exempted from the mandatory contributions imposed under s. 409.915, F.S., for the cost of the special exception reimbursement for hospitals serving a disproportionate share of low-income persons and providing graduate medical education.

The existing provisions of subsection (1) relating to reimbursement for hospital outpatient services is designated as paragraph (b) of that subsection, and the current $1,000 cap on annual hospital outpatient services for adults is increased to $1,500. [NOTE: This provision

duplicates a portion of section 17 of the bill.] Added language goes on to authorize AHCA to receive funds from state entities, including but not limited to the Board of Regents, local governments, and other political subdivisions for the purpose of making payments, including federal matching funds, through the Medicaid outpatient reimbursement methodologies. Such funds must be separately accounted for and not commingled with other state and local funds in any manner.

Existing paragraph (b) of subsection (1) is redesignated as paragraph (c). This paragraph, relating to disproportionate share reimbursement, is amended to delete reference to the non-existent extraordinary disproportionate share program.

Existing paragraph (c) is redesignated as paragraph (d), but is not otherwise amended.

Section 31. Provides a July 1, 2000, effective date.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

These revenues are based on the amounts provided in the General Appropriations Act for FY 2000-01 for issues included in HB 2329, and assume similar policies will be funded in FY 2001-02.

	FY 00-01	FY 01-02
General Revenue	$500,000	$500,000
Transfers from Board of Regents	$14,500,000	$14,500,000
Transfers from Local Governments	$96,592,190	$96,592,190
Title XIX Medical Assistance Payments (Federal Matching Funds)	$144,743,889	$144,743,889
Total Recurring Revenues	$256,336,079	$256,336,079

2. Expenditures:

These expenditures are based on the amounts provided in the General Appropriations Act for FY 2000-01 for issues included in HB 2329, except that the amount funded in the General Appropriations Act for the DSH program for specialty hospitals for children uses an incorrect funding split. The total funding is correct, and the amounts can be corrected through a budget amendment. Assumes similar policies will be funded in FY 2001-02.

	FY 00-01	FY 01-02
Community Health Education Administrative Trust Fund	$750,000	$750,000
Medicaid Waiver for Ventilator Patients		
General Revenue	$500,000	$500,000
Medical Care Trust Fund (Federal)	$782,807	$782,807
TOTAL	$1,282,807	$1,282,807

DSH Program for Specialty Hospitals for Children		
Grants and Donations Trust Fund	$1,516,000	$1,516,000
Medical Care Trust Fund (Federal)	$1,978,698	$1,978,698
TOTAL	$3,494,698	$3,494,698
Reduce Regular DSH Program		
Grants and Donations Trust Fund	($1,516,000)	($1,516,000)
Medical Care Trust Fund (Federal)	($1,978,698)	($1,978,698)
TOTAL	($3,494,698)	($3,494,698)
Increase in Annual Hospital Outpatient Cap for Adults		
Grants and Donations Trust Fund	$7,533,036	$7,533,036
Medical Care Trust Fund (Federal)	$9,828,190	$9,828,190
TOTAL	$17,361,226	$17,361,226
Remove Hospital Inpatient Reimbursement Rate Ceilings		
Grants and Donations Trust Fund	$30,501,044	$30,501,044
Medical Care Trust Fund (Federal)	$39,794,056	$39,794,056
TOTAL	$70,295,100	$70,295,100
Remove Hospital Outpatient Reimbursement Rate Ceilings		
Grants and Donations Trust Fund	$9,675,008	$9,675,008
Medical Care Trust Fund (Federal)	$12,622,774	$12,622,774
TOTAL	$22,297,782	$22,297,782
Special Medicaid Inpatient Services Payments to Hospitals		
Grants and Donations Trust Fund	$58,901,562	$58,901,562
Medical Care Trust Fund (Federal)	$76,847,602	$76,847,602
TOTAL	$135,749,164	$135,749,164
Special Medicaid Medical Education Payments to Hospitals		
Grants and Donations Trust Fund	$3,731,540	$3,731,540
Medical Care Trust Fund (Federal)	$4,868,460	$4,868,460
TOTAL	$8,600,000	$8,600,000
Total All Issues		
General Revenue	$500,000	$500,000
Administrative Trust Fund	$750,000	$750,000
Grants and Donations Trust Fund	$110,342,190	$110,342,190
Medical Care Trust Fund (Federal)	$144,743,889	$144,743,889
GRAND TOTAL	$256,336,079	

$256,336,079

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

See above.

2. Expenditures:

See above.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Some providers wishing to enter or continue Medicaid provider agreements can expect to face higher surety bond requirements. This should be viewed as a cost of doing business.

Hospital providers will be compensated more for services rendered to Medicaid recipients, providing a measure of fiscal relief to the hospitals. According to AHCA, hospitals will receive approximately 254.3 million in compensation from Medicaid as a result of the increase in the annual cap on hospital outpatient reimbursements and outpatient rate ceiling increases for certain hospitals.

These funds will also bolster graduate medical education funding programs in the state.

As a result of this infusion of funds, adult Medicaid recipients should have greater access to hospital services.

The Medicaid waiver for ventilator-dependent adults should provide greater access to more appropriate care for such individuals, and reduce the fiscal burden on facilities.

D. FISCAL COMMENTS:

N/A

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

This bill does not require counties or municipalities to spend funds or to take action requiring the expenditure of funds.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

The bill does not reduce the authority that counties or municipalities have to raise revenues in the aggregate.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

This bill does not reduce the percentage of a state tax shared with counties or municipalities.

V. COMMENTS:

A. CONSTITUTIONAL ISSUES:

N/A

B. RULE-MAKING AUTHORITY:

The bill does not provide new rulemaking authority. It merely corrects an inadvertent error in drafting of a 1999 reviser's bill, restoring to the Department of Children and Family Services specific rulemaking authority for Medicaid eligibility determinations.

C. OTHER COMMENTS:

N/A

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

When the Committee on Health Care Services heard PCB HCS 00-06 on March 30, 2000, several amendments were adopted which: provided, in statute, for the ongoing adjustment in Optional State Supplementation based on the federal benefits rate, rather than re-authorizing such adjustments in each year's General Appropriations Act; deleted from the bill any change to current law relating to surety bond amounts under Medicaid; and deleted from existing statutes an obsolete and potentially confusing provision relating to Medicaid's ability to contract with prepaid plan providers that are not in full compliance with Department of Insurance standards for health maintenance organizations.

On April 26, 2000, the Committee on Health and Human Services Appropriations adopted three amendments which: stated that the Long-Term Care Reimbursement Plan in Medicaid may not grant interim rate increases in the cost of general or professional liability insurance; authorized AHCA to require a surety bond for specified amounts for certain Medicaid providers; and authorized AHCA to extend or renew the contract with the Medicaid fiscal agent at the agency's discretion.

When the bill was heard by the full House of Representatives on second reading on April 28, 2000, the House concurred with amendments traveling with the bill, and a series of other amendments were adopted. These amendments: clarified the circumstances under which nursing home liability insurance can be included in nursing home interim rate adjustments, and required an AHCA study of nursing home liability costs; added language authorizing "other qualified providers," as defined, as participating providers in community diversion pilot projects; and incorporated the substance of HB 2047, relating to access to the Attorney General's Medicaid Fraud Control Unit.

When the bill was heard by the full House of Representatives on third reading on May 2, 2000, the House adopted a series of amendments which: incorporated several technical revisions proposed by the Rules Committee; designated February 6th of each year as Florida Alzheimer's Disease Day; incorporated a modified version of HB 1905, relating to graduate medical education funding; and modified the language relating to "other qualified providers" as participants in community diversion pilot projects. Further action on the bill was temporarily postponed.

On May 3, 2000, the House again considered the bill. Amendments were adopted which: further modified the language relating to “other qualified providers” as participants in community diversion pilot projects; further modified language relating to Medicaid interim reimbursement rate adjustments for the costs of nursing home liability insurance; and provided legislative findings, intent, and clarification regarding physician provider reimbursement for dually-eligible patients. The bill as amended was unanimously passed.

On May 4, 2000, the Senate substituted HB 2329 for CS/CS/SB 2242, and unanimously passed the bill.

VII. SIGNATURES:

COMMITTEE ON HEALTH CARE SERVICES:

Prepared by:	Staff Director:
Phil E. Williams	Phil E. Williams

AS REVISED BY THE COMMITTEE ON HEALTH AND HUMAN SERVICES APPROPRIATIONS:

Prepared by:	Staff Director:
Lynn Dixon	Lynn Dixon

FINAL ANALYSIS PREPARED BY THE COMMITTEE ON HEALTH CARE SERVICES:

Prepared by:	Staff Director:
Phil E. Williams	Phil E. Williams