Bill No. HB 59-E, 1st Eng.

Amendment No. ___ Barcode 713184

CHAMBER ACTION

Senate		House
	.	

Senator Silver moved the following amendment:

Senate Amendment (with title amendment)

Delete everything after the enacting clause

and insert:

Section 1. Section 16.59, Florida Statutes, is amended to read:

16.59 Medicaid fraud control.--There is created in the Department of Legal Affairs the Medicaid Fraud Control Unit, which may investigate all violations of s. 409.920 and any criminal violations discovered during the course of those investigations. The Medicaid Fraud Control Unit may refer any criminal violation so uncovered to the appropriate prosecuting authority. Offices of the Medicaid Fraud Control Unit and the offices of the Agency for Health Care Administration Medicaid program integrity program shall, to the extent possible, be collocated. The agency and the Department of Legal Affairs shall conduct joint training and other joint activities designed to increase communication and coordination in recovering overpayments.

1 Section 2. Subsections (3), (5), and (7) of section
2 112.3187, Florida Statutes, are amended to read:
3 112.3187 Adverse action against employee for
4 disclosing information of specified nature prohibited;
5 employee remedy and relief.--
6 (3) DEFINITIONS.--As used in this act, unless
7 otherwise specified, the following words or terms shall have
8 the meanings indicated:
9 (a) "Agency" means any state, regional, county, local,
10 or municipal government entity, whether executive, judicial,
11 or legislative; any official, officer, department, division,
12 bureau, commission, authority, or political subdivision
13 therein; or any public school, community college, or state
14 university.
15 (b) "Employee" means a person who performs services
16 for, and under the control and direction of, or contracts
17 with, an agency or independent contractor for wages or other
18 remuneration.
19 (c) "Adverse personnel action" means the discharge,
20 suspension, transfer, or demotion of any employee or the
21 withholding of bonuses, the reduction in salary or benefits,
22 or any other adverse action taken against an employee within
23 the terms and conditions of employment by an agency or
24 independent contractor.
25 (d) "Independent contractor" means a person, other
26 than an agency, engaged in any business and who enters into a
27 contract or provider agreement with an agency.
28 (e) "Gross mismanagement" means a continuous pattern
29 of managerial abuses, wrongful or arbitrary and capricious
30 actions, or fraudulent or criminal conduct which may have a
31 substantial adverse economic impact.

1 (5) NATURE OF INFORMATION DISCLOSED.--The information
2 disclosed under this section must include:
3 (a) Any violation or suspected violation of any
4 federal, state, or local law, rule, or regulation committed by
5 an employee or agent of an agency or independent contractor
6 which creates and presents a substantial and specific danger
7 to the public's health, safety, or welfare.
8 (b) Any act or suspected act of gross mismanagement,
9 malfeasance, misfeasance, gross waste of public funds,
10 suspected or actual Medicaid fraud or abuse,or gross neglect
11 of duty committed by an employee or agent of an agency or
12 independent contractor.
13 (7) EMPLOYEES AND PERSONS PROTECTED.--This section
14 protects employees and persons who disclose information on
15 their own initiative in a written and signed complaint; who
16 are requested to participate in an investigation, hearing, or
17 other inquiry conducted by any agency or federal government
18 entity; who refuse to participate in any adverse action
19 prohibited by this section; or who initiate a complaint
20 through the whistle-blower's hotline or the hotline of the
21 Medicaid Fraud Control Unit of the Department of Legal
22 Affairs;or employees who file any written complaint to their
23 supervisory officials or employees who submit a complaint to
24 the Chief Inspector General in the Executive Office of the
25 Governor, to the employee designated as agency inspector
26 general under s. 112.3189(1), or to the Florida Commission on
27 Human Relations. The provisions of this section may not be
28 used by a person while he or she is under the care, custody,
29 or control of the state correctional system or, after release
30 from the care, custody, or control of the state correctional
31 system, with respect to circumstances that occurred during any

1 period of incarceration. No remedy or other protection under
2 ss. 112.3187-112.31895 applies to any person who has committed
3 or intentionally participated in committing the violation or
4 suspected violation for which protection under ss.
5 112.3187-112.31895 is being sought.
6 Section 3. Paragraph (d) of subsection (5) of section
7 400.179, Florida Statutes, is amended to read:
8 400.179 Sale or transfer of ownership of a nursing
9 facility; liability for Medicaid underpayments and
10 overpayments.--
11 (5) Because any transfer of a nursing facility may
12 expose the fact that Medicaid may have underpaid or overpaid
13 the transferor, and because in most instances, any such
14 underpayment or overpayment can only be determined following a
15 formal field audit, the liabilities for any such underpayments
16 or overpayments shall be as follows:
17 (d) Where the transfer involves a facility that has
18 been leased by the transferor:
19 1. The transferee shall, as a condition to being
20 issued a license by the agency, acquire, maintain, and provide
21 proof to the agency of a bond with a term of 30 months,
22 renewable annually, in an amount not less than the total of 3
23 months Medicaid payments to the facility computed on the basis
24 of the preceding 12-month average Medicaid payments to the
25 facility.
26 2. The leasehold operator may meet the bond
27 requirement through other arrangements acceptable to the
28 department.
29 3. All existing nursing facility licensees, operating
30 the facility as a leasehold, shall acquire, maintain, and
31 provide proof to the agency of the 30-month bond required in

1 subparagraph 1., above, on and after July 1, 1993, for each
2 license renewal.
3 4. It shall be the responsibility of all nursing
4 facility operators, operating the facility as a leasehold, to
5 renew the 30-month bond and to provide proof of such renewal
6 to the agency annually at the time of application for license
7 renewal.
8 5. Any failure of the nursing facility operator to
9 acquire, maintain, renew annually, or provide proof to the
10 agency shall be grounds for the agency to deny, cancel,
11 revoke, or suspend the facility license to operate such
12 facility and to take any further action, including, but not
13 limited to, enjoining the facility, asserting a moratorium, or
14 applying for a receiver, deemed necessary to ensure compliance
15 with this section and to safeguard and protect the health,
16 safety, and welfare of the facility's residents.
17 6. Notwithstanding other provisions of this section, a
18 lease agreement required as a condition of bond financing or
19 refinancing under s. 154.213 by a health facilities authority
20 or under s. 159.30 by a county or municipality is not
21 considered as a leasehold and therefore, is not subject to the
22 bond requirement of this paragraph.
23 Section 4. Section 408.831, Florida Statutes, is
24 created to read:
25 408.831 Denial, suspension, revocation of a license,
26 registration, certificate or application.--
27 (1) In addition to any other remedies provided by law,
28 the agency may deny each application or suspend or revoke each
29 license, registration, or certificate of entities regulated or
30 licensed by it:
31 (a) If the applicant, licensee, registrant, or

certificateholder, or, in the case of a corporation, partnership, or other business entity, if any officer, director, agent, or managing employee of that business entity or any affiliated person, partner, or shareholder having an ownership interest equal to 5 percent or greater in that business entity, has failed to pay all outstanding fines, liens, or overpayments assessed by final order of the agency or final order of the Centers for Medicare and Medicaid Services unless a repayment plan is approved by the agency; or

(b) For failure to comply with any repayment plan.

(2) For all legal proceedings that may result from a denial, suspension, or revocation under this section, testimony or documentation from the financial entity charged with monitoring such payment shall constitute evidence of the failure to pay an outstanding fine, lien, or overpayment and shall be sufficient grounds for the denial, suspension, or revocation.

(3) This section provides standards of enforcement applicable to all entities licensed or regulated by the Agency for Health Care Administration. This section controls over any conflicting provisions of chapters 39, 381, 383, 390, 391, 393, 394, 395, 400, 408, 468, 483, and 641 or rules adopted pursuant to those chapters.

Section 5. Section 409.8177, Florida Statutes, is amended to read:

409.8177 Program evaluation.--

(1) The agency, in consultation with the Department of Health, the Department of Children and Family Services, and the Florida Healthy Kids Corporation, shall contract for an evaluation of the Florida Kidcare program and shall by January 1 of each year submit to the Governor, the President of the

Senate, and the Speaker of the House of Representatives a report of the ~~Florida Kidcare~~ program. In addition to the items specified under s. 2108 of Title XXI of the Social Security Act, the report shall include an assessment of crowd-out and access to health care, as well as the following:

(a)~~(1)~~ An assessment of the operation of the program, including the progress made in reducing the number of uncovered low-income children.

(b)~~(2)~~ An assessment of the effectiveness in increasing the number of children with creditable health coverage, including an assessment of the impact of outreach.

(c)~~(3)~~ The characteristics of the children and families assisted under the program, including ages of the children, family income, and access to or coverage by other health insurance prior to the program and after disenrollment from the program.

(d)~~(4)~~ The quality of health coverage provided, including the types of benefits provided.

(e)~~(5)~~ The amount and level, including payment of part or all of any premium, of assistance provided.

(f)~~(6)~~ The average length of coverage of a child under the program.

(g)~~(7)~~ The program's choice of health benefits coverage and other methods used for providing child health assistance.

(h)~~(8)~~ The sources of nonfederal funding used in the program.

(i)~~(9)~~ An assessment of the effectiveness of Medikids, Children's Medical Services network, and other public and private programs in the state in increasing the availability of affordable quality health insurance and health care for

children.

(j)~~(10)~~ A review and assessment of state activities to coordinate the program with other public and private programs.

(k)~~(11)~~ An analysis of changes and trends in the state that affect the provision of health insurance and health care to children.

(l)~~(12)~~ A description of any plans the state has for improving the availability of health insurance and health care for children.

(m)~~(13)~~ Recommendations for improving the program.

(n)~~(14)~~ Other studies as necessary.

(2) The agency shall also submit each month to the Governor, the President of the Senate, and the Speaker of the House of Representatives a report of enrollment for each program component of the Florida Kidcare program.

Section 6. Section 409.902, Florida Statutes, is amended to read:

409.902 Designated single state agency; payment requirements; program title; release of medical records.--The Agency for Health Care Administration is designated as the single state agency authorized to make payments for medical assistance and related services under Title XIX of the Social Security Act. These payments shall be made, subject to any limitations or directions provided for in the General Appropriations Act, only for services included in the program, shall be made only on behalf of eligible individuals, and shall be made only to qualified providers in accordance with federal requirements for Title XIX of the Social Security Act and the provisions of state law. This program of medical assistance is designated the "Medicaid program." The Department of Children and Family Services is responsible for

1 Medicaid eligibility determinations, including, but not
2 limited to, policy, rules, and the agreement with the Social
3 Security Administration for Medicaid eligibility
4 determinations for Supplemental Security Income recipients, as
5 well as the actual determination of eligibility. As a
6 condition of Medicaid eligibility, the Agency for Health Care
7 Administration and the Department of Children and Family
8 Services shall ensure that each recipient of Medicaid consents
9 to the release of her or his medical records to the Agency for
10 Health Care Administration and the Medicaid Fraud Control Unit
11 of the Department of Legal Affairs.
12 Section 7. Effective July 1, 2002, subsection (2) of
13 section 409.904, Florida Statutes, as amended by section 2 of
14 chapter 2001-377, Laws of Florida, is amended to read:
15 409.904 Optional payments for eligible persons.--The
16 agency may make payments for medical assistance and related
17 services on behalf of the following persons who are determined
18 to be eligible subject to the income, assets, and categorical
19 eligibility tests set forth in federal and state law. Payment
20 on behalf of these Medicaid eligible persons is subject to the
21 availability of moneys and any limitations established by the
22 General Appropriations Act or chapter 216.
23 (2)~~(a)~~ A caretaker relative/parent, a pregnant woman,
24 a child under age 19 who would otherwise qualify for Florida
25 Kidcare Medicaid, a child up to age 21 who would otherwise
26 qualify under s. 409.903(1), a person age 65 or over, or a
27 blind or disabled person who would otherwise be eligible for
28 Florida Medicaid, except that the income or assets of such
29 family or person exceed established limitations.~~A pregnant~~
30 ~~woman who would otherwise qualify for Medicaid under s.~~
31 ~~409.903(5) except for her level of income and whose assets~~

~~fall within the limits established by the Department of Children and Family Services for the medically needy. A pregnant woman who applies for medically needy eligibility may not be made presumptively eligible.~~

~~(b) A child under age 21 who would otherwise qualify for Medicaid or the Florida Kidcare program except for the family's level of income and whose assets fall within the limits established by the Department of Children and Family Services for the medically needy.~~

For a family or person in one of these coverage groups ~~this group~~, medical expenses are deductible from income in accordance with federal requirements in order to make a determination of eligibility. Expenses used to meet spend-down liability are not reimbursable by Medicaid. Effective January 1, 2003, when determining the eligibility of a pregnant woman, a child, or an aged, blind, or disabled individual, $270 will be deducted from the countable income of the filing unit. When determining the eligibility of the parent or caretaker relative as defined by Title XIX of the Social Security Act, the additional income disregard of $270 does not apply.A family or person eligible under the coverage ~~in this group, which group is~~ known as the "medically needy," is eligible to receive the same services as other Medicaid recipients, with the exception of services in skilled nursing facilities and intermediate care facilities for the developmentally disabled.

Section 8. Paragraph (c) of subsection (5) of section 409.905, Florida Statutes, is amended to read:

409.905 Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act,

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

(5) HOSPITAL INPATIENT SERVICES.--The agency shall pay for all covered services provided for the medical care and treatment of a recipient who is admitted as an inpatient by a licensed physician or dentist to a hospital licensed under part I of chapter 395. However, the agency shall limit the payment for inpatient hospital services for a Medicaid recipient 21 years of age or older to 45 days or the number of days necessary to comply with the General Appropriations Act.

(c) Agency for Health Care Administration shall adjust a hospital's current inpatient per diem rate to reflect the cost of serving the Medicaid population at that institution if:

1. The hospital experiences an increase in Medicaid caseload by more than 25 percent in any year, primarily resulting from the closure of a hospital in the same service area occurring after July 1, 1995; ~~or~~

2. The hospital's Medicaid per diem rate is at least 25 percent below the Medicaid per patient cost for that year; or~~.~~

3. The hospital is located in a county that has five or fewer hospitals, began offering obstetrical services on or after September 1999, and has submitted a request in writing to the agency for a rate adjustment after July 1, 2000, but before September 30, 2000, in which case such hospital's Medicaid inpatient per diem rate shall be adjusted to cost, effective July 1, 2002.

No later than October 1 of each year ~~November 1, 2001~~, the agency must provide estimated costs for any adjustment in a hospital inpatient per diem pursuant to this paragraph to the Executive Office of the Governor, the House of Representatives General Appropriations Committee, and the Senate Appropriations Committee. Before the agency implements a change in a hospital's inpatient per diem rate pursuant to this paragraph, the Legislature must have specifically appropriated sufficient funds in the General Appropriations Act to support the increase in cost as estimated by the agency.

Section 9. Effective July 1, 2002, subsections (1), (12), and (23) of section 409.906, Florida Statutes, as amended by section 3 of chapter 2001-377, Laws of Florida, are amended to read:

409.906 Optional Medicaid services.--Subject to specific appropriations, the agency may make payments for services which are optional to the state under Title XIX of the Social Security Act and are furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any optional service that is provided shall be provided only when medically necessary and in accordance with state and federal law.

1 Optional services rendered by providers in mobile units to
2 Medicaid recipients may be restricted or prohibited by the
3 agency. Nothing in this section shall be construed to prevent
4 or limit the agency from adjusting fees, reimbursement rates,
5 lengths of stay, number of visits, or number of services, or
6 making any other adjustments necessary to comply with the
7 availability of moneys and any limitations or directions
8 provided for in the General Appropriations Act or chapter 216.
9 If necessary to safeguard the state's systems of providing
10 services to elderly and disabled persons and subject to the
11 notice and review provisions of s. 216.177, the Governor may
12 direct the Agency for Health Care Administration to amend the
13 Medicaid state plan to delete the optional Medicaid service
14 known as "Intermediate Care Facilities for the Developmentally
15 Disabled." Optional services may include:
16 (1) ADULT DENTURE SERVICES.--The agency may pay for
17 dentures, the procedures required to seat dentures, and the
18 repair and reline of dentures, provided by or under the
19 direction of a licensed dentist, for a recipient who is age 21
20 or older. However, Medicaid will not provide reimbursement for
21 dental services provided in a mobile dental unit, except for a
22 mobile dental unit:
23 (a) Owned by, operated by, or having a contractual
24 agreement with the Department of Health and complying with
25 Medicaid's county health department clinic services program
26 specifications as a county health department clinic services
27 provider.
28 (b) Owned by, operated by, or having a contractual
29 arrangement with a federally qualified health center and
30 complying with Medicaid's federally qualified health center
31 specifications as a federally qualified health center

provider.

(c) Rendering dental services to Medicaid recipients, 21 years of age and older, at nursing facilities.

(d) Owned by, operated by, or having a contractual agreement with a state-approved dental educational institution.

~~(e) This subsection is repealed July 1, 2002.~~

(12) ~~CHILDREN'S~~ HEARING SERVICES.--The agency may pay for hearing and related services, including hearing evaluations, hearing aid devices, dispensing of the hearing aid, and related repairs, if provided to a recipient ~~under age 21~~ by a licensed hearing aid specialist, otolaryngologist, otologist, audiologist, or physician.

(23) ~~CHILDREN'S~~ VISUAL SERVICES.--The agency may pay for visual examinations, eyeglasses, and eyeglass repairs for a recipient ~~under age 21~~, if they are prescribed by a licensed physician specializing in diseases of the eye or by a licensed optometrist.

Section 10. Subsection (2) of section 409.9065, Florida Statutes, as amended by section 5 of chapter 2001-377, Laws of Florida, is amended to read:

409.9065 Pharmaceutical expense assistance.--

(2) ELIGIBILITY.--Eligibility for the program is limited to those individuals who qualify for limited assistance under the Florida Medicaid program as a result of being dually eligible for both Medicare and Medicaid, but whose limited assistance or Medicare coverage does not include any pharmacy benefit. To the extent funds are appropriated, specifically eligible individuals are individuals ~~low-income senior citizens~~ who:

(a) Are Florida residents age 65 and over;

1 (b) Have an income:
2 1. Between 88 ~~90~~ and 120 percent of the federal
3 poverty level;
4 2. Between 88 and 150 percent of the federal poverty
5 level if the Federal Government increases the federal Medicaid
6 match for persons between 100 and 150 percent of the federal
7 poverty level; or
8 3. Between 88 percent of the federal poverty level and
9 a level that can be supported with funds provided in the
10 General Appropriations Act for the program offered under this
11 section along with federal matching funds approved by the
12 Federal Government under a s. 1115 waiver. The agency is
13 authorized to submit and implement a federal waiver pursuant
14 to this subparagraph. The agency shall design a pharmacy
15 benefit that includes annual per-member benefit limits and
16 cost-sharing provisions and limits enrollment to available
17 appropriations and matching federal funds. Prior to
18 implementing this program, the agency must submit a budget
19 amendment pursuant to chapter 216;
20 (c) Are eligible for both Medicare and Medicaid;
21 (d) Are not enrolled in a Medicare health maintenance
22 organization that provides a pharmacy benefit; and
23 (e) Request to be enrolled in the program.
24 Section 11. Subsections (7) and (9) of section
25 409.907, Florida Statutes, as amended by section 6 of chapter
26 2001-377, Laws of Florida, are amended to read:
27 409.907 Medicaid provider agreements.--The agency may
28 make payments for medical assistance and related services
29 rendered to Medicaid recipients only to an individual or
30 entity who has a provider agreement in effect with the agency,
31 who is performing services or supplying goods in accordance

1 with federal, state, and local law, and who agrees that no
2 person shall, on the grounds of handicap, race, color, or
3 national origin, or for any other reason, be subjected to
4 discrimination under any program or activity for which the
5 provider receives payment from the agency.
6 (7) The agency may require, as a condition of
7 participating in the Medicaid program and before entering into
8 the provider agreement, that the provider submit information,
9 in an initial and any required renewal applications,
10 concerning the professional, business, and personal background
11 of the provider and permit an onsite inspection of the
12 provider's service location by agency staff or other personnel
13 designated by the agency to perform this function. The agency
14 shall perform a random onsite inspection, within 60 days after
15 receipt of a fully complete new provider's application, of the
16 provider's service location prior to making its first payment
17 to the provider for Medicaid services to determine the
18 applicant's ability to provide the services that the applicant
19 is proposing to provide for Medicaid reimbursement. The agency
20 is not required to perform an onsite inspection of a provider
21 or program that is licensed by the agency, that provides
22 services under waiver programs for home and community-based
23 services, or that is licensed as a medical foster home by the
24 Department of Children and Family Services.As a continuing
25 condition of participation in the Medicaid program, a provider
26 shall immediately notify the agency of any current or pending
27 bankruptcy filing. Before entering into the provider
28 agreement, or as a condition of continuing participation in
29 the Medicaid program, the agency may also require that
30 Medicaid providers reimbursed on a fee-for-services basis or
31 fee schedule basis which is not cost-based, post a surety bond

1 not to exceed $50,000 or the total amount billed by the
2 provider to the program during the current or most recent
3 calendar year, whichever is greater. For new providers, the
4 amount of the surety bond shall be determined by the agency
5 based on the provider's estimate of its first year's billing.
6 If the provider's billing during the first year exceeds the
7 bond amount, the agency may require the provider to acquire an
8 additional bond equal to the actual billing level of the
9 provider. A provider's bond shall not exceed $50,000 if a
10 physician or group of physicians licensed under chapter 458,
11 chapter 459, or chapter 460 has a 50 percent or greater
12 ownership interest in the provider or if the provider is an
13 assisted living facility licensed under part III of chapter
14 400. The bonds permitted by this section are in addition to
15 the bonds referenced in s. 400.179(4)(d). If the provider is a
16 corporation, partnership, association, or other entity, the
17 agency may require the provider to submit information
18 concerning the background of that entity and of any principal
19 of the entity, including any partner or shareholder having an
20 ownership interest in the entity equal to 5 percent or
21 greater, and any treating provider who participates in or
22 intends to participate in Medicaid through the entity. The
23 information must include:
24 (a) Proof of holding a valid license or operating
25 certificate, as applicable, if required by the state or local
26 jurisdiction in which the provider is located or if required
27 by the Federal Government.
28 (b) Information concerning any prior violation, fine,
29 suspension, termination, or other administrative action taken
30 under the Medicaid laws, rules, or regulations of this state
31 or of any other state or the Federal Government; any prior

1 violation of the laws, rules, or regulations relating to the
2 Medicare program; any prior violation of the rules or
3 regulations of any other public or private insurer; and any
4 prior violation of the laws, rules, or regulations of any
5 regulatory body of this or any other state.
6 (c) Full and accurate disclosure of any financial or
7 ownership interest that the provider, or any principal,
8 partner, or major shareholder thereof, may hold in any other
9 Medicaid provider or health care related entity or any other
10 entity that is licensed by the state to provide health or
11 residential care and treatment to persons.
12 (d) If a group provider, identification of all members
13 of the group and attestation that all members of the group are
14 enrolled in or have applied to enroll in the Medicaid program.
15 (9) Upon receipt of a completed, signed, and dated
16 application, and completion of any necessary background
17 investigation and criminal history record check, the agency
18 must either:
19 (a) Enroll the applicant as a Medicaid provider no
20 earlier than the effective date of the approval of the
21 provider application. With respect to providers who were
22 recently granted a change of ownership and those who primarily
23 provide emergency medical services transportation or emergency
24 services and care pursuant to s. 401.45 or s. 395.1041, and
25 out-of-state providers, upon approval of the provider
26 application, the effective date of approval is considered to
27 be the date the agency receives the provider application; or
28 (b) Deny the application if the agency finds that it
29 is in the best interest of the Medicaid program to do so. The
30 agency may consider the factors listed in subsection (10), as
31 well as any other factor that could affect the effective and

1 efficient administration of the program, including, but not
2 limited to, the applicant's demonstrated ability to provide
3 services, conduct business, and operate a financially viable
4 concern;the current availability of medical care, services,
5 or supplies to recipients, taking into account geographic
6 location and reasonable travel time; the number of providers
7 of the same type already enrolled in the same geographic area;
8 and the credentials, experience, success, and patient outcomes
9 of the provider for the services that it is making application
10 to provide in the Medicaid program. The agency shall deny the
11 application if the agency finds that a provider; any officer,
12 director, agent, managing employee, or affiliated person; or
13 any partner or shareholder having an ownership interest equal
14 to 5 percent or greater in the provider if the provider is a
15 corporation, partnership, or other business entity, has failed
16 to pay all outstanding fines or overpayments assessed by final
17 order of the agency or final order of the Centers for Medicare
18 and Medicaid Services, unless the provider agrees to a
19 repayment plan that includes withholding Medicaid
20 reimbursement until the amount due is paid in full.
21 Section 12. Section 409.908, Florida Statutes, as
22 amended by section 7 of chapter 2001-377, Laws of Florida, is
23 amended to read:
24 409.908 Reimbursement of Medicaid providers.--Subject
25 to specific appropriations, the agency shall reimburse
26 Medicaid providers, in accordance with state and federal law,
27 according to methodologies set forth in the rules of the
28 agency and in policy manuals and handbooks incorporated by
29 reference therein. These methodologies may include fee
30 schedules, reimbursement methods based on cost reporting,
31 negotiated fees, competitive bidding pursuant to s. 287.057,

1 and other mechanisms the agency considers efficient and
2 effective for purchasing services or goods on behalf of
3 recipients. If a provider is reimbursed based on cost
4 reporting and submits a cost report late and that cost report
5 would have been used to set a lower reimbursement rate for a
6 rate semester, then the provider's rate for that semester
7 shall be retroactively calculated using the new cost report,
8 and full payment at the recalculated rate shall be effected
9 retroactively. Medicare granted extensions for filing cost
10 reports, if applicable, shall also apply to Medicaid cost
11 reports.Payment for Medicaid compensable services made on
12 behalf of Medicaid eligible persons is subject to the
13 availability of moneys and any limitations or directions
14 provided for in the General Appropriations Act or chapter 216.
15 Further, nothing in this section shall be construed to prevent
16 or limit the agency from adjusting fees, reimbursement rates,
17 lengths of stay, number of visits, or number of services, or
18 making any other adjustments necessary to comply with the
19 availability of moneys and any limitations or directions
20 provided for in the General Appropriations Act, provided the
21 adjustment is consistent with legislative intent.
22 (1) Reimbursement to hospitals licensed under part I
23 of chapter 395 must be made prospectively or on the basis of
24 negotiation.
25 (a) Reimbursement for inpatient care is limited as
26 provided for in s. 409.905(5), except for:
27 1. The raising of rate reimbursement caps, excluding
28 rural hospitals.
29 2. Recognition of the costs of graduate medical
30 education.
31 3. Other methodologies recognized in the General

1 Appropriations Act.
2 4. Hospital inpatient rates shall be reduced by 6
3 percent effective July 1, 2001, and restored effective April
4 1, 2002.
5
6 During the years funds are transferred from the Department of
7 Health, any reimbursement supported by such funds shall be
8 subject to certification by the Department of Health that the
9 hospital has complied with s. 381.0403. The agency is
10 authorized to receive funds from state entities, including,
11 but not limited to, the Department of Health, local
12 governments, and other local political subdivisions, for the
13 purpose of making special exception payments, including
14 federal matching funds, through the Medicaid inpatient
15 reimbursement methodologies. Funds received from state
16 entities or local governments for this purpose shall be
17 separately accounted for and shall not be commingled with
18 other state or local funds in any manner. The agency may
19 certify all local governmental funds used as state match under
20 Title XIX of the Social Security Act, to the extent that the
21 identified local health care provider that is otherwise
22 entitled to and is contracted to receive such local funds is
23 the benefactor under the state's Medicaid program as
24 determined under the General Appropriations Act and pursuant
25 to an agreement between the Agency for Health Care
26 Administration and the local governmental entity. The local
27 governmental entity shall use a certification form prescribed
28 by the agency. At a minimum, the certification form shall
29 identify the amount being certified and describe the
30 relationship between the certifying local governmental entity
31 and the local health care provider. The agency shall prepare

an annual statement of impact which documents the specific activities undertaken during the previous fiscal year pursuant to this paragraph, to be submitted to the Legislature no later than January 1, annually.

(b) Reimbursement for hospital outpatient care is limited to $1,500 per state fiscal year per recipient, except for:

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

2. Renal dialysis services.

3. Other exceptions made by the agency.

The agency is authorized to receive funds from state entities, including, but not limited to, the Department of Health, the Board of Regents, local governments, and other local political subdivisions, for the purpose of making payments, including federal matching funds, through the Medicaid outpatient reimbursement methodologies. Funds received from state entities and local governments for this purpose shall be separately accounted for and shall not be commingled with other state or local funds in any manner.

(c) Hospitals that provide services to a disproportionate share of low-income Medicaid recipients, or that participate in the regional perinatal intensive care center program under chapter 383, or that participate in the statutory teaching hospital disproportionate share program may receive additional reimbursement. The total amount of payment for disproportionate share hospitals shall be fixed by the General Appropriations Act. The computation of these payments must be made in compliance with all federal regulations and

1 the methodologies described in ss. 409.911, 409.9112, and
2 409.9113.
3 (d) The agency is authorized to limit inflationary
4 increases for outpatient hospital services as directed by the
5 General Appropriations Act.
6 (2)(a)1. Reimbursement to nursing homes licensed under
7 part II of chapter 400 and state-owned-and-operated
8 intermediate care facilities for the developmentally disabled
9 licensed under chapter 393 must be made prospectively.
10 2. Unless otherwise limited or directed in the General
11 Appropriations Act, reimbursement to hospitals licensed under
12 part I of chapter 395 for the provision of swing-bed nursing
13 home services must be made on the basis of the average
14 statewide nursing home payment, and reimbursement to a
15 hospital licensed under part I of chapter 395 for the
16 provision of skilled nursing services must be made on the
17 basis of the average nursing home payment for those services
18 in the county in which the hospital is located. When a
19 hospital is located in a county that does not have any
20 community nursing homes, reimbursement must be determined by
21 averaging the nursing home payments, in counties that surround
22 the county in which the hospital is located. Reimbursement to
23 hospitals, including Medicaid payment of Medicare copayments,
24 for skilled nursing services shall be limited to 30 days,
25 unless a prior authorization has been obtained from the
26 agency. Medicaid reimbursement may be extended by the agency
27 beyond 30 days, and approval must be based upon verification
28 by the patient's physician that the patient requires
29 short-term rehabilitative and recuperative services only, in
30 which case an extension of no more than 15 days may be
31 approved. Reimbursement to a hospital licensed under part I of

1 chapter 395 for the temporary provision of skilled nursing
2 services to nursing home residents who have been displaced as
3 the result of a natural disaster or other emergency may not
4 exceed the average county nursing home payment for those
5 services in the county in which the hospital is located and is
6 limited to the period of time which the agency considers
7 necessary for continued placement of the nursing home
8 residents in the hospital.
9 (b) Subject to any limitations or directions provided
10 for in the General Appropriations Act, the agency shall
11 establish and implement a Florida Title XIX Long-Term Care
12 Reimbursement Plan (Medicaid) for nursing home care in order
13 to provide care and services in conformance with the
14 applicable state and federal laws, rules, regulations, and
15 quality and safety standards and to ensure that individuals
16 eligible for medical assistance have reasonable geographic
17 access to such care.
18 1. Changes of ownership or of licensed operator do not
19 qualify for increases in reimbursement rates associated with
20 the change of ownership or of licensed operator. The agency
21 shall amend the Title XIX Long Term Care Reimbursement Plan to
22 provide that the initial nursing home reimbursement rates, for
23 the operating, patient care, and MAR components, associated
24 with related and unrelated party changes of ownership or
25 licensed operator filed on or after September 1, 2001, are
26 equivalent to the previous owner's reimbursement rate.
27 2. The agency shall amend the long-term care
28 reimbursement plan and cost reporting system to create direct
29 care and indirect care subcomponents of the patient care
30 component of the per diem rate. These two subcomponents
31 together shall equal the patient care component of the per

1 diem rate. Separate cost-based ceilings shall be calculated
2 for each patient care subcomponent. The direct care
3 subcomponent of the per diem rate shall be limited by the
4 cost-based class ceiling, and the indirect care subcomponent
5 shall be limited by the lower of the cost-based class ceiling,
6 by the target rate class ceiling, or by the individual
7 provider target. The agency shall adjust the patient care
8 component effective January 1, 2002. The cost to adjust the
9 direct care subcomponent shall be net of the total funds
10 previously allocated for the case mix add-on. The agency shall
11 make the required changes to the nursing home cost reporting
12 forms to implement this requirement effective January 1, 2002.
13 3. The direct care subcomponent shall include salaries
14 and benefits of direct care staff providing nursing services
15 including registered nurses, licensed practical nurses, and
16 certified nursing assistants who deliver care directly to
17 residents in the nursing home facility. This excludes nursing
18 administration, MDS, and care plan coordinators, staff
19 development, and staffing coordinator.
20 4. All other patient care costs shall be included in
21 the indirect care cost subcomponent of the patient care per
22 diem rate. There shall be no costs directly or indirectly
23 allocated to the direct care subcomponent from a home office
24 or management company.
25 5. On July 1 of each year, the agency shall report to
26 the Legislature direct and indirect care costs, including
27 average direct and indirect care costs per resident per
28 facility and direct care and indirect care salaries and
29 benefits per category of staff member per facility.
30 6. Under the plan, interim rate adjustments shall not
31 be granted to reflect increases in the cost of general or

1 professional liability insurance for nursing homes unless the
2 following criteria are met: have at least a 65 percent
3 Medicaid utilization in the most recent cost report submitted
4 to the agency, and the increase in general or professional
5 liability costs to the facility for the most recent policy
6 period affects the total Medicaid per diem by at least 5
7 percent. This rate adjustment shall not result in the per diem
8 exceeding the class ceiling. This provision shall be
9 implemented to the extent existing appropriations are
10 available.
11
12 It is the intent of the Legislature that the reimbursement
13 plan achieve the goal of providing access to health care for
14 nursing home residents who require large amounts of care while
15 encouraging diversion services as an alternative to nursing
16 home care for residents who can be served within the
17 community. The agency shall base the establishment of any
18 maximum rate of payment, whether overall or component, on the
19 available moneys as provided for in the General Appropriations
20 Act. The agency may base the maximum rate of payment on the
21 results of scientifically valid analysis and conclusions
22 derived from objective statistical data pertinent to the
23 particular maximum rate of payment.
24 (3) Subject to any limitations or directions provided
25 for in the General Appropriations Act, the following Medicaid
26 services and goods may be reimbursed on a fee-for-service
27 basis. For each allowable service or goods furnished in
28 accordance with Medicaid rules, policy manuals, handbooks, and
29 state and federal law, the payment shall be the amount billed
30 by the provider, the provider's usual and customary charge, or
31 the maximum allowable fee established by the agency, whichever

1 amount is less, with the exception of those services or goods
2 for which the agency makes payment using a methodology based
3 on capitation rates, average costs, or negotiated fees.
4 (a) Advanced registered nurse practitioner services.
5 (b) Birth center services.
6 (c) Chiropractic services.
7 (d) Community mental health services.
8 (e) Dental services, including oral and maxillofacial
9 surgery.
10 (f) Durable medical equipment.
11 (g) Hearing services.
12 (h) Occupational therapy for Medicaid recipients under
13 age 21.
14 (i) Optometric services.
15 (j) Orthodontic services.
16 (k) Personal care for Medicaid recipients under age
17 21.
18 (l) Physical therapy for Medicaid recipients under age
19 21.
20 (m) Physician assistant services.
21 (n) Podiatric services.
22 (o) Portable X-ray services.
23 (p) Private-duty nursing for Medicaid recipients under
24 age 21.
25 (q) Registered nurse first assistant services.
26 (r) Respiratory therapy for Medicaid recipients under
27 age 21.
28 (s) Speech therapy for Medicaid recipients under age
29 21.
30 (t) Visual services.
31 (4) Subject to any limitations or directions provided

1 for in the General Appropriations Act, alternative health
2 plans, health maintenance organizations, and prepaid health
3 plans shall be reimbursed a fixed, prepaid amount negotiated,
4 or competitively bid pursuant to s. 287.057, by the agency and
5 prospectively paid to the provider monthly for each Medicaid
6 recipient enrolled. The amount may not exceed the average
7 amount the agency determines it would have paid, based on
8 claims experience, for recipients in the same or similar
9 category of eligibility. The agency shall calculate
10 capitation rates on a regional basis and, beginning September
11 1, 1995, shall include age-band differentials in such
12 calculations. Effective July 1, 2001, the cost of exempting
13 statutory teaching hospitals, specialty hospitals, and
14 community hospital education program hospitals from
15 reimbursement ceilings and the cost of special Medicaid
16 payments shall not be included in premiums paid to health
17 maintenance organizations or prepaid health care plans. Each
18 rate semester, the agency shall calculate and publish a
19 Medicaid hospital rate schedule that does not reflect either
20 special Medicaid payments or the elimination of rate
21 reimbursement ceilings, to be used by hospitals and Medicaid
22 health maintenance organizations, in order to determine the
23 Medicaid rate referred to in ss. 409.912(16), 409.9128(5), and
24 641.513(6).
25 (5) An ambulatory surgical center shall be reimbursed
26 the lesser of the amount billed by the provider or the
27 Medicare-established allowable amount for the facility.
28 (6) A provider of early and periodic screening,
29 diagnosis, and treatment services to Medicaid recipients who
30 are children under age 21 shall be reimbursed using an
31 all-inclusive rate stipulated in a fee schedule established by

1 the agency. A provider of the visual, dental, and hearing
2 components of such services shall be reimbursed the lesser of
3 the amount billed by the provider or the Medicaid maximum
4 allowable fee established by the agency.
5 (7) A provider of family planning services shall be
6 reimbursed the lesser of the amount billed by the provider or
7 an all-inclusive amount per type of visit for physicians and
8 advanced registered nurse practitioners, as established by the
9 agency in a fee schedule.
10 (8) A provider of home-based or community-based
11 services rendered pursuant to a federally approved waiver
12 shall be reimbursed based on an established or negotiated rate
13 for each service. These rates shall be established according
14 to an analysis of the expenditure history and prospective
15 budget developed by each contract provider participating in
16 the waiver program, or under any other methodology adopted by
17 the agency and approved by the Federal Government in
18 accordance with the waiver. Effective July 1, 1996, privately
19 owned and operated community-based residential facilities
20 which meet agency requirements and which formerly received
21 Medicaid reimbursement for the optional intermediate care
22 facility for the mentally retarded service may participate in
23 the developmental services waiver as part of a
24 home-and-community-based continuum of care for Medicaid
25 recipients who receive waiver services.
26 (9) A provider of home health care services or of
27 medical supplies and appliances shall be reimbursed on the
28 basis of competitive bidding or for the lesser of the amount
29 billed by the provider or the agency's established maximum
30 allowable amount, except that, in the case of the rental of
31 durable medical equipment, the total rental payments may not

1 exceed the purchase price of the equipment over its expected
2 useful life or the agency's established maximum allowable
3 amount, whichever amount is less.
4 (10) A hospice shall be reimbursed through a
5 prospective system for each Medicaid hospice patient at
6 Medicaid rates using the methodology established for hospice
7 reimbursement pursuant to Title XVIII of the federal Social
8 Security Act.
9 (11) A provider of independent laboratory services
10 shall be reimbursed on the basis of competitive bidding or for
11 the least of the amount billed by the provider, the provider's
12 usual and customary charge, or the Medicaid maximum allowable
13 fee established by the agency.
14 (12)(a) A physician shall be reimbursed the lesser of
15 the amount billed by the provider or the Medicaid maximum
16 allowable fee established by the agency.
17 (b) The agency shall adopt a fee schedule, subject to
18 any limitations or directions provided for in the General
19 Appropriations Act, based on a resource-based relative value
20 scale for pricing Medicaid physician services. Under this fee
21 schedule, physicians shall be paid a dollar amount for each
22 service based on the average resources required to provide the
23 service, including, but not limited to, estimates of average
24 physician time and effort, practice expense, and the costs of
25 professional liability insurance. The fee schedule shall
26 provide increased reimbursement for preventive and primary
27 care services and lowered reimbursement for specialty services
28 by using at least two conversion factors, one for cognitive
29 services and another for procedural services. The fee
30 schedule shall not increase total Medicaid physician
31 expenditures unless moneys are available, and shall be phased

1 in over a 2-year period beginning on July 1, 1994. The Agency
2 for Health Care Administration shall seek the advice of a
3 16-member advisory panel in formulating and adopting the fee
4 schedule. The panel shall consist of Medicaid physicians
5 licensed under chapters 458 and 459 and shall be composed of
6 50 percent primary care physicians and 50 percent specialty
7 care physicians.
8 (c) Notwithstanding paragraph (b), reimbursement fees
9 to physicians for providing total obstetrical services to
10 Medicaid recipients, which include prenatal, delivery, and
11 postpartum care, shall be at least $1,500 per delivery for a
12 pregnant woman with low medical risk and at least $2,000 per
13 delivery for a pregnant woman with high medical risk. However,
14 reimbursement to physicians working in Regional Perinatal
15 Intensive Care Centers designated pursuant to chapter 383, for
16 services to certain pregnant Medicaid recipients with a high
17 medical risk, may be made according to obstetrical care and
18 neonatal care groupings and rates established by the agency.
19 Nurse midwives licensed under part I of chapter 464 or
20 midwives licensed under chapter 467 shall be reimbursed at no
21 less than 80 percent of the low medical risk fee. The agency
22 shall by rule determine, for the purpose of this paragraph,
23 what constitutes a high or low medical risk pregnant woman and
24 shall not pay more based solely on the fact that a caesarean
25 section was performed, rather than a vaginal delivery. The
26 agency shall by rule determine a prorated payment for
27 obstetrical services in cases where only part of the total
28 prenatal, delivery, or postpartum care was performed. The
29 Department of Health shall adopt rules for appropriate
30 insurance coverage for midwives licensed under chapter 467.
31 Prior to the issuance and renewal of an active license, or

reactivation of an inactive license for midwives licensed under chapter 467, such licensees shall submit proof of coverage with each application.

(d) For fiscal years 2001-2002 and 2002-2003 ~~the 2001-2002 fiscal year~~ only and if necessary to meet the requirements for grants and donations for the special Medicaid payments authorized in the 2001-2002 and 2002-2003 General Appropriations Acts ~~Act~~, the agency may make special Medicaid payments to qualified Medicaid providers designated by the agency, notwithstanding any provision of this subsection to the contrary, and may use intergovernmental transfers from state entities or other governmental entities to serve as the state share of such payments.

(13) Medicare premiums for persons eligible for both Medicare and Medicaid coverage shall be paid at the rates established by Title XVIII of the Social Security Act. For Medicare services rendered to Medicaid-eligible persons, Medicaid shall pay Medicare deductibles and coinsurance as follows:

(a) Medicaid shall make no payment toward deductibles and coinsurance for any service that is not covered by Medicaid.

(b) Medicaid's financial obligation for deductibles and coinsurance payments shall be based on Medicare allowable fees, not on a provider's billed charges.

(c) Medicaid will pay no portion of Medicare deductibles and coinsurance when payment that Medicare has made for the service equals or exceeds what Medicaid would have paid if it had been the sole payor. The combined payment of Medicare and Medicaid shall not exceed the amount Medicaid would have paid had it been the sole payor. The Legislature

1 finds that there has been confusion regarding the
2 reimbursement for services rendered to dually eligible
3 Medicare beneficiaries. Accordingly, the Legislature clarifies
4 that it has always been the intent of the Legislature before
5 and after 1991 that, in reimbursing in accordance with fees
6 established by Title XVIII for premiums, deductibles, and
7 coinsurance for Medicare services rendered by physicians to
8 Medicaid eligible persons, physicians be reimbursed at the
9 lesser of the amount billed by the physician or the Medicaid
10 maximum allowable fee established by the Agency for Health
11 Care Administration, as is permitted by federal law. It has
12 never been the intent of the Legislature with regard to such
13 services rendered by physicians that Medicaid be required to
14 provide any payment for deductibles, coinsurance, or
15 copayments for Medicare cost sharing, or any expenses incurred
16 relating thereto, in excess of the payment amount provided for
17 under the State Medicaid plan for such service. This payment
18 methodology is applicable even in those situations in which
19 the payment for Medicare cost sharing for a qualified Medicare
20 beneficiary with respect to an item or service is reduced or
21 eliminated. This expression of the Legislature is in
22 clarification of existing law and shall apply to payment for,
23 and with respect to provider agreements with respect to, items
24 or services furnished on or after the effective date of this
25 act. This paragraph applies to payment by Medicaid for items
26 and services furnished before the effective date of this act
27 if such payment is the subject of a lawsuit that is based on
28 the provisions of this section, and that is pending as of, or
29 is initiated after, the effective date of this act.
30 (d) Notwithstanding paragraphs (a)-(c):
31 1. Medicaid payments for Nursing Home Medicare part A

1 coinsurance shall be the lesser of the Medicare coinsurance
2 amount or the Medicaid nursing home per diem rate.
3 2. Medicaid shall pay all deductibles and coinsurance
4 for Medicare-eligible recipients receiving freestanding end
5 stage renal dialysis center services.
6 3. Medicaid payments for general hospital inpatient
7 services shall be limited to the Medicare deductible per spell
8 of illness. Medicaid shall make no payment toward coinsurance
9 for Medicare general hospital inpatient services.
10 4. Medicaid shall pay all deductibles and coinsurance
11 for Medicare emergency transportation services provided by
12 ambulances licensed pursuant to chapter 401.
13 (14) A provider of prescribed drugs shall be
14 reimbursed the least of the amount billed by the provider, the
15 provider's usual and customary charge, or the Medicaid maximum
16 allowable fee established by the agency, plus a dispensing
17 fee. The agency is directed to implement a variable dispensing
18 fee for payments for prescribed medicines while ensuring
19 continued access for Medicaid recipients. The variable
20 dispensing fee may be based upon, but not limited to, either
21 or both the volume of prescriptions dispensed by a specific
22 pharmacy provider, the volume of prescriptions dispensed to an
23 individual recipient, and dispensing of preferred-drug-list
24 products. The agency shall increase the pharmacy dispensing
25 fee authorized by statute and in the annual General
26 Appropriations Act by $0.50 for the dispensing of a Medicaid
27 preferred-drug-list product and reduce the pharmacy dispensing
28 fee by $0.50 for the dispensing of a Medicaid product that is
29 not included on the preferred-drug list. The agency is
30 authorized to limit reimbursement for prescribed medicine in
31 order to comply with any limitations or directions provided

1 for in the General Appropriations Act, which may include
2 implementing a prospective or concurrent utilization review
3 program.
4 (15) A provider of primary care case management
5 services rendered pursuant to a federally approved waiver
6 shall be reimbursed by payment of a fixed, prepaid monthly sum
7 for each Medicaid recipient enrolled with the provider.
8 (16) A provider of rural health clinic services and
9 federally qualified health center services shall be reimbursed
10 a rate per visit based on total reasonable costs of the
11 clinic, as determined by the agency in accordance with federal
12 regulations.
13 (17) A provider of targeted case management services
14 shall be reimbursed pursuant to an established fee, except
15 where the Federal Government requires a public provider be
16 reimbursed on the basis of average actual costs.
17 (18) Unless otherwise provided for in the General
18 Appropriations Act, a provider of transportation services
19 shall be reimbursed the lesser of the amount billed by the
20 provider or the Medicaid maximum allowable fee established by
21 the agency, except when the agency has entered into a direct
22 contract with the provider, or with a community transportation
23 coordinator, for the provision of an all-inclusive service, or
24 when services are provided pursuant to an agreement negotiated
25 between the agency and the provider. The agency, as provided
26 for in s. 427.0135, shall purchase transportation services
27 through the community coordinated transportation system, if
28 available, unless the agency determines a more cost-effective
29 method for Medicaid clients. Nothing in this subsection shall
30 be construed to limit or preclude the agency from contracting
31 for services using a prepaid capitation rate or from

1 establishing maximum fee schedules, individualized
2 reimbursement policies by provider type, negotiated fees,
3 prior authorization, competitive bidding, increased use of
4 mass transit, or any other mechanism that the agency considers
5 efficient and effective for the purchase of services on behalf
6 of Medicaid clients, including implementing a transportation
7 eligibility process. The agency shall not be required to
8 contract with any community transportation coordinator or
9 transportation operator that has been determined by the
10 agency, the Department of Legal Affairs Medicaid Fraud Control
11 Unit, or any other state or federal agency to have engaged in
12 any abusive or fraudulent billing activities. The agency is
13 authorized to competitively procure transportation services or
14 make other changes necessary to secure approval of federal
15 waivers needed to permit federal financing of Medicaid
16 transportation services at the service matching rate rather
17 than the administrative matching rate.
18 (19) County health department services may be
19 reimbursed a rate per visit based on total reasonable costs of
20 the clinic, as determined by the agency in accordance with
21 federal regulations under the authority of 42 C.F.R. s.
22 431.615.
23 (20) A renal dialysis facility that provides dialysis
24 services under s. 409.906(9) must be reimbursed the lesser of
25 the amount billed by the provider, the provider's usual and
26 customary charge, or the maximum allowable fee established by
27 the agency, whichever amount is less.
28 (21) The agency shall reimburse school districts which
29 certify the state match pursuant to ss. 236.0812 and 409.9071
30 for the federal portion of the school district's allowable
31 costs to deliver the services, based on the reimbursement

1 schedule. The school district shall determine the costs for
2 delivering services as authorized in ss. 236.0812 and 409.9071
3 for which the state match will be certified. Reimbursement of
4 school-based providers is contingent on such providers being
5 enrolled as Medicaid providers and meeting the qualifications
6 contained in 42 C.F.R. s. 440.110, unless otherwise waived by
7 the federal Health Care Financing Administration. Speech
8 therapy providers who are certified through the Department of
9 Education pursuant to rule 6A-4.0176, Florida Administrative
10 Code, are eligible for reimbursement for services that are
11 provided on school premises. Any employee of the school
12 district who has been fingerprinted and has received a
13 criminal background check in accordance with Department of
14 Education rules and guidelines shall be exempt from any agency
15 requirements relating to criminal background checks.
16 (22) The agency shall request and implement Medicaid
17 waivers from the federal Health Care Financing Administration
18 to advance and treat a portion of the Medicaid nursing home
19 per diem as capital for creating and operating a
20 risk-retention group for self-insurance purposes, consistent
21 with federal and state laws and rules.
22 Section 13. Paragraph (b) of subsection (7) of section
23 409.910, Florida Statutes, is amended to read:
24 409.910 Responsibility for payments on behalf of
25 Medicaid-eligible persons when other parties are liable.--
26 (7) The agency shall recover the full amount of all
27 medical assistance provided by Medicaid on behalf of the
28 recipient to the full extent of third-party benefits.
29 (b) Upon receipt of any recovery or other collection
30 pursuant to this section, the agency shall distribute the
31 amount collected as follows:

1 1. To itself, an amount equal to the state Medicaid
2 expenditures for the recipient plus any incentive payment made
3 in accordance with paragraph (14)(a). From this share the
4 agency shall credit a county on its county billing invoice the
5 county's proportionate share of Medicaid third-party
6 recoveries in the areas of estate recoveries and casualty
7 claims, minus the agency's cost of recovering the third-party
8 payments, based on the county's percentage of the sum of total
9 county billing divided by total Medicaid expenditures.
10 However, if a county has been billed for its participation but
11 has not paid the amount due, the agency shall offset that
12 amount and notify the county of the amount of the offset. If
13 the county has divided its financial responsibility between
14 the county and a special taxing district or authority as
15 contemplated in s. 409.915(6), the county must proportionately
16 divide any refund or offset in accordance with the proration
17 that it has established.
18 2. To the Federal Government, the federal share of the
19 state Medicaid expenditures minus any incentive payment made
20 in accordance with paragraph (14)(a) and federal law, and
21 minus any other amount permitted by federal law to be
22 deducted.
23 3. To the recipient, after deducting any known amounts
24 owed to the agency for any related medical assistance or to
25 health care providers, any remaining amount. This amount shall
26 be treated as income or resources in determining eligibility
27 for Medicaid.
28
29 The provisions of this subsection do not apply to any proceeds
30 received by the state, or any agency thereof, pursuant to a
31 final order, judgment, or settlement agreement, in any matter

1 in which the state asserts claims brought on its own behalf,
2 and not as a subrogee of a recipient, or under other theories
3 of liability. The provisions of this subsection do not apply
4 to any proceeds received by the state, or an agency thereof,
5 pursuant to a final order, judgment, or settlement agreement,
6 in any matter in which the state asserted both claims as a
7 subrogee and additional claims, except as to those sums
8 specifically identified in the final order, judgment, or
9 settlement agreement as reimbursements to the recipient as
10 expenditures for the named recipient on the subrogation claim.
11 Section 14. Paragraph (g) of subsection (3) and
12 paragraph (c) of subsection (37) of section 409.912, Florida
13 Statutes, as amended by sections 8 and 9 of chapter 2001-377,
14 Laws of Florida, are amended to read:
15 409.912 Cost-effective purchasing of health care.--The
16 agency shall purchase goods and services for Medicaid
17 recipients in the most cost-effective manner consistent with
18 the delivery of quality medical care. The agency shall
19 maximize the use of prepaid per capita and prepaid aggregate
20 fixed-sum basis services when appropriate and other
21 alternative service delivery and reimbursement methodologies,
22 including competitive bidding pursuant to s. 287.057, designed
23 to facilitate the cost-effective purchase of a case-managed
24 continuum of care. The agency shall also require providers to
25 minimize the exposure of recipients to the need for acute
26 inpatient, custodial, and other institutional care and the
27 inappropriate or unnecessary use of high-cost services. The
28 agency may establish prior authorization requirements for
29 certain populations of Medicaid beneficiaries, certain drug
30 classes, or particular drugs to prevent fraud, abuse, overuse,
31 and possible dangerous drug interactions. The Pharmaceutical

1 and Therapeutics Committee shall make recommendations to the
2 agency on drugs for which prior authorization is required. The
3 agency shall inform the Pharmaceutical and Therapeutics
4 Committee of its decisions regarding drugs subject to prior
5 authorization.
6 (3) The agency may contract with:
7 (g) Children's provider networks that provide care
8 coordination and care management for Medicaid-eligible
9 pediatric patients, primary care, authorization of specialty
10 care, and other urgent and emergency care through organized
11 providers designed to service Medicaid eligibles under age 18
12 and pediatric emergency departments' diversion programs. The
13 networks shall provide after-hour operations, including
14 evening and weekend hours, to promote, when appropriate, the
15 use of the children's networks rather than hospital emergency
16 departments.
17 (37)
18 (c) The agency shall submit quarterly reports a report
19 to the Governor, the President of the Senate, and the Speaker
20 of the House of Representatives which by January 15 of each
21 year. The report must include, but need not be limited to, the
22 progress made in implementing this subsection and its Medicaid
23 cost-containment measures and their effect on Medicaid
24 prescribed-drug expenditures.
25 Section 15. Subsection (7) of section 409.9116,
26 Florida Statutes, is amended to read:
27 409.9116 Disproportionate share/financial assistance
28 program for rural hospitals.--In addition to the payments made
29 under s. 409.911, the Agency for Health Care Administration
30 shall administer a federally matched disproportionate share
31 program and a state-funded financial assistance program for

statutory rural hospitals. The agency 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. The disproportionate share program payments shall be limited by and conform with federal requirements. Funds shall be distributed quarterly in each fiscal year for which an appropriation is made. Notwithstanding the provisions of s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients.

(7) This section applies only to hospitals that were defined as statutory rural hospitals, or their successor-in-interest hospital, prior to January 1, 2001 ~~July 1, 1998~~. Any additional hospital that is defined as a statutory rural hospital, or its successor-in-interest hospital, on or after January 1, 2001 ~~July 1, 1998~~, is not eligible for programs under this section unless additional funds are appropriated each fiscal year specifically to the rural hospital disproportionate share and financial assistance programs in an amount necessary to prevent any hospital, or its successor-in-interest hospital, eligible for the programs prior to January 1, 2001 ~~July 1, 1998~~, from incurring a reduction in payments because of the eligibility of an additional hospital to participate in the programs. A hospital, or its successor-in-interest hospital, which received funds pursuant to this section before January 1, 2001 ~~July 1, 1998~~, and which qualifies under s. 395.602(2)(e), shall be included in the programs under this section and is not required to seek additional appropriations under this

subsection.

Section 16. Paragraphs (f) and (k) of subsection (2) of section 409.9122, Florida Statutes, as amended by section 11 of chapter 2001-377, Laws of Florida, are amended to read:

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

(2)

(f) When a Medicaid recipient does not choose a managed care plan or MediPass provider, the agency shall assign the Medicaid recipient to a managed care plan or MediPass provider. Medicaid recipients who are subject to mandatory assignment but who fail to make a choice shall be assigned to managed care plans ~~or provider service networks~~ until an ~~equal~~ enrollment of 45 ~~50~~ percent in MediPass and 55 ~~50~~ percent in managed care plans is achieved. Once that ~~equal~~ enrollment is achieved, the assignments shall be divided in order to maintain an ~~equal~~ enrollment in MediPass and managed care plans which is in a 45 percent and 55 percent proportion, respectively. Thereafter, assignment of Medicaid recipients who fail to make a choice shall be based proportionally on the preferences of recipients who have made a choice in the previous period. Such proportions shall be revised at least quarterly to reflect an update of the preferences of Medicaid recipients. The agency shall also disproportionately assign Medicaid-eligible children in families who are required to but have failed to make a choice of managed care plan or MediPass for their child and who are to be assigned to the MediPass program or managed care plans to children's networks as described in s. 409.912(3)(g) and where available. The disproportionate assignment of children to children's networks shall be made until the agency has determined that the

1 children's networks have sufficient numbers to be economically
2 operated. For purposes of this section ~~paragraph, when~~
3 ~~referring to assignment~~, the term "managed care plans"
4 includes health maintenance organizations, exclusive provider
5 organizations, provider service networks, minority physician
6 networks, children's medical service networks, and pediatric
7 emergency department diversion programs authorized by this
8 chapter or the General Appropriations Act. When making
9 assignments, the agency shall take into account the following
10 criteria:
11 1. A managed care plan has sufficient network capacity
12 to meet the need of members.
13 2. The managed care plan or MediPass has previously
14 enrolled the recipient as a member, or one of the managed care
15 plan's primary care providers or MediPass providers has
16 previously provided health care to the recipient.
17 3. The agency has knowledge that the member has
18 previously expressed a preference for a particular managed
19 care plan or MediPass provider as indicated by Medicaid
20 fee-for-service claims data, but has failed to make a choice.
21 4. The managed care plan's or MediPass primary care
22 providers are geographically accessible to the recipient's
23 residence.
24 (k) When a Medicaid recipient does not choose a
25 managed care plan or MediPass provider, the agency shall
26 assign the Medicaid recipient to a managed care plan, except
27 in those counties in which there are fewer than two managed
28 care plans accepting Medicaid enrollees, in which case
29 assignment shall be to a managed care plan or a MediPass
30 provider. Medicaid recipients in counties with fewer than two
31 managed care plans accepting Medicaid enrollees who are

subject to mandatory assignment but who fail to make a choice shall be assigned to managed care plans until an ~~equal~~ enrollment of 45 ~~50~~ percent in MediPass ~~and provider service networks~~ and 55 ~~50~~ percent in managed care plans is achieved. Once that ~~equal~~ enrollment is achieved, the assignments shall be divided in order to maintain an ~~equal~~ enrollment in MediPass and managed care plans which is in a 45 percent and 55 percent proportion, respectively. When making assignments, the agency shall take into account the following criteria:

1. A managed care plan has sufficient network capacity to meet the need of members.

2. The managed care plan or MediPass has previously enrolled the recipient as a member, or one of the managed care plan's primary care providers or MediPass providers has previously provided health care to the recipient.

3. The agency has knowledge that the member has previously expressed a preference for a particular managed care plan or MediPass provider as indicated by Medicaid fee-for-service claims data, but has failed to make a choice.

4. The managed care plan's or MediPass primary care providers are geographically accessible to the recipient's residence.

5. The agency has authority to make mandatory assignments based on quality of service and performance of managed care plans.

Section 17. Section 409.913, Florida Statutes, as amended by section 12 of chapter 2001-377, Laws of Florida, is amended to read:

409.913 Oversight of the integrity of the Medicaid program.--The agency shall operate a program to oversee the activities of Florida Medicaid recipients, and providers and

1 their representatives, to ensure that fraudulent and abusive
2 behavior and neglect of recipients occur to the minimum extent
3 possible, and to recover overpayments and impose sanctions as
4 appropriate. Beginning January 1, 2003, and each year
5 thereafter, the agency and the Medicaid Fraud Control Unit of
6 the Department of Legal Affairs shall submit a joint report to
7 the Legislature documenting the effectiveness of the state's
8 efforts to control Medicaid fraud and abuse and to recover
9 Medicaid overpayments during the previous fiscal year. The
10 report must describe the number of cases opened and
11 investigated each year; the sources of the cases opened; the
12 disposition of the cases closed each year; the amount of
13 overpayments alleged in preliminary and final audit letters;
14 the number and amount of fines or penalties imposed; any
15 reductions in overpayment amounts negotiated in settlement
16 agreements or by other means; the amount of final agency
17 determinations of overpayments; the amount deducted from
18 federal claiming as a result of overpayments; the amount of
19 overpayments recovered each year; the amount of cost of
20 investigation recovered each year; the average length of time
21 to collect from the time the case was opened until the
22 overpayment is paid in full; the amount determined as
23 uncollectible and the portion of the uncollectible amount
24 subsequently reclaimed from the Federal Government; the number
25 of providers, by type, that are terminated from participation
26 in the Medicaid program as a result of fraud and abuse; and
27 all costs associated with discovering and prosecuting cases of
28 Medicaid overpayments and making recoveries in such cases. The
29 report must also document actions taken to prevent
30 overpayments and the number of providers prevented from
31 enrolling in or reenrolling in the Medicaid program as a

1 result of documented Medicaid fraud and abuse and must
2 recommend changes necessary to prevent or recover
3 overpayments. For the 2001-2002 fiscal year, the agency shall
4 prepare a report that contains as much of this information as
5 is available to it.
6 (1) For the purposes of this section, the term:
7 (a) "Abuse" means:
8 1. Provider practices that are inconsistent with
9 generally accepted business or medical practices and that
10 result in an unnecessary cost to the Medicaid program or in
11 reimbursement for goods or services that are not medically
12 necessary or that fail to meet professionally recognized
13 standards for health care.
14 2. Recipient practices that result in unnecessary cost
15 to the Medicaid program.
16 (b) "Complaint" means an allegation that fraud, abuse
17 or an overpayment has occurred.
18 (c)~~(b)~~ "Fraud" means an intentional deception or
19 misrepresentation made by a person with the knowledge that the
20 deception results in unauthorized benefit to herself or
21 himself or another person. The term includes any act that
22 constitutes fraud under applicable federal or state law.
23 (d)~~(c)~~ "Medical necessity" or "medically necessary"
24 means any goods or services necessary to palliate the effects
25 of a terminal condition, or to prevent, diagnose, correct,
26 cure, alleviate, or preclude deterioration of a condition that
27 threatens life, causes pain or suffering, or results in
28 illness or infirmity, which goods or services are provided in
29 accordance with generally accepted standards of medical
30 practice. For purposes of determining Medicaid reimbursement,
31 the agency is the final arbiter of medical necessity.

1 Determinations of medical necessity must be made by a licensed
2 physician employed by or under contract with the agency and
3 must be based upon information available at the time the goods
4 or services are provided.
5 (e)~~(d)~~ "Overpayment" includes any amount that is not
6 authorized to be paid by the Medicaid program whether paid as
7 a result of inaccurate or improper cost reporting, improper
8 claiming, unacceptable practices, fraud, abuse, or mistake.
9 (f)~~(e)~~ "Person" means any natural person, corporation,
10 partnership, association, clinic, group, or other entity,
11 whether or not such person is enrolled in the Medicaid program
12 or is a provider of health care.
13 (2) The agency shall conduct, or cause to be conducted
14 by contract or otherwise, reviews, investigations, analyses,
15 audits, or any combination thereof, to determine possible
16 fraud, abuse, overpayment, or recipient neglect in the
17 Medicaid program and shall report the findings of any
18 overpayments in audit reports as appropriate.
19 (3) The agency may conduct, or may contract for,
20 prepayment review of provider claims to ensure cost-effective
21 purchasing, billing, and provision of care to Medicaid
22 recipients. Such prepayment reviews may be conducted as
23 determined appropriate by the agency, without any suspicion or
24 allegation of fraud, abuse, or neglect.
25 (4) Any suspected criminal violation identified by the
26 agency must be referred to the Medicaid Fraud Control Unit of
27 the Office of the Attorney General for investigation. The
28 agency and the Attorney General shall enter into a memorandum
29 of understanding, which must include, but need not be limited
30 to, a protocol for regularly sharing information and
31 coordinating casework. The protocol must establish a

1 procedure for the referral by the agency of cases involving
2 suspected Medicaid fraud to the Medicaid Fraud Control Unit
3 for investigation, and the return to the agency of those cases
4 where investigation determines that administrative action by
5 the agency is appropriate. Offices of the Medicaid program
6 integrity program and the Medicaid Fraud Control Unit of the
7 Department of Legal Affairs, shall, to the extent possible, be
8 collocated. The agency and the Department of Legal Affairs
9 shall periodically conduct joint training and other joint
10 activities designed to increase communication and coordination
11 in recovering overpayments.
12 (5) A Medicaid provider is subject to having goods and
13 services that are paid for by the Medicaid program reviewed by
14 an appropriate peer-review organization designated by the
15 agency. The written findings of the applicable peer-review
16 organization are admissible in any court or administrative
17 proceeding as evidence of medical necessity or the lack
18 thereof.
19 (6) Any notice required to be given to a provider
20 under this section is presumed to be sufficient notice if sent
21 to the address last shown on the provider enrollment file. It
22 is the responsibility of the provider to furnish and keep the
23 agency informed of the provider's current address. United
24 States Postal Service proof of mailing or certified or
25 registered mailing of such notice to the provider at the
26 address shown on the provider enrollment file constitutes
27 sufficient proof of notice. Any notice required to be given to
28 the agency by this section must be sent to the agency at an
29 address designated by rule.
30 (7) When presenting a claim for payment under the
31 Medicaid program, a provider has an affirmative duty to

1 supervise the provision of, and be responsible for, goods and
2 services claimed to have been provided, to supervise and be
3 responsible for preparation and submission of the claim, and
4 to present a claim that is true and accurate and that is for
5 goods and services that:
6 (a) Have actually been furnished to the recipient by
7 the provider prior to submitting the claim.
8 (b) Are Medicaid-covered goods or services that are
9 medically necessary.
10 (c) Are of a quality comparable to those furnished to
11 the general public by the provider's peers.
12 (d) Have not been billed in whole or in part to a
13 recipient or a recipient's responsible party, except for such
14 copayments, coinsurance, or deductibles as are authorized by
15 the agency.
16 (e) Are provided in accord with applicable provisions
17 of all Medicaid rules, regulations, handbooks, and policies
18 and in accordance with federal, state, and local law.
19 (f) Are documented by records made at the time the
20 goods or services were provided, demonstrating the medical
21 necessity for the goods or services rendered. Medicaid goods
22 or services are excessive or not medically necessary unless
23 both the medical basis and the specific need for them are
24 fully and properly documented in the recipient's medical
25 record.
26 (8) A Medicaid provider shall retain medical,
27 professional, financial, and business records pertaining to
28 services and goods furnished to a Medicaid recipient and
29 billed to Medicaid for a period of 5 years after the date of
30 furnishing such services or goods. The agency may investigate,
31 review, or analyze such records, which must be made available

1 during normal business hours. However, 24-hour notice must be
2 provided if patient treatment would be disrupted. The provider
3 is responsible for furnishing to the agency, and keeping the
4 agency informed of the location of, the provider's
5 Medicaid-related records. The authority of the agency to
6 obtain Medicaid-related records from a provider is neither
7 curtailed nor limited during a period of litigation between
8 the agency and the provider.
9 (9) Payments for the services of billing agents or
10 persons participating in the preparation of a Medicaid claim
11 shall not be based on amounts for which they bill nor based on
12 the amount a provider receives from the Medicaid program.
13 (10) The agency may require repayment for
14 inappropriate, medically unnecessary, or excessive goods or
15 services from the person furnishing them, the person under
16 whose supervision they were furnished, or the person causing
17 them to be furnished.
18 (11) The complaint and all information obtained
19 pursuant to an investigation of a Medicaid provider, or the
20 authorized representative or agent of a provider, relating to
21 an allegation of fraud, abuse, or neglect are confidential and
22 exempt from the provisions of s. 119.07(1):
23 (a) Until the agency takes final agency action with
24 respect to the provider and requires repayment of any
25 overpayment, or imposes an administrative sanction;
26 (b) Until the Attorney General refers the case for
27 criminal prosecution;
28 (c) Until 10 days after the complaint is determined
29 without merit; or
30 (d) At all times if the complaint or information is
31 otherwise protected by law.

1 (12) The agency may terminate participation of a
2 Medicaid provider in the Medicaid program and may seek civil
3 remedies or impose other administrative sanctions against a
4 Medicaid provider, if the provider has been:
5 (a) Convicted of a criminal offense related to the
6 delivery of any health care goods or services, including the
7 performance of management or administrative functions relating
8 to the delivery of health care goods or services;
9 (b) Convicted of a criminal offense under federal law
10 or the law of any state relating to the practice of the
11 provider's profession; or
12 (c) Found by a court of competent jurisdiction to have
13 neglected or physically abused a patient in connection with
14 the delivery of health care goods or services.
15 (13) If the provider has been suspended or terminated
16 from participation in the Medicaid program or the Medicare
17 program by the Federal Government or any state, the agency
18 must immediately suspend or terminate, as appropriate, the
19 provider's participation in the Florida Medicaid program for a
20 period no less than that imposed by the Federal Government or
21 any other state, and may not enroll such provider in the
22 Florida Medicaid program while such foreign suspension or
23 termination remains in effect. This sanction is in addition
24 to all other remedies provided by law.
25 (14) The agency may seek any remedy provided by law,
26 including, but not limited to, the remedies provided in
27 subsections (12) and (15) and s. 812.035, if:
28 (a) The provider's license has not been renewed, or
29 has been revoked, suspended, or terminated, for cause, by the
30 licensing agency of any state;
31 (b) The provider has failed to make available or has

1 refused access to Medicaid-related records to an auditor,
2 investigator, or other authorized employee or agent of the
3 agency, the Attorney General, a state attorney, or the Federal
4 Government;
5 (c) The provider has not furnished or has failed to
6 make available such Medicaid-related records as the agency has
7 found necessary to determine whether Medicaid payments are or
8 were due and the amounts thereof;
9 (d) The provider has failed to maintain medical
10 records made at the time of service, or prior to service if
11 prior authorization is required, demonstrating the necessity
12 and appropriateness of the goods or services rendered;
13 (e) The provider is not in compliance with provisions
14 of Medicaid provider publications that have been adopted by
15 reference as rules in the Florida Administrative Code; with
16 provisions of state or federal laws, rules, or regulations;
17 with provisions of the provider agreement between the agency
18 and the provider; or with certifications found on claim forms
19 or on transmittal forms for electronically submitted claims
20 that are submitted by the provider or authorized
21 representative, as such provisions apply to the Medicaid
22 program;
23 (f) The provider or person who ordered or prescribed
24 the care, services, or supplies has furnished, or ordered the
25 furnishing of, goods or services to a recipient which are
26 inappropriate, unnecessary, excessive, or harmful to the
27 recipient or are of inferior quality;
28 (g) The provider has demonstrated a pattern of failure
29 to provide goods or services that are medically necessary;
30 (h) The provider or an authorized representative of
31 the provider, or a person who ordered or prescribed the goods

1 or services, has submitted or caused to be submitted false or
2 a pattern of erroneous Medicaid claims that have resulted in
3 overpayments to a provider or that exceed those to which the
4 provider was entitled under the Medicaid program;
5 (i) The provider or an authorized representative of
6 the provider, or a person who has ordered or prescribed the
7 goods or services, has submitted or caused to be submitted a
8 Medicaid provider enrollment application, a request for prior
9 authorization for Medicaid services, a drug exception request,
10 or a Medicaid cost report that contains materially false or
11 incorrect information;
12 (j) The provider or an authorized representative of
13 the provider has collected from or billed a recipient or a
14 recipient's responsible party improperly for amounts that
15 should not have been so collected or billed by reason of the
16 provider's billing the Medicaid program for the same service;
17 (k) The provider or an authorized representative of
18 the provider has included in a cost report costs that are not
19 allowable under a Florida Title XIX reimbursement plan, after
20 the provider or authorized representative had been advised in
21 an audit exit conference or audit report that the costs were
22 not allowable;
23 (l) The provider is charged by information or
24 indictment with fraudulent billing practices. The sanction
25 applied for this reason is limited to suspension of the
26 provider's participation in the Medicaid program for the
27 duration of the indictment unless the provider is found guilty
28 pursuant to the information or indictment;
29 (m) The provider or a person who has ordered, or
30 prescribed the goods or services is found liable for negligent
31 practice resulting in death or injury to the provider's

1 patient;
2 (n) The provider fails to demonstrate that it had
3 available during a specific audit or review period sufficient
4 quantities of goods, or sufficient time in the case of
5 services, to support the provider's billings to the Medicaid
6 program;
7 (o) The provider has failed to comply with the notice
8 and reporting requirements of s. 409.907; ~~or~~
9 (p) The agency has received reliable information of
10 patient abuse or neglect or of any act prohibited by s.
11 409.920; or~~.~~
12 (q) The provider has failed to comply with an
13 agreed-upon repayment schedule.
14 (15) The agency shall ~~may~~ impose any of the following
15 sanctions or disincentives on a provider or a person for any
16 of the acts described in subsection (14):
17 (a) Suspension for a specific period of time of not
18 more than 1 year.
19 (b) Termination for a specific period of time of from
20 more than 1 year to 20 years.
21 (c) Imposition of a fine of up to $5,000 for each
22 violation. Each day that an ongoing violation continues, such
23 as refusing to furnish Medicaid-related records or refusing
24 access to records, is considered, for the purposes of this
25 section, to be a separate violation. Each instance of
26 improper billing of a Medicaid recipient; each instance of
27 including an unallowable cost on a hospital or nursing home
28 Medicaid cost report after the provider or authorized
29 representative has been advised in an audit exit conference or
30 previous audit report of the cost unallowability; each
31 instance of furnishing a Medicaid recipient goods or

professional services that are inappropriate or of inferior quality as determined by competent peer judgment; each instance of knowingly submitting a materially false or erroneous Medicaid provider enrollment application, request for prior authorization for Medicaid services, drug exception request, or cost report; each instance of inappropriate prescribing of drugs for a Medicaid recipient as determined by competent peer judgment; and each false or erroneous Medicaid claim leading to an overpayment to a provider is considered, for the purposes of this section, to be a separate violation.

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

(e) A fine, not to exceed $10,000, for a violation of paragraph (14)(i).

(f) Imposition of liens against provider assets, including, but not limited to, financial assets and real property, not to exceed the amount of fines or recoveries sought, upon entry of an order determining that such moneys are due or recoverable.

<u>(g) Prepayment reviews of claims for a specified period of time.</u>

<u>(h) Comprehensive follow-up reviews of providers every 6 months to ensure that they are billing Medicaid correctly.</u>

<u>(i) Corrective-action plans that would remain in effect for providers for up to 3 years and that would be monitored by the agency every 6 months while in effect.</u>

<u>(j)</u>~~(g)~~ Other remedies as permitted by law to effect the recovery of a fine or overpayment.

1 The Secretary of Health Care Administration may make a
2 determination that imposition of a sanction or disincentive is
3 not in the best interest of the Medicaid program, in which
4 case a sanction or disincentive shall not be imposed.
5 (16) In determining the appropriate administrative
6 sanction to be applied, or the duration of any suspension or
7 termination, the agency shall consider:
8 (a) The seriousness and extent of the violation or
9 violations.
10 (b) Any prior history of violations by the provider
11 relating to the delivery of health care programs which
12 resulted in either a criminal conviction or in administrative
13 sanction or penalty.
14 (c) Evidence of continued violation within the
15 provider's management control of Medicaid statutes, rules,
16 regulations, or policies after written notification to the
17 provider of improper practice or instance of violation.
18 (d) The effect, if any, on the quality of medical care
19 provided to Medicaid recipients as a result of the acts of the
20 provider.
21 (e) Any action by a licensing agency respecting the
22 provider in any state in which the provider operates or has
23 operated.
24 (f) The apparent impact on access by recipients to
25 Medicaid services if the provider is suspended or terminated,
26 in the best judgment of the agency.
27
28 The agency shall document the basis for all sanctioning
29 actions and recommendations.
30 (17) The agency may take action to sanction, suspend,
31 or terminate a particular provider working for a group

1 provider, and may suspend or terminate Medicaid participation
2 at a specific location, rather than or in addition to taking
3 action against an entire group.
4 (18) The agency shall establish a process for
5 conducting followup reviews of a sampling of providers who
6 have a history of overpayment under the Medicaid program.
7 This process must consider the magnitude of previous fraud or
8 abuse and the potential effect of continued fraud or abuse on
9 Medicaid costs.
10 (19) In making a determination of overpayment to a
11 provider, the agency must use accepted and valid auditing,
12 accounting, analytical, statistical, or peer-review methods,
13 or combinations thereof. Appropriate statistical methods may
14 include, but are not limited to, sampling and extension to the
15 population, parametric and nonparametric statistics, tests of
16 hypotheses, and other generally accepted statistical methods.
17 Appropriate analytical methods may include, but are not
18 limited to, reviews to determine variances between the
19 quantities of products that a provider had on hand and
20 available to be purveyed to Medicaid recipients during the
21 review period and the quantities of the same products paid for
22 by the Medicaid program for the same period, taking into
23 appropriate consideration sales of the same products to
24 non-Medicaid customers during the same period. In meeting its
25 burden of proof in any administrative or court proceeding, the
26 agency may introduce the results of such statistical methods
27 as evidence of overpayment.
28 (20) When making a determination that an overpayment
29 has occurred, the agency shall prepare and issue an audit
30 report to the provider showing the calculation of
31 overpayments.

1 (21) The audit report, supported by agency work
2 papers, showing an overpayment to a provider constitutes
3 evidence of the overpayment. A provider may not present or
4 elicit testimony, either on direct examination or
5 cross-examination in any court or administrative proceeding,
6 regarding the purchase or acquisition by any means of drugs,
7 goods, or supplies; sales or divestment by any means of drugs,
8 goods, or supplies; or inventory of drugs, goods, or supplies,
9 unless such acquisition, sales, divestment, or inventory is
10 documented by written invoices, written inventory records, or
11 other competent written documentary evidence maintained in the
12 normal course of the provider's business. Notwithstanding the
13 applicable rules of discovery, all documentation that will be
14 offered as evidence at an administrative hearing on a Medicaid
15 overpayment must be exchanged by all parties at least 14 days
16 before the administrative hearing or must be excluded from
17 consideration.
18 (22)(a) In an audit or investigation of a violation
19 committed by a provider which is conducted pursuant to this
20 section, the agency is entitled to recover all investigative,
21 legal, and expert witness costs if the agency's findings were
22 not contested by the provider or, if contested, the agency
23 ultimately prevailed.
24 (b) The agency has the burden of documenting the
25 costs, which include salaries and employee benefits and
26 out-of-pocket expenses. The amount of costs that may be
27 recovered must be reasonable in relation to the seriousness of
28 the violation and must be set taking into consideration the
29 financial resources, earning ability, and needs of the
30 provider, who has the burden of demonstrating such factors.
31 (c) The provider may pay the costs over a period to be

1 determined by the agency if the agency determines that an
2 extreme hardship would result to the provider from immediate
3 full payment. Any default in payment of costs may be
4 collected by any means authorized by law.
5 (23) If the agency imposes an administrative sanction
6 under this section upon any provider or other person who is
7 regulated by another state entity, the agency shall notify
8 that other entity of the imposition of the sanction. Such
9 notification must include the provider's or person's name and
10 license number and the specific reasons for sanction.
11 (24)(a) The agency may withhold Medicaid payments, in
12 whole or in part, to a provider upon receipt of reliable
13 evidence that the circumstances giving rise to the need for a
14 withholding of payments involve fraud, willful
15 misrepresentation, or abuse under the Medicaid program, or a
16 crime committed while rendering goods or services to Medicaid
17 recipients, pending completion of legal proceedings. If it is
18 determined that fraud, willful misrepresentation, abuse, or a
19 crime did not occur, the payments withheld must be paid to the
20 provider within 14 days after such determination with interest
21 at the rate of 10 percent a year. Any money withheld in
22 accordance with this paragraph shall be placed in a suspended
23 account, readily accessible to the agency, so that any payment
24 ultimately due the provider shall be made within 14 days.
25 (b) Overpayments owed to the agency bear interest at
26 the rate of 10 percent per year from the date of determination
27 of the overpayment by the agency, and payment arrangements
28 must be made at the conclusion of legal proceedings. A
29 provider who does not enter into or adhere to an agreed-upon
30 repayment schedule may be terminated by the agency for
31 nonpayment or partial payment.

1 (c) The agency, upon entry of a final agency order, a
2 judgment or order of a court of competent jurisdiction, or a
3 stipulation or settlement, may collect the moneys owed by all
4 means allowable by law, including, but not limited to,
5 notifying any fiscal intermediary of Medicare benefits that
6 the state has a superior right of payment. Upon receipt of
7 such written notification, the Medicare fiscal intermediary
8 shall remit to the state the sum claimed.
9 (25) The agency may impose administrative sanctions
10 against a Medicaid recipient, or the agency may seek any other
11 remedy provided by law, including, but not limited to, the
12 remedies provided in s. 812.035, if the agency finds that a
13 recipient has engaged in solicitation in violation of s.
14 409.920 or that the recipient has otherwise abused the
15 Medicaid program.
16 (26) When the Agency for Health Care Administration
17 has made a probable cause determination and alleged that an
18 overpayment to a Medicaid provider has occurred, the agency,
19 after notice to the provider, may:
20 (a) Withhold, and continue to withhold during the
21 pendency of an administrative hearing pursuant to chapter 120,
22 any medical assistance reimbursement payments until such time
23 as the overpayment is recovered, unless within 30 days after
24 receiving notice thereof the provider:
25 1. Makes repayment in full; or
26 2. Establishes a repayment plan that is satisfactory
27 to the Agency for Health Care Administration.
28 (b) Withhold, and continue to withhold during the
29 pendency of an administrative hearing pursuant to chapter 120,
30 medical assistance reimbursement payments if the terms of a
31 repayment plan are not adhered to by the provider.

~~If a provider requests an administrative hearing pursuant to chapter 120, such hearing must be conducted within 90 days following receipt by the provider of the final audit report, absent exceptionally good cause shown as determined by the administrative law judge or hearing officer. Upon issuance of a final order, the balance outstanding of the amount determined to constitute the overpayment shall become due. Any withholding of payments by the Agency for Health Care Administration pursuant to this section shall be limited so that the monthly medical assistance payment is not reduced by more than 10 percent.~~

(27) Venue for all Medicaid program integrity overpayment cases shall lie in Leon County, at the discretion of the agency.

(28) Notwithstanding other provisions of law, the agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs may review a provider's Medicaid-related records in order to determine the total output of a provider's practice to reconcile quantities of goods or services billed to Medicaid against quantities of goods or services used in the provider's total practice.

(29) The agency may terminate a provider's participation in the Medicaid program if the provider fails to reimburse an overpayment that has been determined by final order within 35 days after the date of the final order, unless the provider and the agency have entered into a repayment agreement. If the final order is overturned on appeal, the provider shall be reinstated.

(30) If a provider requests an administrative hearing pursuant to chapter 120, such hearing must be conducted within

1 90 days following assignment of an administrative law judge,
2 absent exceptionally good cause shown as determined by the
3 administrative law judge or hearing officer. Upon issuance of
4 a final order, the outstanding balance of the amount
5 determined to constitute the overpayment shall become due. If
6 a provider fails to make payments in full, fails to enter into
7 a satisfactory repayment plan, or fails to comply with the
8 terms of a repayment plan or settlement agreement, the agency
9 may withhold medical-assistance-reimbursement payments until
10 the amount due is paid in full.
11 (31) Duly authorized agents and employees of the
12 agency shall have the power to inspect, during normal business
13 hours, the records of any pharmacy, wholesale establishment,
14 or manufacturer, or any other place in which drugs and medical
15 supplies are manufactured, packed, packaged, made, stored,
16 sold, or kept for sale, for the purpose of verifying the
17 amount of drugs and medical supplies ordered, delivered, or
18 purchased by a provider. The agency shall provide at least 2
19 business days' prior notice of any such inspection. The notice
20 must identify the provider whose records will be inspected,
21 and the inspection shall include only records specifically
22 related to that provider.
23 (32) The agency shall request that the Attorney
24 General review any settlement of an overpayment in which the
25 agency reduces the amount due to the state by $10,000 or more.
26 (33) With respect to recoveries of Medicaid
27 overpayments collected by the agency, by September 30 each
28 year the agency shall credit a county on its county billing
29 invoices for the county's proportionate share of Medicaid
30 overpayments recovered during the previous fiscal year from
31 hospitals for inpatient services and from nursing homes.

1 However, if a county has been billed for its participation but
2 has not paid the amount due, the agency shall offset that
3 amount and notify the county of the amount of the offset. If
4 the county has divided its financial responsibility between
5 the county and a special taxing district or authority as
6 provided in s. 409.915(6), the county must proportionately
7 divide any credit or offset in accordance with the proration
8 that it has established. The credit or offset shall be
9 calculated separately for inpatient and nursing home services
10 as follows:
11 (a) The state share of the amount recovered from
12 hospitals for inpatient services and from nursing homes for
13 which the county has not previously received credit;
14 (b) Less the state share of the agency's cost of
15 recovering such payment; and
16 (c) Multiplied by the total county share. The total
17 county share shall be calculated as the sum of total county
18 billing for inpatient services and nursing home services,
19 respectively, divided by the state share of Medicaid
20 expenditures for inpatient services and nursing home services,
21 respectively.
22
23 The credit given to each county shall be its proportionate
24 share of the total county share calculated under paragraph
25 (c).
26 Section 18. Subsections (7) and (8) of section
27 409.920, Florida Statutes, are amended to read:
28 409.920 Medicaid provider fraud.--
29 (7) The Attorney General shall conduct a statewide
30 program of Medicaid fraud control. To accomplish this purpose,
31 the Attorney General shall:

(a) Investigate the possible criminal violation of any applicable state law pertaining to fraud in the administration of the Medicaid program, in the provision of medical assistance, or in the activities of providers of health care under the Medicaid program.

(b) Investigate the alleged abuse or neglect of patients in health care facilities receiving payments under the Medicaid program, in coordination with the agency.

(c) Investigate the alleged misappropriation of patients' private funds in health care facilities receiving payments under the Medicaid program.

(d) Refer to the Office of Statewide Prosecution or the appropriate state attorney all violations indicating a substantial potential for criminal prosecution.

(e) Refer to the agency all suspected abusive activities not of a criminal or fraudulent nature.

~~(f) Refer to the agency for collection each instance of overpayment to a provider of health care under the Medicaid program which is discovered during the course of an investigation.~~

(f)~~(g)~~ 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, or both, without the patient's written consent.

(g) 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 bring a civil action under the Florida False Claims Act to obtain a monetary award.

(8) In carrying out the duties and responsibilities

1 under this section subsection, the Attorney General may:
2 (a) Enter upon the premises of any health care
3 provider, excluding a physician, participating in the Medicaid
4 program to examine all accounts and records that may, in any
5 manner, be relevant in determining the existence of fraud in
6 the Medicaid program, to investigate alleged abuse or neglect
7 of patients, or to investigate alleged misappropriation of
8 patients' private funds. A participating physician is required
9 to make available any accounts or records that may, in any
10 manner, be relevant in determining the existence of fraud in
11 the Medicaid program. The accounts or records of a
12 non-Medicaid patient may not be reviewed by, or turned over
13 to, the Attorney General without the patient's written
14 consent.
15 (b) Subpoena witnesses or materials, including medical
16 records relating to Medicaid recipients, within or outside the
17 state and, through any duly designated employee, administer
18 oaths and affirmations and collect evidence for possible use
19 in either civil or criminal judicial proceedings.
20 (c) Request and receive the assistance of any state
21 attorney or law enforcement agency in the investigation and
22 prosecution of any violation of this section.
23 (d) Seek any civil remedy provided by law, including,
24 but not limited to, the remedies provided in ss.
25 68.081-68.092, s. 812.035, and this chapter.
26 (e) Refer to the agency for collection each instance
27 of overpayment to a provider of health care under the Medicaid
28 program which is discovered during the course of an
29 investigation.
30 Section 19. Paragraph (a) of subsection (1) of section
31 499.012, Florida Statutes, is amended to read:

1 499.012 Wholesale distribution; definitions; permits;
2 general requirements.--
3 (1) As used in this section, the term:
4 (a) "Wholesale distribution" means distribution of
5 prescription drugs to persons other than a consumer or
6 patient, but does not include:
7 1. Any of the following activities, which is not a
8 violation of s. 499.005(21) if such activity is conducted in
9 accordance with s. 499.014:
10 a. The purchase or other acquisition by a hospital or
11 other health care entity that is a member of a group
12 purchasing organization of a prescription drug for its own use
13 from the group purchasing organization or from other hospitals
14 or health care entities that are members of that organization.
15 b. The sale, purchase, or trade of a prescription drug
16 or an offer to sell, purchase, or trade a prescription drug by
17 a charitable organization described in s. 501(c)(3) of the
18 Internal Revenue Code of 1986, as amended and revised, to a
19 nonprofit affiliate of the organization to the extent
20 otherwise permitted by law.
21 c. The sale, purchase, or trade of a prescription drug
22 or an offer to sell, purchase, or trade a prescription drug
23 among hospitals or other health care entities that are under
24 common control. For purposes of this section, "common control"
25 means the power to direct or cause the direction of the
26 management and policies of a person or an organization,
27 whether by ownership of stock, by voting rights, by contract,
28 or otherwise.
29 d. The sale, purchase, trade, or other transfer of a
30 prescription drug from or for any federal, state, or local
31 government agency or any entity eligible to purchase

1 prescription drugs at public health services prices pursuant
2 to Pub. L. No. 102-585, s. 602 to a contract provider or its
3 subcontractor for eligible patients of the agency or entity
4 under the following conditions:
5 (I) The agency or entity must obtain written
6 authorization for the sale, purchase, trade, or other transfer
7 of a prescription drug under this sub-subparagraph from the
8 Secretary of Health or his or her designee.
9 (II) The contract provider or subcontractor must be
10 authorized by law to administer or dispense prescription
11 drugs.
12 (III) In the case of a subcontractor, the agency or
13 entity must be a party to and execute the subcontract.
14 (IV) A contract provider or subcontractor must
15 maintain separate and apart from other prescription drug
16 inventory any prescription drugs of the agency or entity in
17 its possession.
18 (V) The contract provider and subcontractor must
19 maintain and produce immediately for inspection all records of
20 movement or transfer of all the prescription drugs belonging
21 to the agency or entity, including, but not limited to, the
22 records of receipt and disposition of prescription drugs. Each
23 contractor and subcontractor dispensing or administering these
24 drugs must maintain and produce records documenting the
25 dispensing or administration. Records that are required to be
26 maintained include, but are not limited to, a perpetual
27 inventory itemizing drugs received and drugs dispensed by
28 prescription number or administered by patient identifier,
29 which must be submitted to the agency or entity quarterly.
30 (VI) The contract provider or subcontractor may
31 administer or dispense the prescription drugs only to the

1 eligible patients of the agency or entity or must return the
2 prescription drugs for or to the agency or entity. The
3 contract provider or subcontractor must require proof from
4 each person seeking to fill a prescription or obtain treatment
5 that the person is an eligible patient of the agency or entity
6 and must, at a minimum, maintain a copy of this proof as part
7 of the records of the contractor or subcontractor required
8 under sub-sub-subparagraph (V).
9 ~~(VII) The prescription drugs transferred pursuant to~~
10 ~~this sub-subparagraph may not be billed to Medicaid.~~
11 (VII)~~(VIII)~~ In addition to the departmental inspection
12 authority set forth in s. 499.051, the establishment of the
13 contract provider and subcontractor and all records pertaining
14 to prescription drugs subject to this sub-subparagraph shall
15 be subject to inspection by the agency or entity. All records
16 relating to prescription drugs of a manufacturer under this
17 sub-subparagraph shall be subject to audit by the manufacturer
18 of those drugs, without identifying individual patient
19 information.
20 2. Any of the following activities, which is not a
21 violation of s. 499.005(21) if such activity is conducted in
22 accordance with rules established by the department:
23 a. The sale, purchase, or trade of a prescription drug
24 among federal, state, or local government health care entities
25 that are under common control and are authorized to purchase
26 such prescription drug.
27 b. The sale, purchase, or trade of a prescription drug
28 or an offer to sell, purchase, or trade a prescription drug
29 for emergency medical reasons. For purposes of this
30 sub-subparagraph, the term "emergency medical reasons"
31 includes transfers of prescription drugs by a retail pharmacy

1 to another retail pharmacy to alleviate a temporary shortage.
2 c. The transfer of a prescription drug acquired by a
3 medical director on behalf of a licensed emergency medical
4 services provider to that emergency medical services provider
5 and its transport vehicles for use in accordance with the
6 provider's license under chapter 401.
7 d. The revocation of a sale or the return of a
8 prescription drug to the person's prescription drug wholesale
9 supplier.
10 e. The donation of a prescription drug by a health
11 care entity to a charitable organization that has been granted
12 an exemption under s. 501(c)(3) of the Internal Revenue Code
13 of 1986, as amended, and that is authorized to possess
14 prescription drugs.
15 f. The transfer of a prescription drug by a person
16 authorized to purchase or receive prescription drugs to a
17 person licensed or permitted to handle reverse distributions
18 or destruction under the laws of the jurisdiction in which the
19 person handling the reverse distribution or destruction
20 receives the drug.
21 3. The distribution of prescription drug samples by
22 manufacturers' representatives or distributors'
23 representatives conducted in accordance with s. 499.028.
24 4. The sale, purchase, or trade of blood and blood
25 components intended for transfusion. As used in this
26 subparagraph, the term "blood" means whole blood collected
27 from a single donor and processed either for transfusion or
28 further manufacturing, and the term "blood components" means
29 that part of the blood separated by physical or mechanical
30 means.
31 5. The lawful dispensing of a prescription drug in

1 accordance with chapter 465.
2 Section 20. (1) The Agency for Health Care
3 Administration shall conduct a study of health care services
4 provided to the medically fragile or
5 medical-technology-dependent children in the state and conduct
6 a pilot program in Miami-Dade County to provide subacute
7 pediatric transitional care to a maximum of 30 children at any
8 one time. The purposes of the study and the pilot program are
9 to determine ways to permit medically fragile or
10 medical-technology-dependent children to successfully make a
11 transition from acute care in a health care institution to
12 live with their families when possible, and to provide
13 cost-effective, subacute transitional care services.
14 (2) The Agency for Health Care Administration, in
15 cooperation with the Children's Medical Services Program in
16 the Department of Health, shall conduct a study to identify
17 the total number of medically fragile or
18 medical-technology-dependent children, from birth through age
19 21, in the state. By January 1, 2003, the agency must report
20 to the Legislature regarding the children's ages, the
21 locations where the children are served, the types of services
22 received, itemized costs of the services, and the sources of
23 funding that pay for the services, including the proportional
24 share when more than one funding source pays for a service.
25 The study must include information regarding medically fragile
26 or medical-technology-dependent children residing in
27 hospitals, nursing homes, and medical foster care, and those
28 who live with their parents. The study must describe children
29 served in prescribed pediatric extended-care centers,
30 including their ages and the services they receive. The report
31 must identify the total services provided for each child and

1 the method for paying for those services. The report must also
2 identify the number of such children who could, if appropriate
3 transitional services were available, return home or move to a
4 less-institutional setting.
5 (3) Within 30 days after the effective date of this
6 act, the agency shall establish minimum staffing standards and
7 quality requirements for a subacute pediatric transitional
8 care center to be operated as a 2-year pilot program in Dade
9 County. The pilot program must operate under the license of a
10 hospital licensed under chapter 395, Florida Statutes, or a
11 nursing home licensed under chapter 400, Florida Statutes, and
12 shall use existing beds in the hospital or nursing home. A
13 child's placement in the subacute pediatric transitional care
14 center may not exceed 90 days. The center shall arrange for an
15 alternative placement at the end of a child's stay and a
16 transitional plan for children expected to remain in the
17 facility for the maximum allowed stay.
18 (4) Within 60 days after the effective date of this
19 act, the agency must amend the state Medicaid plan and request
20 any federal waivers necessary to implement and fund the pilot
21 program.
22 (5) The subacute pediatric transitional care center
23 must require level I background screening as provided in
24 chapter 435, Florida Statutes, for all employees or
25 prospective employees of the center who are expected to, or
26 whose responsibilities may require them to, provide personal
27 care or services to children, have access to children's living
28 areas, or have access to children's funds or personal
29 property.
30 (6) The subacute pediatric transitional care center
31 must have an advisory board. Membership on the advisory board

1 must include, but need not be limited to:
2 (a) A physician and an advanced registered nurse
3 practitioner who is familiar with services for medically
4 fragile or medical-technology-dependent children;
5 (b) A registered nurse who has experience in the care
6 of medically fragile or medical-technology-dependent children;
7 (c) A child development specialist who has experience
8 in the care of medically fragile or
9 medical-technology-dependent children and their families;
10 (d) A social worker who has experience in the care of
11 medically fragile or medical-technology-dependent children and
12 their families; and
13 (e) A consumer representative who is a parent or
14 guardian of a child placed in the center.
15 (7) The advisory board shall:
16 (a) Review the policy and procedure components of the
17 center to assure conformance with applicable standards
18 developed by the Agency for Health Care Administration; and
19 (b) Provide consultation with respect to the
20 operational and programmatic components of the center.
21 (8) The subacute pediatric transitional care center
22 must have written policies and procedures governing the
23 admission, transfer, and discharge of children.
24 (9) The admission of each child to the center must be
25 under the supervision of the center nursing administrator or
26 his or her designee, and must be in accordance with the
27 center's policies and procedures. Each Medicaid admission must
28 be approved as appropriate for placement in the facility by
29 the Children's Medical Services Multidisciplinary Assessment
30 Team of the Department of Health, in conjunction with the
31 Agency for Health Care Administration.

1 (10) Each child admitted to the center shall be
2 admitted upon prescription of the medical director of the
3 center, licensed pursuant to chapter 458 or chapter 459,
4 Florida Statutes, and the child shall remain under the care of
5 the medical director and the advanced registered nurse
6 practitioner for the duration of his or her stay in the
7 center.
8 (11) Each child admitted to the center must meet at
9 least the following criteria:
10 (a) The child must be medically fragile or
11 medical-technology-dependent.
12 (b) The child may not, prior to admission, present
13 significant risk of infection to other children or personnel.
14 The medical and nursing directors shall review, on a
15 case-by-case basis, the condition of any child who is
16 suspected of having an infectious disease to determine whether
17 admission is appropriate.
18 (c) The child must be medically stabilized and require
19 skilled nursing care or other interventions.
20 (12) If the child meets the criteria specified in
21 paragraphs (11)(a), (b), and (c), the medical director or
22 nursing director of the center shall implement a preadmission
23 plan that delineates services to be provided and appropriate
24 sources for such services.
25 (a) If the child is hospitalized at the time of
26 referral, preadmission planning must include the participation
27 of the child's parent or guardian and relevant medical,
28 nursing, social services, and developmental staff to assure
29 that the hospital's discharge plans will be implemented
30 following the child's placement in the center.
31 (b) A consent form, outlining the purpose of the

1 center, family responsibilities, authorized treatment,
2 appropriate release of liability, and emergency disposition
3 plans, must be signed by the parent or guardian and witnessed
4 before the child is admitted to the center. The parent or
5 guardian shall be provided a copy of the consent form.
6 (13) By January 1, 2003, the Agency for Health Care
7 Administration shall report to the Legislature concerning the
8 progress of the pilot program. By January 1, 2004, the agency
9 shall submit to the Legislature a report on the success of the
10 pilot program.
11 Section 21. The Office of Legislative Services shall
12 contract for a business case study of the feasibility of
13 outsourcing the administrative, investigative, legal, and
14 prosecutorial functions and other tasks and services that are
15 necessary to carry out the regulatory responsibilities of the
16 Board of Dentistry, employing its own executive director and
17 other staff, and obtaining authority over collections and
18 expenditures of funds paid by professions regulated by the
19 board into the Medical Quality Assurance Trust Fund. This
20 feasibility study must include a business plan and an
21 assessment of the direct and indirect costs associated with
22 outsourcing these functions. The sum of $50,000 is
23 appropriated from the Board of Dentistry account within the
24 Medical Quality Assurance Trust Fund to the Office of
25 Legislative Services for the purpose of contracting for the
26 study. The Office of Legislative Services shall submit the
27 completed study to the Governor, the President of the Senate,
28 and the Speaker of the House of Representatives by January 1,
29 2003.
30 Section 22. (1) Notwithstanding section 409.911(3),
31 Florida Statutes, for the state fiscal year 2002-2003 only,

the agency shall distribute moneys under the regular disproportionate share program only to hospitals that meet the federal minimum requirements and to public hospitals. Public hospitals are defined as those hospitals identified as government owned or operated in the Financial Hospital Uniform Reporting System (FHURS) data available to the agency as of January 1, 2002. The following methodology shall be used to distribute disproportionate share dollars to hospitals that meet the federal minimum requirements and to the public hospitals:

(a) For hospitals that meet the federal minimum requirements, the following formula shall be used:

TAA = TA * (1/5.5)

DSHP = (HMD/TMSD)*TA

TAA = total amount available.

TA = total appropriation.

DSHP = disproportionate share hospital payment.

HMD = hospital Medicaid days.

TSD = total state Medicaid days.

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

1. For state mental health hospitals:

DSHP = (HMD/TMD) * TAAMH

The total amount available for the state mental health hospitals shall be the difference between the federal cap for Institutions for

1 Mental Diseases and the amounts paid under the
2 mental health disproportionate share program.
3 2. For non-state government owned or operated
4 hospitals with 3,200 or more Medicaid days:
5
6 DSHP = [(.85*HCCD/TCCD) + (.15*HMD/TMD)] *
7 TAAPH
8 TAAPH = TAA - TAAMH
9
10 3. For non-state government owned or operated
11 hospitals with less than 3,200 Medicaid days, a total of
12 $400,000 shall be distributed equally among these hospitals.
13
14 Where:
15
16 TAA = total available appropriation.
17 TAAPH = total amount available for public
18 hospitals.
19 TAAMH = total amount available for mental
20 health hospitals.
21 DSHP = disproportionate share hospital
22 payments.
23 HMD = hospital Medicaid days.
24 TMD = total state Medicaid days for public
25 hospitals.
26 HCCD = hospital charity care dollars.
27 TCCD = total state charity care dollars for
28 public hospitals.
29
30 In computing the above amounts for public hospitals and
31 hospitals that qualify under the federal minimum requirements,

1 the agency shall use the 1997 audited data. In the event there
2 is no 1997 audited data for a hospital, the agency shall use
3 the 1994 audited data.
4 (2) Notwithstanding section 409.9112, Florida
5 Statutes, for state fiscal year 2002-2003, only
6 disproportionate share payments to regional perinatal
7 intensive care centers shall be distributed in the same
8 proportion as the disproportionate share payments made to the
9 regional perinatal intensive care centers in the state fiscal
10 year 2001-2002.
11 (3) Notwithstanding section 409.9117, Florida
12 Statutes, for state fiscal year 2002-2003 only,
13 disproportionate share payments to hospitals that qualify for
14 primary care disproportionate share payments shall be
15 distributed in the same proportion as the primary care
16 disproportionate share payments made to those hospitals in the
17 state fiscal year 2001-2002.
18 (4) In the event the Centers for Medicare and Medicaid
19 Services does not approve Florida's inpatient hospital state
20 plan amendment for the public disproportionate share program
21 by November 1, 2002, the agency may make payments to hospitals
22 under the regular disproportionate share program, regional
23 perinatal intensive care centers disproportionate share
24 program, and the primary care disproportionate share program
25 using the same methodologies used in state fiscal year
26 2001-2002.
27 (5) For state fiscal year 2002-2003 only, no
28 disproportionate share payments shall be made to specialty
29 hospitals for children under the provisions of section
30 409.9119, Florida Statutes.
31 (6) This section expires July 1, 2003.

1 Section 23. The Agency for Health Care Administration
2 may conduct a 2-year pilot project to authorize overnight
3 stays in one ambulatory surgical center located in Acute Care
4 Subdistrict 9-1. An overnight stay shall be permitted only to
5 perform plastic and reconstructive surgeries defined by
6 current procedural terminology code numbers 13000-19999. The
7 total time a patient is at the ambulatory surgical center
8 shall not exceed 23 hours and 59 minutes, including the
9 surgery time, and the maximum planned duration of all surgical
10 procedures combined shall not exceed 8 hours. Prior to
11 implementation of the pilot project, the agency shall
12 establish minimum requirements for protecting the health,
13 safety, and welfare of patients receiving overnight care.
14 These shall include, at a minimum, compliance with all
15 statutes and rules applicable to ambulatory surgical centers
16 and the requirements set forth in Rule 64B8-9.009, F.A.C.,
17 relating to Level II and Level III procedures. If the agency
18 implements the pilot project, it shall, within 6 months after
19 its completion, submit a report to the Legislature on whether
20 to expand the pilot to include all ambulatory surgical
21 centers. The recommendation shall be based on consideration of
22 the efficacy and impact to patient safety and quality of
23 patient care of providing plastic and reconstructive surgeries
24 in the ambulatory surgical center setting. The agency is
25 authorized to obtain such data as necessary to implement this
26 section.
27 Section 24. Section 624.91, Florida Statutes, is
28 amended to read:
29 624.91 The Florida Healthy Kids Corporation Act.--
30 (1) SHORT TITLE.--This section may be cited as the
31 "William G. 'Doc' Myers Healthy Kids Corporation Act."

(2) LEGISLATIVE INTENT.--

(a) The Legislature finds that increased access to health care services could improve children's health and reduce the incidence and costs of childhood illness and disabilities among children in this state. Many children do not have comprehensive, affordable health care services available. It is the intent of the Legislature that the Florida Healthy Kids Corporation provide comprehensive health insurance coverage to such children. The corporation is encouraged to cooperate with any existing health service programs funded by the public or the private sector and to work cooperatively with the Florida Partnership for School Readiness.

(b) It is the intent of the Legislature that the Florida Healthy Kids Corporation serve as one of several providers of services to children eligible for medical assistance under Title XXI of the Social Security Act. Although the corporation may serve other children, the Legislature intends the primary recipients of services provided through the corporation be school-age children with a family income below 200 percent of the federal poverty level, who do not qualify for Medicaid. It is also the intent of the Legislature that state and local government Florida Healthy Kids funds, ~~to the extent permissible under federal law,~~be used to continue and expand coverage, within available appropriations, to children not eligible for federal matching funds under Title XXI ~~obtain matching federal dollars~~.

(3) NONENTITLEMENT.--Nothing in this section shall be construed as providing an individual with an entitlement to health care services. No cause of action shall arise against the state, the Florida Healthy Kids Corporation, or a unit of

local government for failure to make health services available under this section.

(4) CORPORATION AUTHORIZATION, DUTIES, POWERS.--

(a) There is created the Florida Healthy Kids Corporation, a not-for-profit corporation ~~which operates on sites designated by the corporation~~.

(b) The Florida Healthy Kids Corporation shall ~~phase in a program to~~:

1. Organize school children groups to facilitate the provision of comprehensive health insurance coverage to children;

2. Arrange for the collection of any family, local contributions, or employer payment or premium, in an amount to be determined by the board of directors, to provide for payment of premiums for comprehensive insurance coverage and for the actual or estimated administrative expenses;

3. Arrange for the collection of any voluntary contributions to provide for payment of premiums for children who are not eligible for medical assistance under Title XXI of the Social Security Act. Each fiscal year, the corporation shall establish a local-match policy for the enrollment of non-Title XXI eligible children in the Healthy Kids program. By May 1 of each year, the corporation shall provide written notification of the amount to be remitted to the corporation for the following fiscal year under that policy. Local-match sources may include, but are not limited to, funds provided by municipalities, counties, school boards, hospitals, health care providers, charitable organizations, special taxing districts, and private organizations. The minimum local-match cash contributions required each fiscal year and local-match credits shall be determined by the General Appropriations Act.

1 The corporation shall calculate a county's local-match rate
2 based upon that county's percentage of the state's total
3 non-Title XXI expenditures as reported in the corporation's
4 most recently audited financial statement. In awarding the
5 local-match credits, the corporation may consider factors
6 including, but not limited to, population density, per-capita
7 income, existing child-health-related expenditures and
8 services in awarding the credits.
9 4. Accept voluntary supplemental local-match
10 contributions that comply with the requirements of Title XXI
11 of the Social Security Act for the purpose of providing
12 additional coverage in contributing counties under Title XXI.
13 5.~~3.~~ Establish the administrative and accounting
14 procedures for the operation of the corporation;
15 6.~~4.~~ Establish, with consultation from appropriate
16 professional organizations, standards for preventive health
17 services and providers and comprehensive insurance benefits
18 appropriate to children; provided that such standards for
19 rural areas shall not limit primary care providers to
20 board-certified pediatricians;
21 7.~~5.~~ Establish eligibility criteria which children
22 must meet in order to participate in the program;
23 8.~~6.~~ Establish procedures under which providers of
24 local match to,applicants to and participants in the program
25 may have grievances reviewed by an impartial body and reported
26 to the board of directors of the corporation;
27 9.~~7.~~ Establish participation criteria and, if
28 appropriate, contract with an authorized insurer, health
29 maintenance organization, or insurance administrator to
30 provide administrative services to the corporation;
31 10.~~8.~~ Establish enrollment criteria which shall

include penalties or waiting periods of not fewer than 60 days for reinstatement of coverage upon voluntary cancellation for nonpayment of family premiums;

11.~~9.~~ If a space is available, establish a special open enrollment period of 30 days' duration for any child who is enrolled in Medicaid or Medikids if such child loses Medicaid or Medikids eligibility and becomes eligible for the Florida Healthy Kids program;

12.~~10.~~ Contract with authorized insurers or any provider of health care services, meeting standards established by the corporation, for the provision of comprehensive insurance coverage to participants. Such standards shall include criteria under which the corporation may contract with more than one provider of health care services in program sites. Health plans shall be selected through a competitive bid process. The selection of health plans shall be based primarily on quality criteria established by the board. The health plan selection criteria and scoring system, and the scoring results, shall be available upon request for inspection after the bids have been awarded;

13. Establish disenrollment criteria in the event local matching funds are insufficient to cover enrollments.

14.~~11.~~ Develop and implement a plan to publicize the Florida Healthy Kids Corporation, the eligibility requirements of the program, and the procedures for enrollment in the program and to maintain public awareness of the corporation and the program;

15.~~12.~~ Secure staff necessary to properly administer the corporation. Staff costs shall be funded from state and local matching funds and such other private or public funds as become available. The board of directors shall determine the

number of staff members necessary to administer the corporation;

16.~~13.~~ As appropriate, enter into contracts with local school boards or other agencies to provide onsite information, enrollment, and other services necessary to the operation of the corporation;

17.~~14.~~ Provide a report on an annual basis to the Governor, Insurance Commissioner, Commissioner of Education, Senate President, Speaker of the House of Representatives, and Minority Leaders of the Senate and the House of Representatives;

18.~~15.~~ Each fiscal year, establish a maximum number of participants ~~by county~~, on a statewide basis, who may enroll in the program; and ~~without the benefit of local matching funds. Thereafter, the corporation may establish local matching requirements for supplemental participation in the program. The corporation may vary local matching requirements and enrollment by county depending on factors which may influence the generation of local match, including, but not limited to, population density, per capita income, existing local tax effort, and other factors. The corporation also may accept in-kind match in lieu of cash for the local match requirement to the extent allowed by Title XXI of the Social Security Act; and~~

19.~~16.~~ Establish eligibility criteria, premium and cost-sharing requirements, and benefit packages which conform to the provisions of the Florida Kidcare program, as created in ss. 409.810-409.820.

(c) Coverage under the corporation's program is secondary to any other available private coverage held by the participant child or family member. The corporation may

1 establish procedures for coordinating benefits under this
2 program with benefits under other public and private coverage.
3 (d) The Florida Healthy Kids Corporation shall be a
4 private corporation not for profit, organized pursuant to
5 chapter 617, and shall have all powers necessary to carry out
6 the purposes of this act, including, but not limited to, the
7 power to receive and accept grants, loans, or advances of
8 funds from any public or private agency and to receive and
9 accept from any source contributions of money, property,
10 labor, or any other thing of value, to be held, used, and
11 applied for the purposes of this act.
12 (5) BOARD OF DIRECTORS.--
13 (a) The Florida Healthy Kids Corporation shall operate
14 subject to the supervision and approval of a board of
15 directors chaired by the Insurance Commissioner or her or his
16 designee, and composed of 14 ~~12~~ other members selected for
17 3-year terms of office as follows:
18 1. One member appointed by the Commissioner of
19 Education from among three persons nominated by the Florida
20 Association of School Administrators;
21 2. One member appointed by the Commissioner of
22 Education from among three persons nominated by the Florida
23 Association of School Boards;
24 3. One member appointed by the Commissioner of
25 Education from the Office of School Health Programs of the
26 Florida Department of Education;
27 4. One member appointed by the Governor from among
28 three members nominated by the Florida Pediatric Society;
29 5. One member, appointed by the Governor, who
30 represents the Children's Medical Services Program;
31 6. One member appointed by the Insurance Commissioner

1 from among three members nominated by the Florida Hospital
2 Association;
3 7. Two members, appointed by the Insurance
4 Commissioner, who are representatives of authorized health
5 care insurers or health maintenance organizations;
6 8. One member, appointed by the Insurance
7 Commissioner, who represents the Institute for Child Health
8 Policy;
9 9. One member, appointed by the Governor, from among
10 three members nominated by the Florida Academy of Family
11 Physicians;
12 10. One member, appointed by the Governor, who
13 represents the Agency for Health Care Administration; ~~and~~
14 11. The State Health Officer or her or his designee;~~.~~
15 12. One member, appointed by the Insurance
16 Commissioner from among three members nominated by the Florida
17 Association of Counties, representing rural counties; and
18 13. One member, appointed by the Governor from among
19 three members nominated by the Florida Association of
20 Counties, representing urban counties.
21 (b) A member of the board of directors may be removed
22 by the official who appointed that member. The board shall
23 appoint an executive director, who is responsible for other
24 staff authorized by the board.
25 (c) Board members are entitled to receive, from funds
26 of the corporation, reimbursement for per diem and travel
27 expenses as provided by s. 112.061.
28 (d) There shall be no liability on the part of, and no
29 cause of action shall arise against, any member of the board
30 of directors, or its employees or agents, for any action they
31 take in the performance of their powers and duties under this

1 act.
2 (6) LICENSING NOT REQUIRED; FISCAL OPERATION.--
3 (a) The corporation shall not be deemed an insurer.
4 The officers, directors, and employees of the corporation
5 shall not be deemed to be agents of an insurer. Neither the
6 corporation nor any officer, director, or employee of the
7 corporation is subject to the licensing requirements of the
8 insurance code or the rules of the Department of Insurance.
9 However, any marketing representative utilized and compensated
10 by the corporation must be appointed as a representative of
11 the insurers or health services providers with which the
12 corporation contracts.
13 (b) The board has complete fiscal control over the
14 corporation and is responsible for all corporate operations.
15 (c) The Department of Insurance shall supervise any
16 liquidation or dissolution of the corporation and shall have,
17 with respect to such liquidation or dissolution, all power
18 granted to it pursuant to the insurance code.
19 (7) ACCESS TO RECORDS; CONFIDENTIALITY;
20 PENALTIES.--Notwithstanding any other laws to the contrary,
21 the Florida Healthy Kids Corporation shall have access to the
22 medical records of a student upon receipt of permission from a
23 parent or guardian of the student. Such medical records may
24 be maintained by state and local agencies. Any identifying
25 information, including medical records and family financial
26 information, obtained by the corporation pursuant to this
27 subsection is confidential and is exempt from the provisions
28 of s. 119.07(1). Neither the corporation nor the staff or
29 agents of the corporation may release, without the written
30 consent of the participant or the parent or guardian of the
31 participant, to any state or federal agency, to any private

1 business or person, or to any other entity, any confidential
2 information received pursuant to this subsection. A violation
3 of this subsection is a misdemeanor of the second degree,
4 punishable as provided in s. 775.082 or s. 775.083.
5 Section 25. By January 1, 2003, the Agency for Health
6 Care Administration shall make recommendations to the
7 Legislature as to limits in the amount of home office
8 management and administrative fees which should be allowable
9 for reimbursement for providers whose rates are set on a
10 cost-reimbursement basis.
11 Section 26. Subsection (5) of section 414.41, Florida
12 Statutes, is repealed.
13 Section 27. If any law that is amended by this act was
14 also amended by a law enacted at the 2002 Regular Session of
15 the Legislature, such laws shall be construed as if they had
16 been enacted at the same session of the Legislature, and full
17 effect should be given to each if that is possible.
18 Section 28. Except as otherwise provided in this act,
19 this act shall take effect upon becoming a law.
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21
22 =============== T I T L E A M E N D M E N T ===============
23 And the title is amended as follows:
24 Delete everything before the enacting clause
25
26 and insert:
27 A bill to be entitled
28 An act relating to health care; amending s.
29 16.59, F.S.; specifying additional requirements
30 for the Medicaid Fraud Control Unit of the
31 Department of Legal Affairs and the Medicaid

1 program integrity program; amending s.
2 112.3187, F.S.; extending whistle-blower
3 protection to employees of Medicaid providers
4 reporting Medicaid fraud or abuse; amending s.
5 400.179, F.S.; providing exceptions to bond
6 requirements; creating s. 408.831, F.S.;
7 allowing the Agency for Health Care
8 Administration to take action against a
9 licensee in certain circumstances; amending s.
10 409.8177, F.S.; requiring the Agency for Health
11 Care Administration to contract for an
12 evaluation of the Florida Kidcare program;
13 amending s. 409.902, F.S.; prescribing an
14 additional condition on Medicaid eligibility;
15 amending s. 409.904, F.S.; revising provisions
16 governing optional payments for medical
17 assistance and related services; amending s.
18 409.905, F.S.; providing additional criteria
19 for the agency to adjust a hospital's inpatient
20 per diem rate for Medicaid; amending s.
21 409.906, F.S.; authorizing the agency to make
22 payments for specified services which are
23 optional under Title XIX of the Social Security
24 Act; amending s. 409.9065, F.S.; revising
25 standards for pharmaceutical expense
26 assistance; amending s. 409.907, F.S.;
27 prescribing additional requirements with
28 respect to provider enrollment; requiring that
29 the Agency for Health Care Administration deny
30 a provider's application under certain
31 circumstances; amending s. 409.908, F.S.;

1 providing additional requirements for
2 cost-reporting; amending s. 409.910, F.S.;
3 revising requirements for the distribution of
4 funds recovered from third parties that are
5 liable for making payments for medical care
6 furnished to Medicaid recipients and in the
7 case of recoveries of overpayments; amending s.
8 409.912, F.S.; revising provisions governing
9 the purchase of goods and services for Medicaid
10 recipients; providing for quarterly reports to
11 the Governor and presiding officers of the
12 Legislature; amending s. 409.9116, F.S.;
13 revising the disproportionate share/financial
14 assistance program for rural hospitals;
15 amending s. 409.9122, F.S.; revising provisions
16 governing mandatory Medicaid managed care
17 enrollment; amending s. 409.913, F.S.;
18 requiring that the agency and Medicaid Fraud
19 Control Unit annually submit a report to the
20 Legislature; defining the term "complaint";
21 specifying additional requirements for the
22 Medicaid program integrity program and the
23 Medicaid Fraud Control Unit of the Department
24 of Legal Affairs; requiring imposition of
25 sanctions or disincentives, except under
26 certain circumstances; providing additional
27 sanctions and disincentives; providing
28 additional grounds under which the agency may
29 terminate a provider's participation in the
30 Medicaid program; providing additional
31 requirements for administrative hearings;

1 providing additional grounds for withholding
2 payments to a provider; authorizing the agency
3 and the Medicaid Fraud Control Unit to review
4 certain records; requiring review by the
5 Attorney General of certain settlements;
6 requiring review by the Auditor General of
7 certain cost reports; requiring that the agency
8 refund to a county any recovery of Medicaid
9 overpayment received for hospital inpatient and
10 nursing home services; providing a formula for
11 calculating the credit; amending s. 409.920,
12 F.S.; providing additional duties of the
13 Medicaid Fraud Control Unit; amending s.
14 499.012, F.S.; redefining the term "wholesale
15 distribution" with respect to regulation of
16 distribution of prescription drugs; requiring
17 the Agency for Health Care Administration to
18 conduct a study of health care services
19 provided to medically fragile or
20 medical-technology-dependent children;
21 requiring the Agency for Health Care
22 Administration to conduct a pilot program for a
23 subacute pediatric transitional care center;
24 requiring background screening of center
25 personnel; requiring the agency to amend the
26 Medicaid state plan and seek federal waivers as
27 necessary; requiring the center to have an
28 advisory board; providing for membership on the
29 advisory board; providing requirements for the
30 admission, transfer, and discharge of a child
31 to the center; requiring the agency to submit

1 certain reports to the Legislature; providing
2 guidelines for the agency to distribute
3 disproportionate share funds during the
4 2002-2003 fiscal year; authorizing the Agency
5 for Health Care Administration to conduct a
6 pilot project on overnight stays in an
7 ambulatory surgical center; amending s. 624.91,
8 F.S.; revising duties of the Florida Healthy
9 Kids Corporation with respect to annual
10 determination of participation in the Healthy
11 Kids Program; prescribing duties of the
12 corporation in establishing local match
13 requirements; revising the composition of the
14 board of directors; requiring recommendations
15 to the Legislature; repealing s. 414.41(5),
16 F.S., relating to interest imposed upon the
17 recovery amount of medical assistance
18 overpayments; providing for construction of
19 laws enacted at the 2002 Regular Session in
20 relation to this act; providing effective
21 dates.
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