**STORAGE NAME:** h1975.frc.doc
**DATE:** February 26, 2002

**HOUSE OF REPRESENTATIVES**

**FISCAL RESPONSIBILITY COUNCIL ANALYSIS**

**BILL #:** HB 1975 (PCB FRC 02-18)

**RELATING TO:** Health Care

**SPONSOR(S):** Fiscal Responsibility Council and Representative Murman

**TIED BILL(S):**

**ORIGINATING COMMITTEE(S)/COUNCIL(S)/COMMITTEE(S) OF REFERENCE:**

(1) FISCAL RESPONSIBILITY COUNCIL YEAS 14 NAYS 8
(2)
(3)
(4)
(5)

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I. SUMMARY:

THIS DOCUMENT IS NOT INTENDED TO BE USED FOR THE PURPOSE OF CONSTRUING STATUTES, OR TO BE CONSTRUED AS AFFECTING, DEFINING, LIMITING, CONTROLLING, SPECIFYING, CLARIFYING, OR MODIFYING ANY LEGISLATION OR STATUTE.

This bill makes a number of changes pertaining to the Medicaid program. These statutory changes implement Medicaid program funding decisions included in the House Appropriations Bill. Specifically, the bill:

- Provides various changes to improve the Agency for Health Care Administration's Medicaid fraud and abuse program;
- Restores eligibility for MEDS-AD at 90% of the federal poverty level;
- Revises a limitation of the county contribution to Medicaid nursing home costs;
- Revises duties of the Florida Healthy Kids Corporation with respect to annual determination of local participation in the Healthy Kids Program;
- Revises eligibility standards for the pharmaceutical expense assistance program to enable participation in a proposed federal expansion;
- Updates the applicability of the financial assistance program for rural hospitals;
- Provides requirements for contracts for Medicaid behavioral health care services;
- Revises enrollment goal of managed care diversion of Medicaid recipients;
- Revises definition of the term "intermediate care facility for the developmentally disabled"; and
- Provides for penalties for violation of laws governing intermediate care facilities for developmentally disabled.

This bill requires a 2/3 vote of each house of the Legislature in order to bind counties, pursuant to Article VII, 18(a) of the Florida Constitution. See section IV of this analysis.

This bill implements budget reductions of $1.5 million in General Revenue, and the projected revenue impact is $36.7 million in the General Revenue Fund.

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 Medicaid fraud and abuse sections give the state government greater access to investigate Medicaid provider activities.

B. PRESENT SITUATION:

**Medicaid Fraud and Abuse**

Medicaid is a medical assistance program that pays for health care for the poor and disabled. The federal, state, and local governments jointly fund the program. The Agency for Health Care Administration (AHCA) is the single state agency responsible for the Florida Medicaid Program. The statutory provisions for the Medicaid program appear in ss. 409.901 through 409.9205, F.S.

The Florida Medicaid program spends nearly $10 billion annually providing health care. The proportion of annual health care expenditures lost to fraud and abuse remains unknown because these losses are not systematically measured. However, conventional wisdom estimates that losses to fraud and abuse may exceed 10 percent of annual Medicaid spending.

Section 409.907, F.S., establishes requirements for 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. Section 409.908, F.S., specifies conditions under which Medicaid providers may be reimbursed.

Section 409.913, F.S., prescribes the activities of the agency related to oversight of the integrity of the Medicaid program. The Medicaid Program Integrity staff investigates Medicaid fraud and abuse. The section requires that any suspected criminal violation identified by the agency be referred to the Medicaid Fraud Control Unit of the Office of the Attorney General, and that the agency and the MFCU develop a memorandum of understanding which includes protocols for referral of cases of suspected criminal fraud and return of these cases where investigation determines that administrative action by the agency is appropriate.

Section 409.920, F.S., requires the Attorney General to conduct a statewide program of Medicaid fraud control.

Section 16.59, F.S., creates the Medicaid Fraud Control Unit (MFCU) within the Department of Legal Affairs. The MFCU is authorized to investigate all violations of s. 409.920, F.S., relating to Medicaid provider fraud, and any criminal violations discovered during the course of those investigations.

Sections 112.3187-112.31895, F.S., are the "Whistle-blower's Act." The legislative intent for the act is to prevent agencies or independent contractors from taking retaliatory action against an employee who reports to an appropriate agency violations of law on the part of a public employer or independent contractor or who discloses information to an appropriate agency alleging improper use of governmental office, gross waste of funds, or any other abuse or gross neglect of duty on the part of an agency, public officer, or employee.

The Office of Program Policy and Government Accountability (OPPAGA) released a justification review of Medicaid program integrity efforts in September of 2001. The report found a number of problems:

- Recoveries are low and probably represent a small portion of dollars lost to fraud and abuse;
- Detection methodologies are imprecise and result in too many false positives;
- Preliminary overpayment findings are subsequently reduced to final amounts;
- AHCA only rarely applies punitive sanctions available to it, such as fines or other discipline;
- Follow-up reviews are inconsistent, and there is no policy or requirement for the extent or depth of follow-up reviews;
- AHCA does not target providers with an identified history of overpayments for pre-payment review of claims;
- AHCA refers few cases to MFCU;
- Accountability is poor– there is no good measure of losses against which to judge effectiveness of MPI operations; and
- AHCA's data system did not permit an analysis of the extent to which providers are actually repaying the money they owe to the Medicaid program.

The AHCA Office of the Inspector General conducted an internal review of AHCA's process of recouping overpayments that indicated various coordination and communication problems:

- The AHCA accounts receivable system used for tracking the amount of funds a provider owes is unable to age accounts or generate collections letters;
- There is no systematic effort to collect receivables, and collection mechanisms allowed in statute are not applied;
- Tracking systems in Medicaid Program Integrity, the Office of the General Counsel and the Accounts Receivable section are not compatible, with the result that it is difficult to assess at what point a case is in the recovery process, whether or not a provider is complying, and what action should be taken; and
- There is a lack of coordination of recovery activities between Medicaid Program Integrity, Medicaid Program Development (responsible for Medicaid policy) and the Office of the General Counsel.

In January, 2001, AHCA contracted with TRAP Systems, Inc., to provide enhanced fraud and abuse detection technologies. A review was conducted of AHCA's Medicaid Program Integrity operations under that contract by Malcolm Sparrow, M.A., M.P.A., PhD, of Harvard University. After the review the following recommendations were made:

- The State of Florida should conduct formal measurement studies of Medicaid overpayments on a biennial basis.
- The State of Florida should adopt a proactive media and public relations posture with respect to fraud and abuse control.
- The State of Florida should authorize and fund an aggressive program of growth for the Medicaid Program Integrity function, to bring investments into line with the scale of the fraud and abuse problem.
- AHCA should establish a cross-functional "Fraud and Abuse Control Committee," under the chairmanship of the Inspector General (or his designee), to provide a forum for the development and implementation of coordinated responses to major non-compliance issues.

- The systems AHCA uses to recover overpayments, and their performance in this regard, should be systematically reviewed.
- Program Integrity should develop a system of performance tracking and reporting.

Federal law governing Medicaid provides that a state must commit to take all reasonable measures to ascertain the legal liability of third parties (including health insurers, group health plans, service benefit plans, and health maintenance organizations) to pay for care and services available under the program. Further, a state must commit to seek reimbursement in situations where a legal liability is found to exist after medical assistance has been made available and where the likely recovery will exceed the costs of securing such recovery. Section 409.910, F.S., is the "Medicaid Third-Party Liability Act," under which the agency is directed to recover the costs of goods and services delivered to a Medicaid recipient when another third party may be responsible for such costs.

Currently, the agency is mandated according to Section 409.910, F.S., to recover the full amount of all medical assistance to the extent of third-party benefits provided by Medicaid on behalf of a recipient. The agency is allocated 43.57% of each dollar collected and the federal government is allocated 56.43%. Effective October 1, 2002, the funding split is 58.83% federal and 41.17% state. The retained state share of the third party benefits is used to provide the state matching funds for the third party liability contracts, staff, and other administrative costs necessary to perform the third party liability functions.

**Florida Healthy Kids Corporation**

The Legislature established the Florida Healthy Kids Corporation (Corporation) in 1990 as a public-private initiative to improve access to comprehensive health insurance for the state's uninsured children. The Corporation helps thousands of uninsured children gain access to affordable, quality health care. Healthy Kids acts as a quasi-single payer financing mechanism by aggregating local, state, federal and family funds to pay premiums to commercial health plans who assume the insurance risk. This program is unique because it is designed to provide affordable access to health insurance coverage for working families for whom the payment of the full premium would be out of reach.

The Corporation has operating sites in all sixty-seven counties. As of February 1, 2002, over 231,000 children were covered through Healthy Kids and they continue to enjoy a benefit structure with broad coverage - immunizations to transplants.

Healthy Kids Corporation is one of the partners of the Title XXI Florida KidCare program. The local match requirement for the Florida Healthy Kids program is found at s. 624.91(4)(b)15, F.S. Currently, counties participating in the Healthy Kids program are allotted 500 free base slots. Counties that want to enroll more children must provide local matching funds. County contribution levels vary. Counties that were participating prior to April 1998, contribute at a 20% match rate. Counties that joined the program after April 1998 were to begin at 5% in the first year, 10% in the second year, 15% in the third year and 20% in the fourth year. Coalitions of counties were permitted in order to allow for contracting with multiple providers and/or to enhance local match opportunities. The match ratio for the coalitions was set at 4% in the first year and increased by 4% for each of the subsequent four years with a cap of 20% by the fifth year.

The General Appropriations Act for FY 2000-01 provided that counties maintain their local match commitments for that year. In FY 2000-2001, 31 of Florida's 67 counties contributed local matching funds. The General Appropriations Act for FY 2001-2002 contained proviso language stating no local matching funds were required for the KidCare program. However, Florida Healthy Kids was required to develop and implement a local match policy for the purpose of continuing and expanding coverage to

uninsured children who do not meet the eligibility requirements of Title XXI. The Corporation was instructed to replace local match funds from FY 2000-2001 funding. In the 2001 legislative session, legislators eliminated local match by inserting proviso language in the Appropriations Act. Because this language was not available for veto, the Governor challenged the language as unconstitutional. In special session in the fall of 2001, legislators voted to statutorily eliminate local matching funds for FY 2001-2002.

**Disproportionate share/financial assistance program for rural hospitals**

The Agency for Health Care Administration manages a financial assistance program for statutory rural hospitals. Section 409.9116, F.S., dictates that the Agency for Health Care Administration shall make disproportionate share payments to statutory rural hospitals that qualify for such payments and financial assistance payments to statutory rural hospitals that do not qualify for disproportionate share payments. This law applies only to hospitals that were defined as statutory rural hospitals, or their successor-in-interest hospital, prior to July 1, 1998. Hospitals defined as statutory rural hospitals on or after July 1, 1998 must seek assistance through specific appropriation each year.

**HMO Diversion**

The current law provides that Medicaid recipients who are already enrolled in a managed care plan or MediPass shall be offered the opportunity to change managed care plans or MediPass providers on a staggered basis, as defined by AHCA.

Section 409.9122, F.S., governs Medicaid enrollment procedures. Recipients are allowed to choose between a managed care plan and a MediPass provider at the time of enrollment, with certain exceptions. Recipients have 90 days in which to make a choice of managed care plans or MediPass providers.

MediPass is a case management program in which physician case managers receive a monthly fee for overseeing and referring their enrollees for appropriate care. Each physician is paid a monthly $3 fee for each recipient.

Paragraph (f) of s. 409.9122, F.S, allows for the diversion of recipients who fail to choose a managed care plan or MediPass provider to managed care plans or provider service networks until an equal enrollment of 50 percent in MediPass and provider service networks and 50 percent in managed care plans is achieved.

**Medicaid Aged and Disabled (MEDS-AD) Program**

Certain aged and disabled persons who have income and assets over the current standards for the Supplemental Security Income (SSI) program, but who have income at or below 90 percent of the federal poverty level and assets no greater than $5,000 for an individual and $6,000 for a couple, are currently eligible for Medicaid coverage at the option of the state.

During a special legislative session called to adjust the FY 2001-02 budget because of a projected shortfall in revenues, the Legislature passed HB 29 C (chapter 2001-377, Laws of Florida) that included changes to the Medicaid program. The income standard for Medicaid coverage for elderly and disabled persons was reduced from 90% to 88% of poverty. The Supplemental Appropriations Act for FY 2001-02 provides non-recurring funds to maintain this program at current funding levels from January 1 through June 30, 2002.

Medicaid is required to provide Medicare “buy-in” coverage for aged and disabled individuals who are Medicare beneficiaries. Therefore, if the Medicaid coverage is eliminated for persons eligible under the

criteria for the MEDS-AD program, those who are eligible for Medicare will continue to have Medicaid coverage for Medicare premiums, deductibles and coinsurance.

**Pharmaceutical Expense Assistance Program**

Created by the 2000 Legislature, the Prescriptions Affordability Act for Seniors provides a catastrophic pharmaceutical expense assistance program for certain individuals.

Eligibility for the program is limited to Florida residents age 65 and over that have an income between 90 and 120 percent of the federal poverty level who qualify for limited assistance under the Medicaid program as a result of being dually eligible for Medicaid and Medicare but whose limited benefit does not provide prescription drug coverage.

**County contributions to Medicaid**

Currently, s. 409.915, F.S., requires that counties contribute 35 percent of the total Medicaid costs for days 11 through 45 of an inpatient hospitalization for a Medicaid recipient for both HMO members and fee-for-service beneficiaries.

Section 409.915, F.S., also requires counties to contribute to the state share of the Medicaid cost of providing nursing home or intermediate facilities care. Counties must pay 35 percent of the total cost for Medicaid payments for nursing home or intermediate care facilities care in excess of $170 per month, except that the cost of skilled nursing care for children under age 21 is excluded from county participation. County financial participation for nursing home or intermediate care is further limited to no more than $55 per month per person.

The county participation for nursing home or intermediate facilities payments has not been increased since the Medicaid program was implemented in Florida in 1970. Prior to the implementation of the Medicaid program, counties were paying for nursing home care for many of their low-income residents. The implementation of Medicaid gave Florida the opportunity to draw down federal dollars using the counties' contributions as a portion of the state match.

The required county financial participation in the Medicaid cost of providing nursing home and intermediate facilities care has not kept pace with the total increases experienced by the Medicaid program for these services. The average Medicaid monthly cost per person for nursing facilities has increased substantially each year while the $55 limit per person per month for the county contribution has remained constant. The county billing limit as a percent of the average Medicaid cost per person per month went from over 10 percent in FY 1978-79 to under 2 percent by FY 2001-02.

Revenues collected from counties under the provisions for s. 409.915, F.S., are deposited into the General Revenue Fund unallocated. In FY 2000-01 counties were billed a total of $131,660,376 for their contributions under 409.915, F.S. Cash collected from the counties for the 12 months ending June 30, 2001, totaled $127,431,803.

C. EFFECT OF PROPOSED CHANGES:

See SECTION-BY-SECTION ANALYSIS.

D. SECTION-BY-SECTION ANALYSIS:

**Section 1.** Amends s. 16.59, F.S., to require the collocation of the Offices of the Medicaid Fraud Control Unit and the offices of the AHCA Medicaid Program Integrity program. The Department of

Legal Affairs and AHCA must conduct joint activities to increase communication and coordination between the programs.

**Section 2.** Subsections (3), (5), and (7) of s. 112.3187, F.S., are amended. They relate to whistleblower retaliation. The change to subsection (3) adds "provider agreement" to the definition of "independent contractor." The change to subsection (5) adds disclosed suspicion or actual Medicaid fraud or abuse to the information that is protected under the Whistle-blower's Act. Subsection (7) lists various ways people may disclose information and still be protected. The change to subsection (7) adds the hotline of the Medicaid Fraud Control Unit of the Department of Legal Affairs to the list of ways people may disclose information and still be protected.

**Section 3.** Section 408.831, F.S., is created to give AHCA direction in performing its administrative duties. AHCA is directed when an application should be denied. AHCA is further directed when to suspend or revoke a license, registration, or certificate. AHCA retains the discretionary authority to take action or not.

**Section 4.** Section 409.8132, F.S., is reenacted to incorporate the amendments made by this act to ss. 409.902, 409.907, 409.908, and 409.913, F.S.

**Section 5.** Section 409.902, F.S., is amended to require that AHCA and the Department of Children and Family Services ensure that each recipient of Medicaid, as a condition of Medicaid eligibility, consents to release of his or her medical records to AHCA and the Medicaid Fraud Control unit of the Department of Legal Affairs. This consent is necessary to enable the review of a Medicaid provider's records. The review is necessary to search for Medicaid fraud and abuse by the Medicaid providers.

**Section 6.** Amends subsection (1) of s. 409.904, F.S., as amended by section 2 of chapter 2001-377, Laws of Florida. The change will retain the eligibility standard to participate in the MEDS-AD program at 90% of the federal poverty level, rather than being reduced to 88% on July 1, 2002.

**Section 7.** Amends s 409.904, F.S., relating to optional payments for Medicaid eligible persons to:

- Provide Medicaid coverage for an unborn child in a family with income above 150% but not more than 200% of the federal poverty level;
- Provide that coverage for an unborn child is dependent upon federal approval of coverage through Title XXI of the Social Security Act.
- Provide Medicaid optional coverage for a pregnant woman who has income above 150% but not more than 185% of the federal poverty level.
- Provide that countable income for the unborn child or for a child under one in a family with income above 150% but not more that 200% of the federal poverty and for a pregnant woman with income above 150% but not more than 185% of the federal poverty level is determined in accordance with state and federal regulations;
- Provide that a pregnant woman who applies for eligibility must be offered the opportunity to be made presumptively eligible subject to federal regulations;
- Provide that coverage for a pregnant woman during her pregnancy shall not be available should coverage become available under Title XXI of the Social Security Act as provided for in subsection (8); and
- Amends provisions relating to eligibility for women for cancer treatment pursuant to the federal Breast and Cervical Cancer and Prevention and Treatment Act of 2000 who are screened through the Mary Brogan Breast and Cervical Cancer Early Detection Program established under s. 381.93, F.S.

**Section 8.** Amends s. 409.9065, F.S., relating to the Pharmaceutical Expense Assistance Program. Provides the statutory framework to raise the maximum income level for eligibility from 120 percent of

the federal poverty level to 150 percent of the federal poverty level. This is contingent on the federal government raising the Medicaid matching rate accordingly.

**Section 9.** Amends subsections (7) and (9) of s. 409.907, F.S., to require that AHCA perform random onsite inspection of a new provider applicant's service location after the receipt of the application to assist in determining the applicant's ability to provide the services the applicant is proposing to provide for Medicaid reimbursement. AHCA is not required to perform an onsite inspection of a provider or program that it has licensed. The bill allows AHCA to consider the applicant's demonstrated ability to provide services, conduct business, and operate a financially viable concern as a factor (in addition to other factors currently in statute) when determining whether or not to enroll a provider. The effective date of an approved application is the date the agency receives the provider application if the providers are out of state, were recently granted a change of ownership, or primarily provide emergency medical services transportation or emergency services.

The agency is required to deny a provider application when it determines that the applicant has failed to pay all outstanding fines or overpayments assessed by final order of the agency or the Centers for Medicare and Medicaid Services, unless the provider agrees to a repayment plan that includes withholding Medicaid reimbursement until the amount is paid in full. This restriction also applies in the instance of a corporation, partnership, or other business entity if any officer, director, agent, managing employee, or affiliated person, partner or shareholder having an ownership interest of 5 percent or greater has failed to pay these fines or liens.

**Section 10.** States the Legislature's determination that this act fulfills an important state interest.

**Section 11.** Amends s. 409.908, F.S., to provide that if a Medicaid provider is reimbursed on cost reporting and fails to submit cost reports at the time specified by AHCA, then AHCA may withhold reimbursement until an acceptable cost report is submitted.

**Section 12.** Amends paragraph (b) of subsection (7) of s. 409.410, F.S., to include a requirement for a pro-rata distribution (or an offset in the instance in which a county has been billed but has not paid the amount due) of Medicaid third-party liability recoveries and collections, and recoveries of overpayments to counties which are liable for making payments for medical care. In the instance of a county with a special taxing district or authority, the county must proportionately divide any refund or offset in accordance with the pro-ration that has been established.

**Section 13**. Amends subsection (7) of s. 409.9116, F.S., to change the date used to qualify a hospital for participation in the disproportionate share/financial assistance program for rural hospitals unless additional funds are appropriated specifically to prevent any hospital eligible for the program from incurring a reduction in payments because of the eligibility of an additional hospital to participate. Eligibility is provided only to hospitals that were defined as statutory teaching hospitals, or their successor-in-interest hospital, prior to July 1, 1999, unless sufficient additional funds are appropriated. The date is currently July 1, 1998.

**Section 14**. Amends s. 409.912, F.S., to provide that all contracts issued pursuant paragraph (b) of subsection (3) to an entity providing comprehensive behavioral health care services through a capitated, prepaid arrangement must require that 80% of the capitation paid to the managed care plan, including health maintenance organizations, be spent for the provision of behavioral health care services. If the managed care plan spends less than 80% for behavioral health services the difference must be returned to the agency. Requires the agency to provide the managed care plan with a certification letter indicating the amount of capitation paid during each calendar year for the provision of behavioral health care services.

Requires the agency to contract by September 30, 2002, with an entity in the state to implement a wireless handheld clinical pharmacology drug information database for high-prescribing practitioners, as determined by the agency. The initiative must be designed to enhance the agency's efforts to reduce fraud, abuse, and errors in the prescription drug benefit program.

**Section 15.** Amends paragraph (f) of subsection (2) of section 409.9122, F.S., as amended by section 11 of chapter of chapter 2001-377, Laws of Florida, to allow for the diversion of Medicaid enrollees into managed care organizations over MediPass until a 55/45 split is achieved.

Provides that when a recipient does not make a choice within 90 days, he will be assigned to a managed care plan in his geographic area that has service network capacity. The definition of "managed care plan" has been revised to include several of the expanded MediPass options, such as provider service networks, pediatric emergency room diversion projects, and exclusive provider organizations. This section also allows SSI recipients to be enrolled in managed care plans.

**Section 16.** Amends s. 409.913, F.S. as amended by section 12 of chapter 2001-377, Laws of Florida, to:

- require AHCA and the Medicaid Fraud Control Unit of the Department of Legal Affairs to annually submit a joint report on the effectiveness of the state's efforts to control Medicaid fraud and abuse and to recover Medicaid overpayments. The report must include specified information;
- define the term "complaint" as used in this section to mean an allegation that fraud, abuse or an overpayment has occurred;
- require that the offices of the Medicaid Fraud Control Unit and AHCA's Medicaid Program Integrity program be collocated to the extent possible, and that AHCA and the Department of Legal Affairs conduct joint training and other activities designed to increase communication and coordination in recovering overpayments;
- allow AHCA to impose penalties on a Medicaid provider who has failed to comply with an agreed-upon repayment schedule;
- require, rather than permit, AHCA to impose a variety of sanctions or disincentives, and adds to the list of sanctions: prepayment reviews of claims for a specified period of time, comprehensive follow-up reviews every 6 months, and corrective action plans of up to 3 years duration which would be monitored every 6 months; with a provision that the Secretary of Health Care Administration may make a determination that imposition of a sanction or disincentive is not in the best interests of Medicaid, in which case a sanction or disincentive is not to be imposed;
- allow AHCA to terminate a provider who does not enter into an agreed-upon repayment schedule;
- allow AHCA and Medicaid Fraud Control Unit to review a provider's Medicaid-related records in order to reconcile quantities of goods or services billed to Medicaid against quantities of goods and services used in the provider's total practice;
- allow the agency to terminate a provider's participation in Medicaid for failure to reimburse an overpayment which has been determined by final order within 35 days unless the provider and the agency have entered into a repayment agreement, and requiring reinstatement if the final order is overturned on appeal;
- require that administrative hearings pursuant to chapter 120 be conducted within 90 days following assignment of an administrative law judge and specifying that upon issuance of a final order the balance outstanding becomes due;
- allow the agency to withhold medical assistance payments to a provider until the amount due is repaid in full if a provider fails to make payments in full, or comply with the terms of a repayment plan or settlement agreement;
- delete a provision which restricted withholding of provider payments to no more than 10 percent of a provider's monthly payments from the agency;

- allow agents and employees of the agency and Medicaid Fraud Control Unit to inspect the records of a pharmacy, wholesale establishment, manufacturer, or other place in the state where drugs and medical supplies are manufactured, packed, stored, sold, or kept for sale, for the purpose of verifying the amount of drugs and medical supplies ordered, delivered or purchased by a provider;

**Section 17.** Amends s. 409.915, F.S., relating to county contributions to Medicaid. Increases the current cap on county contributions for nursing home or intermediate facilities care to $140 per month per person, which equates to approximately 4% of the average cost of care.

**Section 18.** Subsections (7) and (8) of 409.920, F.S., are amended. Allows the Attorney General the discretion to refer to AHCA each instance of provider overpayment for collection. Current law mandates the referral.

Requires the Attorney General to publicize to state employees and the public the ability of persons to bring suit under the provisions of the Florida False Claims Act and the potential for the persons bringing a civil action under the Florida False Claims Act to obtain a monetary award.

Allows the Attorney General to seek any civil remedy provided by law to control Medicaid fraud.

**Section 19.** Amends paragraph (b) of subsection (4) of section 624.91, F.S., as amended by section 20 of chapter 2001-377, Laws of Florida, to allow the Florida Healthy Kids Corporation (FHKC) to annually determine the local match requirements for each county under the formulas and procedure provided in s. 624.915, F.S. Deletes provision effective for FY 2001-2002 only that established a local match requirement of $0.00 for the Title XXI program.

**Section 20.** Creates s. 624.915, F.S., that spells out the formulas and procedures for determining the local match requirements for the Florida Healthy Kids program.

This bill proposes that FHKC annually determine the local match requirements and level of participation for each county using procedures in the newly created s. 624.915, F.S. FHKC would determine the local match requirement for each county by May 1$^{st}$ of each year and provide the counties with written notice of the amount of local match due for the following fiscal year. FHKC would also establish a nonmatch enrollment allocation per county, with each county being assigned to one of three tiers based on the county's population of children, based on the most recent federal census data. Enrollment slots would be allocated to each tier, with no county receiving less than 500 slots, and unused slots could be redistributed to accommodate increased enrollment in other counties. FHKC will calculate the local match requirement for each county with each county being assigned to one of three tiers based on the county's economic census data. The local match percentage rate for the lowest tier must be greater than zero, but no greater than 5 percent, and no greater than 15 percent for the highest tier. The FHKC board of directors will determine the timing and method of payment of local match, and least 90% of the each county's local match requirement must be eligible to match federal Title XXI funds. Local matching funds must be in the form of cash.

The bill allows for the counties to dispute their assignments through a grievance procedure.

**Section 21.** Amends subsection (28) of s. 393.063, F.S., to change the definition of an "intermediate care facility for the developmentally disabled." Provides that a facility no longer has to be state-owned and operated to meet the definition of an intermediate care facility for the developmentally disabled. Changes the definition to require that the facility be state certified to meet the definition.

**Section 22.** Amends s. 400.965, F.S., relating to action by the agency against a licensee if the agency has a reasonable belief that conditions specified in s. 409.965(1), F.S., exist, to provide that the agency must take administrative action as provided in s. 400.968, F.S., or s. 400.969, F.S., or injunctive action as authorized by s. 400.963, F.S.

**Section 23.** Renumbers subsection (4) of section 400.968, F.S., as section 400.969, F.S. and amends the section to provide penalties for violation of part XI of chapter 400, F.S., relating to intermediate care facilities for developmentally disabled persons.

**Section 24.** Requires AHCA to make recommendations to the Legislature as to limits in the amount of home office management and administrative fees which should be allowable for reimbursement for Medicaid providers whose rates are set on a cost-reimbursement basis.

**Section 25.** Provides that this act shall take effect upon becoming a law except as otherwise provided.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

| | **FY 2002-03** | **FY 2003-04** |
|---|---|---|
| County Billings for Nursing Home Care | | |
| General Revenue | $36,664,155 | $48,885,540 |

2. Expenditures:

| | **FY 2002-03** | **FY 2003-04** |
|---|---|---|
| Restore MEDS AD to 90% of FPL | | |
| General Revenue | $14,851,464 | $14,851,454 |
| Administrative Trust Fund | $ 176,199 | $ 176,199 |
| Grants and Donations Trust Fund | $ 5,547,180 | $ 5,547,180 |
| Medical Care Trust Fund | $20,972,237 | $20,972,237 |
| Total | $41,547,080 | $41,547,080 |
| Coverage to Pregnant Women to 200% of FPL | | |
| General Revenue | $ 172,527 | $ 172,527 |
| Medical Care Trust Fund | $40,981,987 | $40,981,987 |
| Total | $41,154,514 | $41,154,514 |
| Mandatory Assignment to 55% HMO/45% MP | | |
| General Revenue | ($ 1,462,378) | ($ 1,462,378) |
| Grants and Donations Trust Fund | ($ 258,711) | ($ 258,711) |
| Medical Care Trust Fund | ($ 1,827,960) | ($ 1,827,960) |
| Total | ($ 3,552,049) | ($ 3,552,049) |

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

2. Expenditures:

The increased county contribution for nursing homes is projected to cost the counties $36.7 million in FY 2002-03 and $48.9 million in FY 2003-04.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The Medicaid fraud and abuse provisions give AHCA and the Attorney General additional powers and remedies to recover Medicaid overpayments, potentially resulting in additional penalties to providers who improperly bill Medicaid.

The continued coverage for the elderly and disabled with incomes between 88% to 90% of poverty, and the additional coverages for pregnant women and pharmacy will benefit health care providers who may have had increased uncompensated care and will provide access to health care for these persons.

D. FISCAL COMMENTS:

The Medicaid fraud and abuse provisions may result in additional recoveries of Medicaid funds for the state in the instance of providers who have been overpaid by the Medicaid program. Historically, the return on investment in Medicaid recovery activities has ranged from approximately $2.50 to $4.90 for each dollar spent.

Funding issues associated with General Revenue receipts from the increased county contributions for nursing home care are identified in the House Appropriations Bill. Proviso language provides that $22,000,000 for the Pharmacy Assistance Program for Seniors and $14,851,464 for restoration of the income standard for the Elderly and Disabled (MEDS A/D) Program from 88 to 90 percent of the federal poverty level, are contingent on legislation becoming law to increase the county contribution for nursing home care to $140 per person per month, effective October 1, 2002.

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

A. APPLICABILITY OF THE MANDATES PROVISION:

This bill will require counties to spend approximately $36.7 million in FY 2002-2003. Section 16 amends s. 409.915, F.S., increasing the current cap on county contributions for nursing home or intermediate facilities care to $140 per month per person. Consequently, the Legislature must determine that the bill fulfills an important state interest and pass the bill by a 2/3 vote of each house in order to bind the counties.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

This bill does not reduce the revenue raising authority of counties or municipalities.

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

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

V. COMMENTS:

A. CONSTITUTIONAL ISSUES:

None.

B. RULE-MAKING AUTHORITY:

None.

C. OTHER COMMENTS:

None.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

On February 22, 2002, the Fiscal Responsibility Council adopted, without objection, an amendment offered by Representative Murman.

SIGNATURES:

COMMITTEE ON HEALTH & HUMAN SERVICES APPROPRIATIONS:

| Prepared by: | Staff Director: |
| --- | --- |
| Bill Speir | David Coburn |