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HOUSE OF REPRESENTATIVES

FISCAL RESPONSIBILITY COUNCIL ANALYSIS

BILL #: HB 59E (PCB FRC 02-11E)

RELATING TO: Health Care

SPONSOR(S): Fiscal Responsibility Council and Representative Murman

TIED BILL(S):

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

(1) FISCAL RESPONSIBILITY COUNCIL YEAS 26 NAYS 0
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I. SUMMARY:

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

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

- Provides various changes to improve the Agency for Health Care Administration's Medicaid fraud and abuse program;
- Creates a fund to ensure recovery of nursing home Medicaid overpayments;
- Revises eligibility standards for the pharmaceutical expense assistance program to allow participation in a proposed federal expansion;
- Updates the applicability of the financial assistance program for rural hospitals;
- Provides requirements for contracts for Medicaid behavioral health care services;
- Revises enrollment goal of managed care diversion of Medicaid recipients;
- Revises definition of the term "intermediate care facility for the developmentally disabled";
- Restores optional Medicaid coverage for adults under the medically needy program;
- Provides for a reimbursement to nursing homes for general and professional liability insurance;
- Restores optional Medicaid coverage for the working disabled under the Ticket to Work program;
- Directs the Florida Healthy Kids Corporation to collect local contributions to be used to pay premiums for children who are not eligible for Title XXI;
- Creates a subacute pediatric transitional care pilot; and
- Requires the Department of Children and Family Services to develop and implement a redesign of the home and community-based services delivery system for persons with developmental disabilities.

II. SUBSTANTIVE ANALYSIS:

A. DOES THE BILL SUPPORT THE FOLLOWING PRINCIPLES:

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

For any principle that received a “no” above, please explain:

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

B. PRESENT SITUATION:

Medicaid Fraud and Abuse

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

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

Section 409.907, F.S., establishes requirements for Medicaid provider agreements. The agency may make payments for medical assistance and related services rendered to Medicaid recipients only to an individual or entity who has a provider agreement in effect with the agency. Section 409.908, F.S., specifies conditions under which Medicaid providers may be reimbursed.

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

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

Sections 112.3187-112.31895, F.S., are the “Whistle-blower’s Act.” The legislative intent for the act is to prevent agencies or independent contractors from taking retaliatory action against an employee who reports to an appropriate agency violations of law on the part of a public employer or independent contractor or who discloses information to an appropriate agency alleging improper use of

governmental office, gross waste of funds, or any other abuse or gross neglect of duty on the part of an agency, public officer, or employee.

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

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

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

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

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

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

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

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

Subacute Pediatric Transitional Care Pilot

Children are identified as medically fragile or technologically dependent children by the Children's Multidisciplinary Assessment Team (CMAT), coordinated by the Division of Children's Medical Services of the Department of Health. Health care professionals determine that the child requires the extensive care and services provided in a Prescribed Pediatric Extended Care (PPEC) center and the local area Medicaid authorization nurse authorizes that care. PPEC licensees receive Medicaid reimbursement for the basic services to the child and additional services are provided to the child, principally by contract staff who are paid for their services independent of and in addition to the payment for basic PPEC contracted services.

Children in Florida who need complex medical care services or therapeutic interventions are currently served in hospitals, nursing homes, medical foster care, and prescribed pediatric extended care (PPEC) centers, ss. 400.901-400.917, F.S.

Seven facilities licensed as skilled nursing facilities, also provide residential, around the clock services to pediatric residents. Those facilities are: Broward Children's Home, Pompano; Central Park Village, Orlando; Halifax Convalescent Center, Daytona Beach; Lakeshore Villas Health Care Center, Tampa; Memorial Manor, Pembroke Pines; Sabal Palms Health Care Center, Largo; and Westminster Care of Orlando, Orlando. Other skilled nursing facilities provide services to pediatric residents, but these seven facilities have established more clearly defined programs for this population. The total population served in these facilities is estimated to be in excess of 200 children. Services in each of these settings are covered by Medicaid funding.

Florida Healthy Kids Corporation

Florida's Kidcare program is an umbrella program that currently includes the following four components: Medicaid for children; Medikids; Florida Healthy Kids; and the Children's Medical Services Network, which includes a behavioral health component.

The Florida Healthy Kids program component of Kidcare is administered by the non-profit Florida Healthy Kids Corporation, established in s. 624.91, F.S. The Healthy Kids program existed prior to the implementation of the federal Title XXI child health insurance program. Florida was one of three states to have the benefit package of an existing child health insurance program (Healthy Kids) grand-fathered in as part of the Balanced Budget Act of 1997, which created the federal child health insurance program.

The Healthy Kids program operates with a combination of local, state, and federal dollars, and family contributions. Healthy Kids has required counties to contribute funds to support the health insurance subsidy for families since 1993. The original concept of the program was that state monies were to be considered seed funds, which would eventually be supplanted entirely by local funds. Early Healthy Kids contracts for local programs required counties in which the program operated to develop a plan to gradually increase county matching contributions from a base amount of five percent of total program costs, with a goal of eventually funding local program operations 100 percent from local funds.

Congress, in response to concerns about the millions of uninsured children in the nation, allotted approximately $40 billion over 10 years to help states expand health insurance coverage to children through the Balanced Budget Act of 1997. The act, which created Title XXI of the Social Security Act, allows states to expand coverage for children through expanding the existing Medicaid program or creating or expanding a separate program specific to the children's initiative.

The federal Title XXI program allowed Florida to access an enhanced federal match rate of 69 percent, meaning that every dollar Florida put into coverage under the Title XXI program leveraged an additional $2.23 in federal funds. The 1998 Legislature authorized implementation of Florida's Title XXI program, Kidcare, and modified operations of the Healthy Kids program to expand the program statewide, and align its operations with the requirements of Title XXI to use Healthy Kids funding to gain the enhanced federal match.

At the time of implementation of Florida's Title XXI expansion of Healthy Kids, approximately $7,000,000 in local matching funds were committed to the program. Restrictions on provider donations for Title XXI required the Healthy Kids program to review the sources of local matching funds.

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

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

The General Appropriations Act for FY 2000-01 provided that counties maintain their local match commitments for that year. In FY 2000-2001, 31 of Florida's 67 counties contributed local matching funds. The General Appropriations Act for FY 2001-2002 contained proviso language stating no local matching funds were required for the KidCare program. However, Florida Healthy Kids was required to develop and implement a local match policy for the purpose of continuing and expanding coverage to uninsured children who do not meet the eligibility requirements of Title XXI. The Corporation was instructed to replace local match funds from FY 2000-2001 funding. In the 2001 legislative session, legislators eliminated local match by inserting proviso language in the Appropriations Act. Because this language was not available for veto, the Governor challenged the language as unconstitutional. In special session in the fall of 2001, legislators voted to statutorily eliminate local matching funds for FY 2001-2002.

Disproportionate share/financial assistance program for rural hospitals

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

HMO Diversion

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

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

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

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

Ticket to Work

The Ticket to Work program allows disabled individuals to continue to work and still receive full Medicaid benefits if their income and resources are within specified limits. The optional coverage for working disabled individuals was eliminated, effective July 1, 2002, in the 2001 Special Session 'C" (Chapter 2001-377, Laws of Florida).

Medically Needy

The Medically Needy program is an optional program under Medicaid that primarily covers persons who have experienced a catastrophic illness and either have no health insurance, or have exhausted their benefits. The program provides Medicaid coverage for those persons who qualify categorically for Medicaid except that their income or assets are greater than the level allowed under other Medicaid programs. There is no limit to the monthly income an individual can have, but to be eligible for Medicaid to pay for care, the individual must incur enough medical bills to offset his or her income to the income level that would qualify the individual for the Medically Needy program. A person eligible for the Medically Needy Program is eligible for all Medicaid services with the exception of services in a skilled nursing facility or an intermediate care facility for the developmentally disabled, and home and community-based services.

About two-thirds of the individuals eligible for the Medically Needy program are in the TANF-related group. The TANF-related group is primarily families with higher incomes who have undergone an illness or injury with substantial medical cost that would reduce their incomes down to the income

standard. For example, a family of four would have to incur medical bills that, if deducted from their income, would reduce their income to $364 per month. The income eligibility standard of $364 per month for a family of four is about one-fourth of the 2001 federal poverty level of $1,471 per month for a family of four. The Supplemental Security Income (SSI) related group is usually without Medicare or other forms of insurance and primarily receives services for critical needs relating to AIDS, cancer, organ transplants, and other catastrophic illness. These individuals must incur medical bills that, if deducted from their income, would reduce their income to $180 per month for an individual or $241 per month for a family of two. This monthly income standard is about one-fourth of the 2001 federal poverty level for an individual ($716 per month) or for a family of two ($968 per month).

Eligibility is determined based on medical and pharmacy bills presented to the Department of Children and Family Services. Once determined eligible, the state reimburses providers based on the current Medicaid reimbursement rates. Individuals do not actually "spend down" to the above income standards in order to qualify for the program. The Medically Needy program for adults was eliminated, effective July 1, 2002, in the 2001 Special Session 'C" (Chapter 2001-377, Laws of Florida).

Pharmaceutical Expense Assistance Program

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

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

Nursing Home Overpayment Bonds

Since 1993, section 400.179, F.S., has required a performance bond as a condition of licensure for leased nursing homes to ensure that providers operating leased facilities satisfy their Medicaid overpayment liabilities. The statute requires a bond equal to three months Medicaid payments to the facility, roughly $700,000. Initially, the bonds could be purchased for about 1% of value. Currently, the bonds cost about 6% to 8% of the value. Many nursing homes are having financial difficulty obtaining the bonds.

C. EFFECT OF PROPOSED CHANGES:

See SECTION-BY-SECTION ANALYSIS.

D. SECTION-BY-SECTION ANALYSIS:

Section 1. Subsections (3), (5), and (7) of s. 112.3187, F.S. are amended. They relate to whistleblower retaliation. The change to subsection (3) adds "provider agreement" to the definition of "independent contractor." The change to subsection (5) adds disclosed suspicion or actual Medicaid fraud or abuse to the information that is protected under the Whistle-blower's Act. Subsection (7) lists various ways people may disclose information and still be protected. The change to subsection (7) adds the hotline of the Medicaid Fraud Control Unit of the Department of Legal Affairs to the list of ways people may disclose information and still be protected.

Section 2. Paragraph (d) of subsection (5) of section 400.179, F.S., is amended to allow continuing care retirement communities and nonprofit nursing homes to meet the requirements of subsection (5)(d)1. by payment of a nonrefundable fee, paid at initial licensure, paid at the time of any subsequent change of ownership, and paid at the time of any subsequent annual license renewal, in the amount of

2% of the total of three months Medicaid payments to the facility computed on the basis of the preceding 12-month average Medicaid payments to the facility.

The fee shall be deposited into the Health Care Trust Fund and shall be accounted for separately as a Medicaid nursing home overpayment account. These fees shall be used at the sole discretion of the agency to repay nursing home Medicaid overpayments. Payment of this fee shall not release the operator from any liability for any Medicaid overpayments nor shall payment bar the agency from seeking to recoup overpayments from the operator and any other liable party.

The agency is granted authority to promulgate all rules pertaining to the administration and management of this account. This subparagraph is repealed on June 30, 2003.

The money will remain in the fund to protect the state's interest in recovering overpayments. This in essence creates a self-insurance pool for Medicaid overpayment liabilities. No bond will be required.

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

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

Section 5. Amends s. 409.8177, F.S., to require the Agency for Health Care Administration, in consultation with the Department of Health, the Department of Children and Family Services, and the Florida Healthy Kids Corporation, to contract for an annual evaluation of the Florida Kidcare program to be submitted to the Governor and the Legislature by January 1 of each year. The 2001-02 General Appropriations Act contains proviso that will no longer be necessary with this statutory change.

Section 6. Section 409.902, F.S., is amended to require that AHCA and the Department of Children and Family Services ensure that each recipient of Medicaid, as a condition of Medicaid eligibility, consents to release of his or her medical records to AHCA and the Medicaid Fraud Control unit of the Department of Legal Affairs. This consent is necessary to enable the review of a Medicaid provider's records. The review is necessary to search for Medicaid fraud and abuse by the Medicaid providers.

Section 7. Amends s. 409.904, F.S., to restore Medicaid coverage for adults eligible through the Medically Needy program. Clarifies that expenses used to meet spend-down requirements are not reimbursable by Medicaid, as required by federal regulation. Effective January 1, 2003, aged, disabled, blind, and children recipients will have $360 of their income disregarded. This will have the effect of allowing these individuals to keep $360 more of their money that they currently are required to spend on medical bills.

Section 8. Amends s. 409.903, F.S., to remove pregnant women with income up to 185% of the Federal Poverty Level from the statutory language listing mandatory Medicaid coverage groups, since this group is optional.

Section 9. Amends s. 409.904, F.S., to properly place pregnant women with income up to 185% of the Federal Poverty Level in the statutory language listing optional coverage groups. Also amends provisions relating to eligibility of women for cancer treatment pursuant to the federal Breast and Cervical Cancer and Prevention and Treatment Act of 2000 who are screened through the Mary Brogan Breast and Cervical Cancer Early Detection Program established under s. 381.93, F.S.

Section 10. Amends s. 409.9065, F.S., relating to the Pharmaceutical Expense Assistance Program. Provides the statutory framework to raise the maximum income level for eligibility from 120 percent of the federal poverty level to 150 percent of the federal poverty level. This is contingent on the federal government raising the Medicaid matching rate accordingly.

Section 11. Amends subsections (7) and (9) of s. 409.907, F.S., to require that AHCA perform onsite inspections of randomly selected new providers' service locations after the receipt of the application, to determine the applicant's ability to provide the services the applicant is proposing to provide for Medicaid reimbursement. AHCA is not required to perform an onsite inspection of a provider or program that it has licensed. AHCA is allowed to consider the applicant's demonstrated ability to provide services, conduct business, and operate a financially viable concern as a factor (in addition to other factors currently in statute) when determining whether or not to enroll a provider. The effective date of an approved application is the date the agency receives the provider application if the providers are out of state, were recently granted a change of ownership, or primarily provide emergency medical services transportation or emergency services.

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

Section 12. Amends s. 409.908, F.S., to provide that if a Medicaid provider is reimbursed on cost reporting and submits a late cost report, then AHCA shall retroactively adjust the provider's reimbursement based on the new cost report if that cost report would result in a lower reimbursement rate for a rate semester.

Section 409.908, F.S., is also amended to direct AHCA to adjust the per diem rate to nursing homes to allow for an add-on for general and professional liability insurance for nursing facilities. The add-on shall be calculated by multiplying $500 the number of Medicaid certified beds divided by the total patient days reported. The total operating cost per diem is capped at the provider's actual, inflated operating cost per diem.

Section 13. Amends s. 409.911, F.S., to apply the statutory definitions to the Florida Hospital Uniform Reporting System manual.

Section 14. Amends subsection (7) of s. 409.9116, F.S., to change the date of July 1, 1998, used to qualify a hospital for participation in the disproportionate share/financial assistance program for rural hospitals unless additional funds are appropriated specifically to prevent any hospital eligible for the program from incurring a reduction in payments because of the eligibility of an additional hospital to participate. This section would change the date to July 1, 1999.

Section 15. Amends subsection (7) of s. 409.91195, F.S., to allow interested parties to testify publicly before the Medicaid Pharmaceutical and Therapeutics Committee prior to any decision being made by that committee for inclusion of a given drug on the preferred drug list.

Section 16. Amends s. 409.912, F.S., to provide that all contracts issued pursuant paragraph (b) of subsection (3) to an entity providing comprehensive behavioral health care services through a capitated, prepaid arrangement must require that 80% of the capitation paid to the managed care plan, including health maintenance organizations, be spent for the provision of behavioral health care services. If the managed care plan spends less than 80% for behavioral health services the difference

must be returned to the agency. Requires the agency to provide the managed care plan with a certification letter indicating the amount of capitation paid during each calendar year for the provision of behavioral health care services.

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

Section 17. Amends paragraphs (f) and (k) of subsection (2) of s. 409.9122, F.S., as amended by section 11 of chapter of chapter 2001-377, Laws of Florida, to allow for the diversion of Medicaid enrollees into managed care organizations over MediPass until a 55/45 split is achieved. However, in areas where the agency is capitating comprehensive behavioral health services, the ratio will remain 50/50 between MediPass and managed care organizations.

The definition of "managed care plan" has been revised to include several of the expanded MediPass options, such as provider service networks, pediatric emergency room diversion projects, and exclusive provider organizations.

Section 18. Creates paragraph (l) of subsection (2) of s. 409.9122, F.S., to give AHCA discretion to renew cost-effective contracts for choice counseling services. The duration of all contract renewals combined cannot be longer than the original term of the contract.

Section 19. Amends s. 409.913, F.S., as amended by section 12 of chapter 2001-377, Laws of Florida, to:

- Require AHCA and the Medicaid Fraud Control Unit of the Department of Legal Affairs to annually submit a joint report on the effectiveness of the state's efforts to control Medicaid fraud and abuse and to recover Medicaid overpayments. The report must include specified information;
- Define the term "complaint" as used in this section to mean an allegation that fraud, abuse or an overpayment has occurred;
- Allow AHCA to impose penalties on a Medicaid provider who has failed to comply with an agreed-upon repayment schedule;
- Require, rather than permit, AHCA to impose a variety of sanctions or disincentives, and adds to the list of sanctions: prepayment reviews of claims for a specified period of time, comprehensive follow-up reviews every 6 months, and corrective action plans of up to 3 years duration which would be monitored every 6 months; with a provision that the Secretary of Health Care Administration may make a determination that imposition of a sanction or disincentive is not in the best interests of Medicaid, in which case a sanction or disincentive is not to be imposed;
- Allow AHCA to terminate a provider who does not enter into an agreed-upon repayment schedule;
- Allow AHCA and Medicaid Fraud Control Unit to review a provider's Medicaid-related records in order to reconcile quantities of goods or services billed to Medicaid against quantities of goods and services used in the provider's total practice;
- Allow the agency to terminate a provider's participation in Medicaid for failure to reimburse an overpayment which has been determined by final order within 35 days unless the provider and the agency have entered into a repayment agreement, and requiring reinstatement if the final order is overturned on appeal;
- Require that administrative hearings pursuant to chapter 120 be conducted within 90 days following assignment of an administrative law judge and specifying that upon issuance of a final order that the balance outstanding becomes due;

- Allow the agency to withhold medical assistance payments to a provider until the amount due is repaid in full if a provider fails to make payments in full, or comply with the terms of a repayment plan or settlement agreement;
- Delete a provision which restricted withholding of provider payments to no more than 10 percent of a provider's monthly payments from the agency;
- Allow agents and employees of the agency and Medicaid Fraud Control Unit to inspect the records of a pharmacy, wholesale establishment, manufacturer, or other place in the state where drugs and medical supplies are manufactured, packed, stored, sold, or kept for sale, for the purpose of verifying the amount of drugs and medical supplies ordered, delivered or purchased by a provider.

Section 20. Amends subsections (7) and (8) of s. 409.920, F.S., to grant the Attorney General the discretion to refer to AHCA each instance of provider overpayment for collection. Current law mandates the referral.

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

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

Section 21. Amends s. 624.91, F.S., to state the intent of the Legislature that state and local funds be used to expand coverage, within available appropriations, to children not eligible for federal matching funds under Title XXI, to delete obsolete language regarding the duties of the corporation, and to revise provisions relating to local matching funds.

Local contributions are to be used to pay premiums for children who are not eligible for Title XXI. Annually, the Corporation is to establish a local match policy for the enrollment of non-Title XXI children in the program, and is to provide notification of the amount of local match to be remitted to the Corporation by May 1 of each year.

Entities that may provide local match include, but are not limited to municipalities, counties, school boards, hospitals, health care providers, charitable organizations, special taxing districts, and private organizations.

Two members are added to the Florida Healthy Kids Corporation board of directors. One of the new members is to be appointed by the Insurance Commissioner from a list of three members nominated by the Florida Association of Counties representing rural counties; the other new member is appointed by the Governor from a list of three members nominated by the Florida Association of Counties representing urban counties.

The Florida Healthy Kids Corporation is to notify the Senate President, the Speaker of the House, and the Governor of any county not meeting its local match requirement.

Section 22. Amends subsection (2) of s. 393.19, F.S., to increase the number of regional perinatal intensive care centers from 11 to 12.

Section 23. Amends subsection (28) of s. 393.063, F.S., to change the definition of an "intermediate care facility for the developmentally disabled." Provides that a facility no longer has to be state-owned and operated to meet the definition of an intermediate care facility for the developmentally disabled. Changes the definition to require that the facility be state certified to meet the definition.

Section 24. Amends s. 400.965, F.S., relating to action by the agency against a licensee if the agency has a reasonable belief that conditions specified in s. 409.965(1), F.S., exist to provide that the agency must take administrative action as provided in s. 400.968, F.S., or s. 400.969, F.S., or injunctive action as authorized by s. 400.963, F.S.

Section 25. Renumbers subsection (4) of section 400.968, F.S., to section 400.969, F.S. and amends the section to provide penalties for violation of part XI of chapter 400 relating to intermediate care facilities for developmentally disabled persons.

Section 26. Requires the Department of Children and Family Services to develop and implement a comprehensive redesign of the home and community-based services delivery system for persons with developmental disabilities.

Section 27. Requires the AHCA to conduct a study of health care services provided to medically fragile or medical-technology-dependent children. In addition to the study, AHCA must conduct a pilot program for subacute pediatric transitional care in Miami-Dade County. The agency must amend the Medicaid state plan and seek federal waivers as necessary for implementation of the pilot program. AHCA is required to report to the Legislature concerning the pilot program and the results of the study.

Section 28. Requires AHCA to make recommendations to the Legislature as to limits in the amount of home office management and administrative fees which should be allowable for reimbursement for Medicaid providers whose rates are set on a cost-reimbursement basis.

Section 29. Disproportionate Share Hospital money is limited to public hospitals only for FY 2002-2003.

Section 30. Requires OPPAGA to perform a study of county contribution to Medicaid costs.

Section 31. Repeals section 1 of chapter 2001-377, Laws of Florida, which repealed the Ticket to Work program effective July 1, 2002. This action restores the Ticket to Work program that was eliminated during 2001 special session. This program provides Medicaid benefits to the working disabled.

Section 32. Declares the provisions of this act to be severable. This protects provisions of this act from court actions affecting other provisions of this act.

Section 33. Provides that this act shall take effect upon becoming a law except as otherwise provided.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues: FY 2002-03

2. Expenditures: FY 2002-03

Subacute Pediatric Transitional Care Pilot (effective 1/1/03)	
General Revenue	$ 778,619
Medical Care Trust Fund	$1,103,467
Total	$1,882,086
Medically Needy	
General Revenue	$ 84,888,383

Medical Care Trust Fund	$146,175,712
Total	$231,064,095
Ticket to Work	
General Revenue	$3,156,481
Medical Care Trust Fund	$4,573,298
Total	$7,729,779
Mandatory Assignment to 55% HMO/45% MP	
General Revenue	($ 1,462,378)
Grants and Donations Trust Fund	($ 258,711)
Medical Care Trust Fund	($ 1,827,960)
Total	($ 3,552,049)

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

2. Expenditures:

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

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

The additional coverage for pharmacy for seniors will benefit and will provide access to health care for these persons.

D. FISCAL COMMENTS:

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

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

A. APPLICABILITY OF THE MANDATES PROVISION:

This bill does not require counties or municipalities to expend funds or to take action that requires the expenditure of funds.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

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

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

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

V. COMMENTS:

A. CONSTITUTIONAL ISSUES:

None.

B. RULE-MAKING AUTHORITY:

None.

C. OTHER COMMENTS:

None.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

N/A

VII. SIGNATURES:

COMMITTEE ON HEALTH & HUMAN SERVICES APPROPRIATIONS:

Prepared by:	Staff Director:
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