By the Committee on Health and Human Services Appropriations; and Senators Saunders and Wilson

603-1998-06

1 A bill to be entitled
2 An act relating to medical services; amending
3 s. 409.906, F.S.; authorizing the Agency for
4 Health Care Administration to pay for full or
5 partial dentures for certain recipients and for
6 procedures relating to the seating and repair
7 of dentures; authorizing the provision of
8 hearing and visual services to Medicaid
9 recipients; amending s. 409.9122, F.S.,
10 relating to mandatory Medicaid managed care
11 enrollment; revising the percentages for the
12 agency to achieve in enrolling certain Medicaid
13 recipients in managed care plans or in
14 MediPass; amending s. 409.911, F.S.; revising
15 the audited data used by the agency to
16 determine the amount distributed to hospitals
17 under the disproportionate share program;
18 revising the number of Medicaid days used in
19 the calculation; deleting obsolete provisions;
20 amending s. 409.9113, F.S.; providing for the
21 distribution of funds to statutorily defined
22 teaching hospitals and family practice teaching
23 hospitals; amending s. 624.91, F.S.; deleting
24 provisions requiring that the Florida Healthy
25 Kids Corporation establish a local match policy
26 each fiscal year for enrolling certain children
27 in the Healthy Kids program; requiring the
28 Office of Program Policy Analysis and
29 Government Accountability to review the
30 Comprehensive Assessment and Review for
31 Long-Term Care Services (CARES) Program within

1 the Department of Elderly Affairs and report to
2 the President of the Senate and the Speaker of
3 the House of Representatives by a specified
4 date; providing an effective date.
5
6 Be It Enacted by the Legislature of the State of Florida:
7
8 Section 1. Paragraph (b) of subsection (1) and
9 subsections (12) and (23) of section 409.906, Florida
10 Statutes, are amended to read:
11 409.906 Optional Medicaid services.--Subject to
12 specific appropriations, the agency may make payments for
13 services which are optional to the state under Title XIX of
14 the Social Security Act and are furnished by Medicaid
15 providers to recipients who are determined to be eligible on
16 the dates on which the services were provided. Any optional
17 service that is provided shall be provided only when medically
18 necessary and in accordance with state and federal law.
19 Optional services rendered by providers in mobile units to
20 Medicaid recipients may be restricted or prohibited by the
21 agency. Nothing in this section shall be construed to prevent
22 or limit the agency from adjusting fees, reimbursement rates,
23 lengths of stay, number of visits, or number of services, or
24 making any other adjustments necessary to comply with the
25 availability of moneys and any limitations or directions
26 provided for in the General Appropriations Act or chapter 216.
27 If necessary to safeguard the state's systems of providing
28 services to elderly and disabled persons and subject to the
29 notice and review provisions of s. 216.177, the Governor may
30 direct the Agency for Health Care Administration to amend the
31 Medicaid state plan to delete the optional Medicaid service

1 known as "Intermediate Care Facilities for the Developmentally
2 Disabled." Optional services may include:
3 (1) ADULT DENTAL SERVICES.--
4 (b) Beginning July 1, 2006 ~~January 1, 2005~~, the agency
5 may pay for full and partial dentures, the procedures required
6 to seat full or partial dentures, and the repair and reline of
7 full or partial dentures, provided by or under the direction
8 of a licensed dentist, for a recipient who is 21 years of age
9 or older.
10 (12) ~~CHILDREN'S~~ HEARING SERVICES.--The agency may pay
11 for hearing and related services, including hearing
12 evaluations, hearing aid devices, dispensing of the hearing
13 aid, and related repairs, if provided to a recipient ~~younger~~
14 ~~than 21 years of age~~ by a licensed hearing aid specialist,
15 otolaryngologist, otologist, audiologist, or physician.
16 (23) ~~CHILDREN'S~~ VISUAL SERVICES.--The agency may pay
17 for visual examinations, eyeglasses, and eyeglass repairs for
18 a recipient ~~younger than 21 years of age,~~ if they are
19 prescribed by a licensed physician specializing in diseases of
20 the eye or by a licensed optometrist.
21 Section 2. Paragraphs (f) and (k) of subsection (2) of
22 section 409.9122, Florida Statutes, are amended to read:
23 409.9122 Mandatory Medicaid managed care enrollment;
24 programs and procedures.--
25 (2)
26 (f) When a Medicaid recipient does not choose a
27 managed care plan or MediPass provider, the agency shall
28 assign the Medicaid recipient to a managed care plan or
29 MediPass provider. Medicaid recipients who are subject to
30 mandatory assignment but who fail to make a choice shall be
31 assigned to managed care plans until an enrollment of 35 ~~40~~

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1 percent in MediPass and 65 ~~60~~ percent in managed care plans is
2 achieved. Once this enrollment is achieved, the assignments
3 shall be divided in order to maintain an enrollment in
4 MediPass and managed care plans which is in a 35 ~~40~~ percent
5 and 65 ~~60~~ percent proportion, respectively. Thereafter,
6 assignment of Medicaid recipients who fail to make a choice
7 shall be based proportionally on the preferences of recipients
8 who have made a choice in the previous period. Such
9 proportions shall be revised at least quarterly to reflect an
10 update of the preferences of Medicaid recipients. The agency
11 shall disproportionately assign Medicaid-eligible recipients
12 who are required to but have failed to make a choice of
13 managed care plan or MediPass, including children, and who are
14 to be assigned to the MediPass program to children's networks
15 as described in s. 409.912(4)(g), Children's Medical Services
16 Network as defined in s. 391.021, exclusive provider
17 organizations, provider service networks, minority physician
18 networks, and pediatric emergency department diversion
19 programs authorized by this chapter or the General
20 Appropriations Act, in such manner as the agency deems
21 appropriate, until the agency has determined that the networks
22 and programs have sufficient numbers to be economically
23 operated. For purposes of this paragraph, when referring to
24 assignment, the term "managed care plans" includes health
25 maintenance organizations, exclusive provider organizations,
26 provider service networks, minority physician networks,
27 Children's Medical Services Network, and pediatric emergency
28 department diversion programs authorized by this chapter or
29 the General Appropriations Act. When making assignments, the
30 agency shall take into account the following criteria:
31

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.

(k) 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, except in those counties in which there are fewer than two managed care plans accepting Medicaid enrollees, in which case assignment shall be to a managed care plan or a MediPass provider. Medicaid recipients in counties with fewer than two 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 enrollment of 35 ~~40~~ percent in MediPass and 65 ~~60~~ percent in managed care plans is achieved. Once that enrollment is achieved, the assignments shall be divided in order to maintain an enrollment in MediPass and managed care plans which is in a 35 ~~40~~ percent and 65 ~~60~~ percent proportion, respectively. In service areas 1 and 6 of the Agency for Health Care Administration where the agency is contracting for the provision of comprehensive behavioral health services through

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1 a capitated prepaid arrangement, recipients who fail to make a
2 choice shall be assigned equally to MediPass or a managed care
3 plan. For purposes of this paragraph, when referring to
4 assignment, the term "managed care plans" includes exclusive
5 provider organizations, provider service networks, Children's
6 Medical Services Network, minority physician networks, and
7 pediatric emergency department diversion programs authorized
8 by this 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 5. The agency has authority to make mandatory
25 assignments based on quality of service and performance of
26 managed care plans.
27 Section 3. Paragraph (a) of subsection (2), subsection
28 (3), and paragraphs (b) and (c) of subsection (4) of section
29 409.911, Florida Statutes, as amended by section 1 of chapter
30 2005-358, Laws of Florida, are amended to read:
31

409.911 Disproportionate share program.--Subject to specific allocations established within the General Appropriations Act and any limitations established pursuant to chapter 216, the agency shall distribute, pursuant to this section, moneys to hospitals providing a disproportionate share of Medicaid or charity care services by making quarterly Medicaid payments as required. 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.

(2) The Agency for Health Care Administration shall use the following actual audited data to determine the Medicaid days and charity care to be used in calculating the disproportionate share payment:

(a) The average of the 2000, 2001 ~~1998, 1999~~, and 2002 ~~2000~~ audited disproportionate share data to determine each hospital's Medicaid days and charity care for the 2006-2007 ~~2004-2005~~ state fiscal year ~~and the average of the 1999, 2000, and 2001 audited disproportionate share data to determine the Medicaid days and charity care for the 2005-2006 state fiscal year~~.

(3) Hospitals that qualify for a disproportionate share payment solely under paragraph (2)(c) shall have their payment calculated in accordance with the following formulas:

DSHP = (HMD/TMSD) x $1 million

Where:

DSHP = disproportionate share hospital payment.

HMD = hospital Medicaid days.

TSD = total state Medicaid days.

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Any funds not allocated to hospitals qualifying under this section shall be redistributed to the non-state government owned or operated hospitals with greater than 3,100 ~~3,300~~ Medicaid days.

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

(b) For non-state government owned or operated hospitals with 3,100 ~~3,300~~ or more Medicaid days:

DSHP = [(.82 x HCCD/TCCD) + (.18 x HMD/TMD)]
x TAAPH
TAAPH = TAA - TAAMH

Where:

TAA = total available appropriation.

TAAPH = total amount available for public hospitals.

DSHP = disproportionate share hospital payments.

HMD = hospital Medicaid days.

TMD = total state Medicaid days for public hospitals.

HCCD = hospital charity care dollars.

TCCD = total state charity care dollars for public non-state hospitals.

~~1. For the 2005-2006 state fiscal year only, the DSHP for the public nonstate hospitals shall be computed using a weighted average of the disproportionate share payments for the 2004-2005 state fiscal year which uses an average of the 1998, 1999, and 2000 audited disproportionate share data and the disproportionate share payments for the 2005-2006 state fiscal year as computed using the formula above and using the~~

~~average of the 1999, 2000, and 2001 audited disproportionate share data. The final DSHP for the public nonstate hospitals shall be computed as an average using the calculated payments for the 2005-2006 state fiscal year weighted at 65 percent and the disproportionate share payments for the 2004-2005 state fiscal year weighted at 35 percent.~~

~~2.~~ The TAAPH shall be reduced by $6,365,257 before computing the DSHP for each public hospital. The $6,365,257 shall be distributed equally between the public hospitals that are also designated statutory teaching hospitals.

(c) For non-state government owned or operated hospitals with less than 3,100 ~~3,300~~ Medicaid days, a total of $750,000 shall be distributed equally among these hospitals.

Section 4. Section 409.9113, Florida Statutes, is amended to read:

409.9113 Disproportionate share program for teaching hospitals.--In addition to the payments made under ss. 409.911 and 409.9112, the Agency for Health Care Administration shall make disproportionate share payments to statutorily defined teaching hospitals for their increased costs associated with medical education programs and for tertiary health care services provided to the indigent. This system of payments shall conform with federal requirements and shall distribute funds in each fiscal year for which an appropriation is made by making quarterly Medicaid payments. Notwithstanding s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients. For the 2006-2007 state fiscal year ~~2005-2006~~, the agency shall ~~not~~ distribute moneys provided in the General Appropriations Act to statutorily defined teaching hospitals and family practice

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1 teaching hospitals under the teaching hospital
2 disproportionate share program. The funds provided for
3 statutorily defined teaching hospitals shall be distributed in
4 the same proportion as funds were distributed under the
5 teaching hospital disproportionate share program during the
6 2003-2004 fiscal year. The funds provided for family practice
7 teaching hospitals shall be distributed equally among the
8 family practice teaching hospitals.
9 (1) On or before September 15 of each year, the Agency
10 for Health Care Administration shall calculate an allocation
11 fraction to be used for distributing funds to state statutory
12 teaching hospitals. Subsequent to the end of each quarter of
13 the state fiscal year, the agency shall distribute to each
14 statutory teaching hospital, as defined in s. 408.07, an
15 amount determined by multiplying one-fourth of the funds
16 appropriated for this purpose by the Legislature times such
17 hospital's allocation fraction. The allocation fraction for
18 each such hospital shall be determined by the sum of three
19 primary factors, divided by three. The primary factors are:
20 (a) The number of nationally accredited graduate
21 medical education programs offered by the hospital, including
22 programs accredited by the Accreditation Council for Graduate
23 Medical Education and the combined Internal Medicine and
24 Pediatrics programs acceptable to both the American Board of
25 Internal Medicine and the American Board of Pediatrics at the
26 beginning of the state fiscal year preceding the date on which
27 the allocation fraction is calculated. The numerical value of
28 this factor is the fraction that the hospital represents of
29 the total number of programs, where the total is computed for
30 all state statutory teaching hospitals.
31

1 (b) The number of full-time equivalent trainees in the
2 hospital, which comprises two components:
3 1. The number of trainees enrolled in nationally
4 accredited graduate medical education programs, as defined in
5 paragraph (a). Full-time equivalents are computed using the
6 fraction of the year during which each trainee is primarily
7 assigned to the given institution, over the state fiscal year
8 preceding the date on which the allocation fraction is
9 calculated. The numerical value of this factor is the fraction
10 that the hospital represents of the total number of full-time
11 equivalent trainees enrolled in accredited graduate programs,
12 where the total is computed for all state statutory teaching
13 hospitals.
14 2. The number of medical students enrolled in
15 accredited colleges of medicine and engaged in clinical
16 activities, including required clinical clerkships and
17 clinical electives. Full-time equivalents are computed using
18 the fraction of the year during which each trainee is
19 primarily assigned to the given institution, over the course
20 of the state fiscal year preceding the date on which the
21 allocation fraction is calculated. The numerical value of this
22 factor is the fraction that the given hospital represents of
23 the total number of full-time equivalent students enrolled in
24 accredited colleges of medicine, where the total is computed
25 for all state statutory teaching hospitals.
26
27 The primary factor for full-time equivalent trainees is
28 computed as the sum of these two components, divided by two.
29 (c) A service index that comprises three components:
30 1. The Agency for Health Care Administration Service
31 Index, computed by applying the standard Service Inventory

1 Scores established by the Agency for Health Care
2 Administration to services offered by the given hospital, as
3 reported on Worksheet A-2 for the last fiscal year reported to
4 the agency before the date on which the allocation fraction is
5 calculated. The numerical value of this factor is the
6 fraction that the given hospital represents of the total
7 Agency for Health Care Administration Service Index values,
8 where the total is computed for all state statutory teaching
9 hospitals.
10 2. A volume-weighted service index, computed by
11 applying the standard Service Inventory Scores established by
12 the Agency for Health Care Administration to the volume of
13 each service, expressed in terms of the standard units of
14 measure reported on Worksheet A-2 for the last fiscal year
15 reported to the agency before the date on which the allocation
16 factor is calculated. The numerical value of this factor is
17 the fraction that the given hospital represents of the total
18 volume-weighted service index values, where the total is
19 computed for all state statutory teaching hospitals.
20 3. Total Medicaid payments to each hospital for direct
21 inpatient and outpatient services during the fiscal year
22 preceding the date on which the allocation factor is
23 calculated. This includes payments made to each hospital for
24 such services by Medicaid prepaid health plans, whether the
25 plan was administered by the hospital or not. The numerical
26 value of this factor is the fraction that each hospital
27 represents of the total of such Medicaid payments, where the
28 total is computed for all state statutory teaching hospitals.
29
30 The primary factor for the service index is computed as the
31 sum of these three components, divided by three.

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(2) By October 1 of each year, the agency shall use the following formula to calculate the maximum additional disproportionate share payment for statutorily defined teaching hospitals:

$$TAP = THAF \times A$$

Where:

TAP = total additional payment.

THAF = teaching hospital allocation factor.

A = amount appropriated for a teaching hospital disproportionate share program.

Section 5. Paragraph (b) of subsection (5) of section 624.91, Florida Statutes, is amended to read:

624.91 The Florida Healthy Kids Corporation Act.--

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

(b) The Florida Healthy Kids Corporation shall:

1. 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.

2. 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~~

1 ~~sources may include, but are not limited to, funds provided by~~
2 ~~municipalities, counties, school boards, hospitals, health~~
3 ~~care providers, charitable organizations, special taxing~~
4 ~~districts, and private organizations. The minimum local match~~
5 ~~cash contributions required each fiscal year and local match~~
6 ~~credits shall be determined by the General Appropriations Act.~~
7 ~~The corporation shall calculate a county's local match rate~~
8 ~~based upon that county's percentage of the state's total~~
9 ~~non-Title XXI expenditures as reported in the corporation's~~
10 ~~most recently audited financial statement. In awarding the~~
11 ~~local match credits, the corporation may consider factors~~
12 ~~including, but not limited to, population density, per capita~~
13 ~~income, and existing child-health-related expenditures and~~
14 ~~services.~~
15 3. Subject to the provisions of s. 409.8134, accept
16 voluntary supplemental local match contributions that comply
17 with the requirements of Title XXI of the Social Security Act
18 for the purpose of providing additional coverage in
19 contributing counties under Title XXI.
20 4. Establish the administrative and accounting
21 procedures for the operation of the corporation.
22 5. Establish, with consultation from appropriate
23 professional organizations, standards for preventive health
24 services and providers and comprehensive insurance benefits
25 appropriate to children, provided that such standards for
26 rural areas shall not limit primary care providers to
27 board-certified pediatricians.
28 6. Determine eligibility for children seeking to
29 participate in the Title XXI-funded components of the Florida
30 KidCare program consistent with the requirements specified in
31

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1 s. 409.814, as well as the non-Title-XXI-eligible children as
2 provided in subsection (3).
3 7. Establish procedures under which providers of local
4 match to, applicants to and participants in the program may
5 have grievances reviewed by an impartial body and reported to
6 the board of directors of the corporation.
7 8. Establish participation criteria and, if
8 appropriate, contract with an authorized insurer, health
9 maintenance organization, or third-party administrator to
10 provide administrative services to the corporation.
11 9. Establish enrollment criteria which shall include
12 penalties or waiting periods of not fewer than 60 days for
13 reinstatement of coverage upon voluntary cancellation for
14 nonpayment of family premiums.
15 10. Contract with authorized insurers or any provider
16 of health care services, meeting standards established by the
17 corporation, for the provision of comprehensive insurance
18 coverage to participants. Such standards shall include
19 criteria under which the corporation may contract with more
20 than one provider of health care services in program sites.
21 Health plans shall be selected through a competitive bid
22 process. The Florida Healthy Kids Corporation shall purchase
23 goods and services in the most cost-effective manner
24 consistent with the delivery of quality medical care. The
25 maximum administrative cost for a Florida Healthy Kids
26 Corporation contract shall be 15 percent. For health care
27 contracts, the minimum medical loss ratio for a Florida
28 Healthy Kids Corporation contract shall be 85 percent. For
29 dental contracts, the remaining compensation to be paid to the
30 authorized insurer or provider under a Florida Healthy Kids
31 Corporation contract shall be no less than an amount which is

1 85 percent of premium; to the extent any contract provision
2 does not provide for this minimum compensation, this section
3 shall prevail. The health plan selection criteria and scoring
4 system, and the scoring results, shall be available upon
5 request for inspection after the bids have been awarded.
6 11. Establish disenrollment criteria in the event
7 local matching funds are insufficient to cover enrollments.
8 12. Develop and implement a plan to publicize the
9 Florida Healthy Kids Corporation, the eligibility requirements
10 of the program, and the procedures for enrollment in the
11 program and to maintain public awareness of the corporation
12 and the program.
13 13. Secure staff necessary to properly administer the
14 corporation. Staff costs shall be funded from state and local
15 matching funds and such other private or public funds as
16 become available. The board of directors shall determine the
17 number of staff members necessary to administer the
18 corporation.
19 14. Provide a report annually to the Governor, Chief
20 Financial Officer, Commissioner of Education, Senate
21 President, Speaker of the House of Representatives, and
22 Minority Leaders of the Senate and the House of
23 Representatives.
24 15. Establish benefit packages which conform to the
25 provisions of the Florida KidCare program, as created in ss.
26 409.810-409.820.
27 Section 6. <u>The Office of Program Policy Analysis and</u>
28 <u>Government Accountability (OPPAGA) shall review the functions</u>
29 <u>currently performed by the Comprehensive Assessment and Review</u>
30 <u>for Long-Term Care Services (CARES) Program within the</u>
31 <u>Department of Elderly Affairs. OPPAGA shall identify the</u>

1 factors affecting the time currently required for CARES staff
2 to assess an individual's eligibility for long-term care
3 services. As part of this study, OPPAGA shall also examine
4 circumstances that could delay an individual's placement into
5 the Long-Term Care Community Diversion pilot project. OPPAGA
6 shall report its findings to the President of the Senate and
7 the Speaker of the House of Representatives by February 1,
8 2007.
9 Section 7. This act shall take effect July 1, 2006.
10
11 STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN
COMMITTEE SUBSTITUTE FOR
12 Senate Bill 390
13
14 Provides Medicaid coverage for partial dentures, effective July 1, 2006.
15
Restores Medicaid coverage of adult vision services, effective
16 July 1, 2006.
17 Restores Medicaid coverage of adult hearing services, effective July 1, 2006.
18
Increases Medicaid managed care enrollment for individuals
19 that do not choose a plan to sixty-five percent managed care and thirty-five percent MediPass.
20
Implements provisions for the Disproportionate Share Program
21 recommended by the Disproportionate Share Council.
22 Deletes provisions requiring the Florida Healthy Kids Corporation to establish a local match policy each year and
23 the minimum local match requirements.
24 Requires the Office of Program Policy Analysis and Government Accountability (OPPAGA) to review functions of the CARES
25 program and report its findings to the President of the Senate and Speaker of the House by February 1, 2007.
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