20131520e1

1 A bill to be entitled
2 An act relating to Medicaid; repealing s. 381.0403,
3 F.S., relating to the Community Hospital Education
4 Act; amending s. 395.602, F.S.; providing that certain
5 rural hospitals remain rural hospitals under specified
6 circumstances; amending s. 409.905, F.S.; requiring
7 the Agency for Health Care Administration to implement
8 a prospective payment system for inpatient hospital
9 services using diagnosis-related groups (DRGs);
10 deleting provisions directing the agency to develop a
11 plan to convert hospital reimbursement for inpatient
12 services to a prospective payment system; requiring
13 hospital reimbursement for outpatient services to be
14 based on allowable costs; providing that adjustments
15 may not be made after a certain date; providing for
16 the reconciliation of errors in source data or
17 calculations; amending s. 409.908, F.S.; revising
18 exceptions to limitations on hospital reimbursement
19 for inpatient services; providing parameters for
20 submission of letters of agreement by local
21 governmental entities to the agency relating to funds
22 for special payments; providing that base rate
23 reimbursement under a diagnosis-related group
24 methodology shall be established in the General
25 Appropriations Act; creating s. 409.909, F.S.;
26 establishing the Statewide Medicaid Residency Program;
27 providing the purposes of the program; providing
28 definitions; providing a formula and limitations for
29 allocating funds to participating hospitals;

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30 authorizing the agency to adopt rules; amending s.
31 409.910, F.S.; revising provisions relating to
32 responsibility for Medicaid payments in settlement
33 proceedings; providing procedures for a recipient to
34 contest the amount payable to the agency; amending s.
35 409.911, F.S.; updating references to data used for
36 calculations in the disproportionate share program;
37 amending s. 409.9118, F.S.; amending parameters for
38 the disproportionate share program for specialty
39 hospitals; limiting reimbursement to tuberculosis
40 services provided under contract with the Department
41 of Health; amending s. 409.9122, F.S.; providing that
42 certain mandatory managed care provisions that apply
43 to a Medicaid recipient diagnosed with HIV/AIDS apply
44 only to a recipient who failed to choose a managed
45 care option; amending s. 409.915, F.S.; specifying the
46 total contribution for certain years and specifying
47 the method for determining the amount in the following
48 years; revising the method for calculating each
49 county’s contribution; providing tables for
50 calculating county contributions; requiring the Agency
51 for Health Care Administration to annually report the
52 status of county billings to the Legislature;
53 authorizing the Department of Revenue to withhold
54 county distributions for failure to remit Medicaid
55 contributions; deleting provisions specifying the care
56 and services that counties must participate in,
57 obsolete bond provisions, and a process for refund
58 requests; specifying the method for calculating each

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59 county’s contribution for the 2013-2014 fiscal year;
60 requiring the agency to submit an annual report to the
61 Governor, the Legislature, and the Florida Association
62 of Counties which includes information necessary to
63 comprehensively evaluate the cost and utilization of
64 health services by Medicaid enrollees; providing for
65 the repeal and replacement of specified proviso in the
66 2013-2014 General Appropriations Act; providing an
67 effective date.
68
69 Be It Enacted by the Legislature of the State of Florida:
70
71 Section 1. Section 381.0403, Florida Statutes, is repealed.
72 Section 2. Paragraph (e) of subsection (2) of section
73 395.602, Florida Statutes, is amended to read:
74 395.602 Rural hospitals.—
75 (2) DEFINITIONS.—As used in this part:
76 (e) “Rural hospital” means an acute care hospital licensed
77 under this chapter, having 100 or fewer licensed beds and an
78 emergency room, which is:
79 1. The sole provider within a county with a population
80 density of no greater than 100 persons per square mile;
81 2. An acute care hospital, in a county with a population
82 density of no greater than 100 persons per square mile, which is
83 at least 30 minutes of travel time, on normally traveled roads
84 under normal traffic conditions, from any other acute care
85 hospital within the same county;
86 3. A hospital supported by a tax district or subdistrict
87 whose boundaries encompass a population of 100 persons or fewer

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88 per square mile;
89 4. A hospital in a constitutional charter county with a
90 population of over 1 million persons that has imposed a local
91 option health service tax pursuant to law and in an area that
92 was directly impacted by a catastrophic event on August 24,
93 1992, for which the Governor of Florida declared a state of
94 emergency pursuant to chapter 125, and has 120 beds or less that
95 serves an agricultural community with an emergency room
96 utilization of no less than 20,000 visits and a Medicaid
97 inpatient utilization rate greater than 15 percent;
98 5. A hospital with a service area that has a population of
99 100 persons or fewer per square mile. As used in this
100 subparagraph, the term “service area” means the fewest number of
101 zip codes that account for 75 percent of the hospital’s
102 discharges for the most recent 5-year period, based on
103 information available from the hospital inpatient discharge
104 database in the Florida Center for Health Information and Policy
105 Analysis at the agency ~~for Health Care Administration~~; or
106 6. A hospital designated as a critical access hospital, as
107 defined in s. 408.07~~(15)~~.
108
109 Population densities used in this paragraph must be based upon
110 the most recently completed United States census. A hospital
111 that received funds under s. 409.9116 for a quarter beginning no
112 later than July 1, 2002, is deemed to have been and shall
113 continue to be a rural hospital from that date through June 30,
114 2015, if the hospital continues to have 100 or fewer licensed
115 beds and an emergency room, or meets the criteria of
116 subparagraph 4. An acute care hospital that has not previously

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117 been designated as a rural hospital and that meets the criteria
118 of this paragraph shall be granted such designation upon
119 application, including supporting documentation, to the agency
120 ~~for Health Care Administration~~. A hospital that was licensed as
121 a rural hospital during the 2010-2011 or 2011-2012 fiscal year
122 shall continue to be a rural hospital from the date of
123 designation through June 30, 2015, if the hospital continues to
124 have 100 or fewer licensed beds and an emergency room.
125 Section 3. Paragraphs (c), (d), and (f) of subsection (5)
126 and subsection (6) of section 409.905, Florida Statutes, are
127 amended to read:
128 409.905 Mandatory Medicaid services.—The agency may make
129 payments for the following services, which are required of the
130 state by Title XIX of the Social Security Act, furnished by
131 Medicaid providers to recipients who are determined to be
132 eligible on the dates on which the services were provided. Any
133 service under this section shall be provided only when medically
134 necessary and in accordance with state and federal law.
135 Mandatory services rendered by providers in mobile units to
136 Medicaid recipients may be restricted by the agency. Nothing in
137 this section shall be construed to prevent or limit the agency
138 from adjusting fees, reimbursement rates, lengths of stay,
139 number of visits, number of services, or any other adjustments
140 necessary to comply with the availability of moneys and any
141 limitations or directions provided for in the General
142 Appropriations Act or chapter 216.
143 (5) HOSPITAL INPATIENT SERVICES.—The agency shall pay for
144 all covered services provided for the medical care and treatment
145 of a recipient who is admitted as an inpatient by a licensed

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146 physician or dentist to a hospital licensed under part I of
147 chapter 395. However, the agency shall limit the payment for
148 inpatient hospital services for a Medicaid recipient 21 years of
149 age or older to 45 days or the number of days necessary to
150 comply with the General Appropriations Act. Effective August 1,
151 2012, the agency shall limit payment for hospital emergency
152 department visits for a nonpregnant Medicaid recipient 21 years
153 of age or older to six visits per fiscal year.
154 (c) The agency shall implement a prospective payment
155 methodology for establishing ~~base~~ reimbursement rates for
156 inpatient hospital services ~~each hospital based on allowable~~
157 ~~costs, as defined by the agency~~. Rates shall be calculated
158 annually and take effect July 1 of each year ~~based on the most~~
159 ~~recent complete and accurate cost report submitted by each~~
160 ~~hospital~~. The methodology shall categorize each inpatient
161 admission into a diagnosis-related group and assign a relative
162 payment weight to the base rate according to the average
163 relative amount of hospital resources used to treat a patient in
164 a specific diagnosis-related group category. The agency may
165 adopt the most recent relative weights calculated and made
166 available by the Nationwide Inpatient Sample maintained by the
167 Agency for Healthcare Research and Quality or may adopt
168 alternative weights if the agency finds that Florida-specific
169 weights deviate with statistical significance from national
170 weights for high-volume diagnosis-related groups. The agency
171 shall establish a single, uniform base rate for all hospitals
172 unless specifically exempt pursuant to s. 409.908(1).
173 1. Adjustments may not be made to the rates after October
174 31 of the state fiscal year in which the rates take effect,

except for cases of insufficient collections of intergovernmental transfers authorized under s. 409.908(1) or the General Appropriations Act. In such cases, the agency shall submit a budget amendment or amendments under chapter 216 requesting approval of rate reductions by amounts necessary for the aggregate reduction to equal the dollar amount of intergovernmental transfers not collected and the corresponding federal match. Notwithstanding the $1 million limitation on increases to an approved operating budget contained in ss. 216.181(11) and 216.292(3), a budget amendment exceeding that dollar amount is subject to notice and objection procedures set forth in s. 216.177.

2. Errors in source data or calculations ~~cost reporting or calculation of rates~~ discovered after October 31 must be reconciled in a subsequent rate period. However, the agency may not make any adjustment to a hospital's reimbursement ~~rate~~ more than 5 years after a hospital is notified of an audited rate established by the agency. The prohibition against adjustments ~~requirement that the agency may not make any adjustment to a hospital's reimbursement rate~~ more than 5 years after notification ~~a hospital is notified of an audited rate established by the agency~~ is remedial and applies to actions by providers involving Medicaid claims for hospital services. Hospital reimbursement is ~~rates are~~ subject to such limits or ceilings as may be established in law or described in the agency's hospital reimbursement plan. Specific exemptions to the limits or ceilings may be provided in the General Appropriations Act.

(d) The agency shall implement a comprehensive utilization

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204 management program for hospital neonatal intensive care stays in
205 certain high-volume participating hospitals, select counties, or
206 statewide, and replace existing hospital inpatient utilization
207 management programs for neonatal intensive care admissions. The
208 program shall be designed to manage appropriate admissions and
209 discharges ~~the lengths of stay~~ for children being treated in
210 neonatal intensive care units and must seek ~~the earliest~~
211 medically appropriate discharge to the child's home or other
212 less costly treatment setting. The agency may competitively bid
213 a contract for the selection of a qualified organization to
214 provide neonatal intensive care utilization management services.
215 The agency may seek federal waivers to implement this
216 initiative.
217 ~~(f) The agency shall develop a plan to convert Medicaid~~
218 ~~inpatient hospital rates to a prospective payment system that~~
219 ~~categorizes each case into diagnosis-related groups (DRG) and~~
220 ~~assigns a payment weight based on the average resources used to~~
221 ~~treat Medicaid patients in that DRG. To the extent possible, the~~
222 ~~agency shall propose an adaptation of an existing prospective~~
223 ~~payment system, such as the one used by Medicare, and shall~~
224 ~~propose such adjustments as are necessary for the Medicaid~~
225 ~~population and to maintain budget neutrality for inpatient~~
226 ~~hospital expenditures.~~
227 ~~1. The plan must:~~
228 ~~a. Define and describe DRGs for inpatient hospital care~~
229 ~~specific to Medicaid in this state;~~
230 ~~b. Determine the use of resources needed for each DRG;~~
231 ~~c. Apply current statewide levels of funding to DRGs based~~
232 ~~on the associated resource value of DRGs. Current statewide~~

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233 ~~funding levels shall be calculated both with and without the use~~
234 ~~of intergovernmental transfers;~~
235 ~~d. Calculate the current number of services provided in the~~
236 ~~Medicaid program based on DRGs defined under this subparagraph;~~
237 ~~e. Estimate the number of cases in each DRG for future~~
238 ~~years based on agency data and the official workload estimates~~
239 ~~of the Social Services Estimating Conference;~~
240 ~~f. Calculate the expected total Medicaid payments in the~~
241 ~~current year for each hospital with a Medicaid provider~~
242 ~~agreement, based on the DRGs and estimated workload;~~
243 ~~g. Propose supplemental DRG payments to augment hospital~~
244 ~~reimbursements based on patient acuity and individual hospital~~
245 ~~characteristics, including classification as a children's~~
246 ~~hospital, rural hospital, trauma center, burn unit, and other~~
247 ~~characteristics that could warrant higher reimbursements, while~~
248 ~~maintaining budget neutrality; and~~
249 ~~h. Estimate potential funding for each hospital with a~~
250 ~~Medicaid provider agreement for DRGs defined pursuant to this~~
251 ~~subparagraph and supplemental DRG payments using current funding~~
252 ~~levels, calculated both with and without the use of~~
253 ~~intergovernmental transfers.~~
254 ~~2. The agency shall engage a consultant with expertise and~~
255 ~~experience in the implementation of DRG systems for hospital~~
256 ~~reimbursement to develop the DRG plan under subparagraph 1.~~
257 ~~3. The agency shall submit the DRG plan, identifying all~~
258 ~~steps necessary for the transition and any costs associated with~~
259 ~~plan implementation, to the Governor, the President of the~~
260 ~~Senate, and the Speaker of the House of Representatives no later~~
261 ~~than January 1, 2013. The plan shall include a timeline~~

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262 ~~necessary to complete full implementation by July 1, 2013. If,~~
263 ~~during implementation of this paragraph, the agency determines~~
264 ~~that these timeframes might not be achievable, the agency shall~~
265 ~~report to the Legislative Budget Commission the status of its~~
266 ~~implementation efforts, the reasons the timeframes might not be~~
267 ~~achievable, and proposals for new timeframes.~~
268 (6) HOSPITAL OUTPATIENT SERVICES.—
269 <u>(a)</u> The agency shall pay for preventive, diagnostic,
270 therapeutic, or palliative care and other services provided to a
271 recipient in the outpatient portion of a hospital licensed under
272 part I of chapter 395, and provided under the direction of a
273 licensed physician or licensed dentist, except that payment for
274 such care and services is limited to $1,500 per state fiscal
275 year per recipient, unless an exception has been made by the
276 agency, and with the exception of a Medicaid recipient under age
277 21, in which case the only limitation is medical necessity.
278 <u>(b) The agency shall implement a methodology for</u>
279 <u>establishing base reimbursement rates for outpatient services</u>
280 <u>for each hospital based on allowable costs, as defined by the</u>
281 <u>agency. Rates shall be calculated annually and take effect July</u>
282 <u>1 of each year based on the most recent complete and accurate</u>
283 <u>cost report submitted by each hospital.</u>
284 <u>1. Adjustments may not be made to the rates after October</u>
285 <u>31 of the state fiscal year in which the rates take effect,</u>
286 <u>except for cases of insufficient collections of</u>
287 <u>intergovernmental transfers authorized under s. 409.908(1) or</u>
288 <u>the General Appropriations Act. In such cases, the agency shall</u>
289 <u>submit a budget amendment or amendments under chapter 216</u>
290 <u>requesting approval of rate reductions by amounts necessary for</u>

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291 the aggregate reduction to equal the dollar amount of
292 intergovernmental transfers not collected and the corresponding
293 federal match. Notwithstanding the $1 million limitation on
294 increases to an approved operating budget under ss. 216.181(11)
295 and 216.292(3), a budget amendment exceeding that dollar amount
296 is subject to notice and objection procedures set forth in s.
297 216.177.
298 2. Errors in source data or calculations discovered after
299 October 31 must be reconciled in a subsequent rate period.
300 However, the agency may not make any adjustment to a hospital's
301 reimbursement more than 5 years after a hospital is notified of
302 an audited rate established by the agency. The prohibition
303 against adjustments more than 5 years after notification is
304 remedial and applies to actions by providers involving Medicaid
305 claims for hospital services. Hospital reimbursement is subject
306 to such limits or ceilings as may be established in law or
307 described in the agency's hospital reimbursement plan. Specific
308 exemptions to the limits or ceilings may be provided in the
309 General Appropriations Act.
310 Section 4. Paragraph (a) of subsection (1) and subsection
311 (23) of section 409.908, Florida Statutes, are amended to read:
312 409.908 Reimbursement of Medicaid providers.—Subject to
313 specific appropriations, the agency shall reimburse Medicaid
314 providers, in accordance with state and federal law, according
315 to methodologies set forth in the rules of the agency and in
316 policy manuals and handbooks incorporated by reference therein.
317 These methodologies may include fee schedules, reimbursement
318 methods based on cost reporting, negotiated fees, competitive
319 bidding pursuant to s. 287.057, and other mechanisms the agency

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320 considers efficient and effective for purchasing services or
321 goods on behalf of recipients. If a provider is reimbursed based
322 on cost reporting and submits a cost report late and that cost
323 report would have been used to set a lower reimbursement rate
324 for a rate semester, then the provider’s rate for that semester
325 shall be retroactively calculated using the new cost report, and
326 full payment at the recalculated rate shall be effected
327 retroactively. Medicare-granted extensions for filing cost
328 reports, if applicable, shall also apply to Medicaid cost
329 reports. Payment for Medicaid compensable services made on
330 behalf of Medicaid eligible persons is subject to the
331 availability of moneys and any limitations or directions
332 provided for in the General Appropriations Act or chapter 216.
333 Further, nothing in this section shall be construed to prevent
334 or limit the agency from adjusting fees, reimbursement rates,
335 lengths of stay, number of visits, or number of services, or
336 making any other adjustments necessary to comply with the
337 availability of moneys and any limitations or directions
338 provided for in the General Appropriations Act, provided the
339 adjustment is consistent with legislative intent.
340 (1) Reimbursement to hospitals licensed under part I of
341 chapter 395 must be made prospectively or on the basis of
342 negotiation.
343 (a) Reimbursement for inpatient care is limited as provided
344 ~~for~~ in s. 409.905(5), except as otherwise provided in this
345 subsection. ~~for:~~
346 1. If authorized by the General Appropriations Act, the
347 agency may modify reimbursement for specific types of services
348 or diagnoses, recipient ages, and hospital provider types ~~The~~

349 ~~raising of rate reimbursement caps, excluding rural hospitals~~.
350 2. The agency may establish an alternative methodology to
351 the DRG-based prospective payment system to set reimbursement
352 rates for:
353 a. State-owned psychiatric hospitals.
354 b. Newborn hearing screening services.
355 c. Transplant services for which the agency has established
356 a global fee.
357 d. Recipients who have tuberculosis that is resistant to
358 therapy who are in need of long-term, hospital-based treatment
359 pursuant to s. 392.62 ~~Recognition of the costs of graduate~~
360 ~~medical education~~.
361 3. The agency shall modify reimbursement according to other
362 methodologies recognized in the General Appropriations Act.
363
364 ~~During the years funds are transferred from the Department of~~
365 ~~Health, any reimbursement supported by such funds shall be~~
366 ~~subject to certification by the Department of Health that the~~
367 ~~hospital has complied with s. 381.0403.~~ The agency may ~~is~~
368 ~~authorized to~~ receive funds from state entities, including, but
369 not limited to, the Department of Health, local governments, and
370 other local political subdivisions, for the purpose of making
371 special exception payments, including federal matching funds,
372 through the Medicaid inpatient reimbursement methodologies.
373 Funds received ~~from state entities or local governments~~ for this
374 purpose shall be separately accounted for and may ~~shall~~ not be
375 commingled with other state or local funds in any manner. The
376 agency may certify all local governmental funds used as state
377 match under Title XIX of the Social Security Act, to the extent

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378 and in the manner authorized under ~~that the identified local~~
379 ~~health care provider that is otherwise entitled to and is~~
380 ~~contracted to receive such local funds is the benefactor under~~
381 ~~the state's Medicaid program as determined under~~ the General
382 Appropriations Act and pursuant to an agreement between the
383 agency ~~for Health Care Administration~~ and the local governmental
384 entity. In order for the agency to certify such local
385 governmental funds, a local governmental entity must submit a
386 final, executed letter of agreement to the agency, which must be
387 received by October 1 of each fiscal year and provide the total
388 amount of local governmental funds authorized by the entity for
389 that fiscal year under this paragraph, paragraph (b), or the
390 General Appropriations Act. The local governmental entity shall
391 use a certification form prescribed by the agency. At a minimum,
392 the certification form must ~~shall~~ identify the amount being
393 certified and describe the relationship between the certifying
394 local governmental entity and the local health care provider.
395 The agency shall prepare an annual statement of impact which
396 documents the specific activities undertaken during the previous
397 fiscal year pursuant to this paragraph, to be submitted to the
398 Legislature annually by ~~no later than~~ January 1~~, annually~~.
399 (23)(a) The agency shall establish rates at a level that
400 ensures no increase in statewide expenditures resulting from a
401 change in unit costs effective July 1, 2011. Reimbursement rates
402 shall be as provided in the General Appropriations Act.
403 (b) Base rate reimbursement under a diagnosis-related group
404 payment methodology shall be provided in the General
405 Appropriations Act.
406 (c) ~~(b)~~ This subsection applies to the following provider

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407 types:
408 1. Inpatient hospitals.
409 2. Outpatient hospitals.
410 3. Nursing homes.
411 4. County health departments.
412 5. Community intermediate care facilities for the
413 developmentally disabled.
414 6. Prepaid health plans.
415 (d) ~~(c)~~ The agency shall apply the effect of this subsection
416 to the reimbursement rates for nursing home diversion programs.
417 Section 5. Section 409.909, Florida Statutes, is created to
418 read:
419 409.909 Statewide Medicaid Residency Program.—
420 (1) The Statewide Medicaid Residency Program is established
421 to improve the quality of care and access to care for Medicaid
422 recipients, expand graduate medical education on an equitable
423 basis, and increase the supply of highly trained physicians
424 statewide. The agency shall make payments to hospitals licensed
425 under part I of chapter 395 for graduate medical education
426 associated with the Medicaid program. This system of payments is
427 designed to generate federal matching funds under Medicaid and
428 distribute the resulting funds to participating hospitals on a
429 quarterly basis in each fiscal year for which an appropriation
430 is made.
431 (2) On or before September 15 of each year, the agency
432 shall calculate an allocation fraction to be used for
433 distributing funds to participating hospitals. On or before the
434 final business day of each quarter of a state fiscal year, the
435 agency shall distribute to each participating hospital one-

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436 fourth of that hospital's annual allocation calculated under
437 subsection (4). The allocation fraction for each participating
438 hospital is based on the hospital's number of full-time
439 equivalent residents and the amount of its Medicaid payments. As
440 used in this section, the term:
441 (a) "Full-time equivalent," or "FTE," means a resident who
442 is in his or her initial residency period, which is defined as
443 the minimum number of years of training required before the
444 resident may become eligible for board certification by the
445 American Osteopathic Association Bureau of Osteopathic
446 Specialists or the American Board of Medical Specialties in the
447 specialty in which he or she first began training, not to exceed
448 5 years. A resident training beyond the initial residency period
449 is counted as 0.5 FTE, unless his or her chosen specialty is in
450 general surgery or primary care, in which case the resident is
451 counted as 1.0 FTE. For the purposes of this section, primary
452 care specialties include:
453 1. Family medicine;
454 2. General internal medicine;
455 3. General pediatrics;
456 4. Preventive medicine;
457 5. Geriatric medicine;
458 6. Osteopathic general practice;
459 7. Obstetrics and gynecology; and
460 8. Emergency medicine.
461 (b) "Medicaid payments" means the estimated total payments
462 for reimbursing a hospital for direct inpatient services for the
463 fiscal year in which the allocation fraction is calculated based
464 on the hospital inpatient appropriation and the parameters for

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465 the inpatient diagnosis-related group base rate, including
466 applicable intergovernmental transfers, specified in the General
467 Appropriations Act, as determined by the agency.
468 (c) “Resident” means a medical intern, fellow, or resident
469 enrolled in a program accredited by the Accreditation Council
470 for Graduate Medical Education, the American Association of
471 Colleges of Osteopathic Medicine, or the American Osteopathic
472 Association at the beginning of the state fiscal year during
473 which the allocation fraction is calculated, as reported by the
474 hospital to the agency.
475 (3) The agency shall use the following formula to calculate
476 a participating hospital’s allocation fraction:
477
478 HAF=[0.9 x (HFTE/TFTE)] + [0.1 x (HMP/TMP)]
479
480 Where:
481 HAF=A hospital’s allocation fraction.
482 HFTE=A hospital’s total number of FTE residents.
483 TFTE=The total FTE residents for all participating
484 hospitals.
485 HMP=A hospital’s Medicaid payments.
486 TMP=The total Medicaid payments for all participating
487 hospitals.
488
489 (4) A hospital’s annual allocation shall be calculated by
490 multiplying the funds appropriated for the Statewide Medicaid
491 Residency Program in the General Appropriations Act by that
492 hospital’s allocation fraction. If the calculation results in an
493 annual allocation that exceeds $50,000 per FTE resident, the

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494 hospital’s annual allocation shall be reduced to a sum equaling
495 no more than $50,000 per FTE resident. The funds calculated for
496 that hospital in excess of $50,000 per FTE resident shall be
497 redistributed to participating hospitals whose annual allocation
498 does not exceed $50,000 per FTE resident, using the same
499 methodology and payment schedule specified in this section.
500 (5) The agency may adopt rules to administer this section.
501 Section 6. Subsection (17) of section 409.910, Florida
502 Statutes, is amended to read:
503 409.910 Responsibility for payments on behalf of Medicaid-
504 eligible persons when other parties are liable.—
505 (17) A recipient or his or her legal representative or any
506 person representing, or acting as agent for, a recipient or the
507 recipient’s legal representative, who has notice, excluding
508 notice charged solely by reason of the recording of the lien
509 pursuant to paragraph (6)(c), or who has actual knowledge of the
510 agency’s rights to third-party benefits under this section, who
511 receives any third-party benefit or proceeds ~~therefrom~~ for a
512 covered illness or injury, must ~~is required either to pay the~~
513 ~~agency~~, within 60 days after receipt of settlement proceeds, pay
514 the agency the full amount of the third-party benefits, but not
515 more than ~~in excess of~~ the total medical assistance provided by
516 Medicaid, or ~~to~~ place the full amount of the third-party
517 benefits in an interest-bearing ~~a~~ trust account for the benefit
518 of the agency pending an ~~judicial or~~ administrative
519 determination of the agency’s right to the benefits ~~thereto~~.
520 Proof that ~~any~~ such person had notice or knowledge that the
521 recipient had received medical assistance from Medicaid, and
522 that third-party benefits or proceeds ~~therefrom~~ were in any way

523 related to a covered illness or injury for which Medicaid had
524 provided medical assistance, and that ~~any~~ such person knowingly
525 obtained possession or control of, or used, third-party benefits
526 or proceeds and failed ~~either~~ to pay the agency the full amount
527 required by this section or to hold the full amount of third-
528 party benefits or proceeds in an interest-bearing trust account
529 pending an ~~judicial or~~ administrative determination, unless
530 adequately explained, gives rise to an inference that such
531 person knowingly failed to credit the state or its agent for
532 payments received from social security, insurance, or other
533 sources, pursuant to s. 414.39(4)(b), and acted with the intent
534 set forth in s. 812.014(1).
535 (a) A recipient may contest the amount designated as
536 recovered medical expense damages payable to the agency pursuant
537 to the formula specified in paragraph (11)(f) by filing a
538 petition under chapter 120 within 21 days after the date of
539 payment of funds to the agency or after the date of placing the
540 full amount of the third-party benefits in the trust account for
541 the benefit of the agency. The petition shall be filed with the
542 Division of Administrative Hearings. For purposes of chapter
543 120, the payment of funds to the agency or the placement of the
544 full amount of the third-party benefits in the trust account for
545 the benefit of the agency constitutes final agency action and
546 notice thereof. Final order authority for the proceedings
547 specified in this subsection rests with the Division of
548 Administrative Hearings. This procedure is the exclusive method
549 for challenging the amount of third-party benefits payable to
550 the agency.
551 1. In order to successfully challenge the amount payable to

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552 the agency, the recipient must prove, by clear and convincing
553 evidence, that a lesser portion of the total recovery should be
554 allocated as reimbursement for past and future medical expenses
555 than the amount calculated by the agency pursuant to the formula
556 set forth in paragraph (11)(f) or that Medicaid provided a
557 lesser amount of medical assistance than that asserted by the
558 agency.
559 2. The agency's provider processing system reports are
560 admissible as prima facie evidence in substantiating the
561 agency's claim.
562 3. Venue for all administrative proceedings pursuant to
563 this subsection lies in Leon County, at the discretion of the
564 agency. Venue for all appellate proceedings arising from the
565 administrative proceeding outlined in this subsection lie at the
566 First District Court of Appeal in Leon County, at the discretion
567 of the agency.
568 4. Each party shall bear its own attorney fees and costs
569 for any administrative proceeding conducted pursuant to this
570 paragraph.
571 (b)(a) In cases of suspected criminal violations or
572 fraudulent activity, the agency may take any civil action
573 permitted at law or equity to recover the greatest possible
574 amount, including, without limitation, treble damages under ss.
575 772.11 and 812.035(7).
576 1.(b) The agency may is authorized to investigate and to
577 request appropriate officers or agencies of the state to
578 investigate suspected criminal violations or fraudulent activity
579 related to third-party benefits, including, without limitation,
580 ss. 414.39 and 812.014. Such requests may be directed, without

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581 limitation, to the Medicaid Fraud Control Unit of the Office of
582 the Attorney General, or to any state attorney. Pursuant to s.
583 409.913, the Attorney General has primary responsibility to
584 investigate and control Medicaid fraud.
585 2.~~(c)~~ In carrying out duties and responsibilities related
586 to Medicaid fraud control, the agency may subpoena witnesses or
587 materials within or outside the state and, through any duly
588 designated employee, administer oaths and affirmations and
589 collect evidence for possible use in either civil or criminal
590 judicial proceedings.
591 3.~~(d)~~ All information obtained and documents prepared
592 pursuant to an investigation of a Medicaid recipient, the
593 recipient's legal representative, or any other person relating
594 to an allegation of recipient fraud or theft is confidential and
595 exempt from s. 119.07(1):
596 a.~~1.~~ Until such time as the agency takes final agency
597 action;
598 b.~~2.~~ Until such time as the Department of Legal Affairs
599 refers the case for criminal prosecution;
600 c.~~3.~~ Until such time as an indictment or criminal
601 information is filed by a state attorney in a criminal case; or
602 d.~~4.~~ At all times if otherwise protected by law.
603 Section 7. Paragraph (a) of subsection (2) and paragraph
604 (d) of subsection (4) of section 409.911, Florida Statutes, are
605 amended to read:
606 409.911 Disproportionate share program.—Subject to specific
607 allocations established within the General Appropriations Act
608 and any limitations established pursuant to chapter 216, the
609 agency shall distribute, pursuant to this section, moneys to

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610 hospitals providing a disproportionate share of Medicaid or
611 charity care services by making quarterly Medicaid payments as
612 required. Notwithstanding the provisions of s. 409.915, counties
613 are exempt from contributing toward the cost of this special
614 reimbursement for hospitals serving a disproportionate share of
615 low-income patients.
616 (2) The Agency for Health Care Administration shall use the
617 following actual audited data to determine the Medicaid days and
618 charity care to be used in calculating the disproportionate
619 share payment:
620 (a) The average of the ~~2004,~~ 2005, ~~and~~ 2006, and 2007
621 audited disproportionate share data to determine each hospital's
622 Medicaid days and charity care for the 2013-2014 ~~2012-2013~~ state
623 fiscal year.
624 (4) The following formulas shall be used to pay
625 disproportionate share dollars to public hospitals:
626 (d) Any nonstate government owned or operated hospital
627 eligible for payments under this section on July 1, 2011,
628 remains eligible for payments during the 2013-2014 ~~2012-2013~~
629 state fiscal year.
630 Section 8. Subsection (2) of section 409.9118, Florida
631 Statutes, is amended to read:
632 409.9118 Disproportionate share program for specialty
633 hospitals.— The Agency for Health Care Administration shall
634 design and implement a system of making disproportionate share
635 payments to those hospitals licensed in accordance with part I
636 of chapter 395 as a specialty hospital which meet all
637 requirements listed in subsection (2). Notwithstanding s.
638 409.915, counties are exempt from contributing toward the cost

639 of this special reimbursement for patients.
640 (2) In order to receive payments under this section, a
641 hospital must be licensed in accordance with part I of chapter
642 395, to participate in the Florida Title XIX program, and meet
643 the following requirements:
644 (a) Be certified or certifiable to be a provider of Title
645 XVIII services.
646 (b) Receive ~~all of its~~ inpatient clients through referrals
647 or admissions from county public health departments, as defined
648 in chapter 154.
649 (c) Require a diagnosis for the control of active
650 tuberculosis or a history of noncompliance with prescribed drug
651 regimens for the treatment of tuberculosis ~~a communicable~~
652 ~~disease~~ for ~~all~~ admissions for inpatient treatment.
653 (d) Retain a contract with the Department of Health to
654 accept clients for admission and inpatient treatment pursuant to
655 s. 392.62.
656 Section 9. Paragraphs (b), (l), and (m) of subsection (2)
657 of section 409.9122, Florida Statutes, are amended, subsections
658 (3) through (21) of that section are renumbered as subsections
659 (4) through (22), respectively, and a new subsection (3) is
660 added to that section, to read:
661 409.9122 Mandatory Medicaid managed care enrollment;
662 programs and procedures.—
663 (2)
664 (b) A Medicaid recipient may ~~shall~~ not be enrolled in or
665 assigned to a managed care plan or MediPass unless the managed
666 care plan or MediPass has complied with the quality-of-care
667 standards specified in paragraphs (4)(a) ~~(3)(a)~~ and (b),

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respectively.

~~(l) If the Medicaid recipient is diagnosed with HIV/AIDS, the agency shall assign the Medicaid recipient to a managed care plan that is a health maintenance organization authorized under chapter 641, is under contract with the agency on July 1, 2011, and which offers a delivery system through a university-based teaching and research-oriented organization that specializes in providing health care services and treatment for individuals diagnosed with HIV/AIDS.~~

(l) ~~(m)~~ Notwithstanding ~~the provisions of~~ chapter 287, the agency may~~, at its discretion,~~ renew cost-effective contracts for choice counseling services once or more for such periods as the agency may decide. However, all such renewals may not combine to exceed a total period longer than the term of the original contract.

This subsection expires October 1, 2014.

(3) Notwithstanding s. 409.961, if a Medicaid recipient is diagnosed with HIV/AIDS, the agency shall assign the recipient to a managed care plan that is a health maintenance organization authorized under chapter 641, that is under contract with the agency as an HIV/AIDS specialty plan as of January 1, 2013, and that offers a delivery system through a university-based teaching and research-oriented organization that specializes in providing health care services and treatment for individuals diagnosed with HIV/AIDS. This subsection applies to recipients who are subject to mandatory managed care enrollment and have failed to choose a managed care option.

Section 10. Section 409.915, Florida Statutes, is amended

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697 to read:
698 409.915 County contributions to Medicaid.—Although the
699 state is responsible for the full portion of the state share of
700 the matching funds required for the Medicaid program, ~~in order~~
701 ~~to acquire a certain portion of these funds,~~ the state shall
702 charge the counties an annual contribution in order to acquire a
703 certain portion of these funds ~~for certain items of care and~~
704 ~~service as provided in this section~~.
705 (1) As used in this section, the term "state Medicaid
706 expenditures" means those expenditures used as matching funds
707 for the federal Medicaid program.
708 (2)(a) For the 2013-2014 state fiscal year, the total
709 amount of the counties' annual contribution is $269.6 million.
710 (b) For the 2014-2015 state fiscal year, the total amount
711 of the counties' annual contribution is $277 million.
712 (c) By March 15, 2015, and each year thereafter, the Social
713 Services Estimating Conference shall determine the percentage
714 change in state Medicaid expenditures by comparing expenditures
715 for the 2 most recent completed state fiscal years.
716 (d) For the 2015-2016 state fiscal year through the 2019-
717 2020 state fiscal year, the total amount of the counties' annual
718 contribution shall be the total contribution for the prior
719 fiscal year adjusted by 50 percent of the percentage change in
720 the state Medicaid expenditures as determined by the Social
721 Services Estimating Conference.
722 (e) For each fiscal year after the 2019-2020 state fiscal
723 year, the total amount of the counties' annual contribution
724 shall be the total contribution for the prior fiscal year
725 adjusted by the percentage change in the state Medicaid

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726 expenditures as determined by the Social Services Estimating
727 Conference.
728 (3)(a)1. The amount of each county's annual contribution is
729 equal to the product of the amount determined under subsection
730 (2) multiplied by the sum of the percentages calculated in sub-
731 subparagraphs a. and b.:
732 a. The enrollment weight provided in subparagraph 2. is
733 multiplied by a fraction, the numerator of which is the number
734 of the county's Medicaid enrollees as of March 1 of each year,
735 and the denominator of which is the number of all counties'
736 Medicaid enrollees as of March 1 of each year. The agency shall
737 calculate this amount for each county and provide the
738 information to the Department of Revenue by May 15 of each year.
739 b. The payment weight provided in subparagraph 2. is
740 multiplied by the percentage share of payments provided in
741 subparagraph 3. for each county.
742 2. The weights for each fiscal year are equal to:
743
744 WEIGHTS
745

FISCAL YEAR	ENROLLMENT	PAYMENT
746		
2013-14	0%	100%
747		
2014-15	0%	100%
748		
2015-16	20%	80%
749		
2016-17	40%	60%

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750

2017-18	60%	40%
2018-19	80%	20%
2019-20+	100%	0%

751
752
753
754 3. The percentage share of payments for each county is:
755

COUNTY	SHARE OF PAYMENTS
Alachua	1.278%
Baker	0.116%
Bay	0.607%
Bradford	0.179%
Brevard	2.471%
Broward	9.228%
Calhoun	0.084%
Charlotte	0.578%
Citrus	0.663%

756
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766

Clay	0.635%
Collier	1.161%
Columbia	0.557%
Dade (Miami-Dade)	18.853%
Desoto	0.167%
Dixie	0.098%
Duval	5.337%
Escambia	1.615%
Flagler	0.397%
Franklin	0.091%
Gadsden	0.239%
Gilchrist	0.078%
Glades	0.055%
Gulf	0.076%

767 768 769 770 771 772 773 774 775 776 777 778 779 780

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	Hamilton	0.075%
781	Hardee	0.110%
782	Hendry	0.163%
783	Hernando	0.862%
784	Highlands	0.468%
785	Hillsborough	6.953%
786	Holmes	0.101%
787	Indian River	0.397%
788	Jackson	0.219%
789	Jefferson	0.083%
790	Lafayette	0.014%
791	Lake	1.525%
792	Lee	2.512%
793	Leon	0.929%
794	Levy	0.256%

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795

Liberty	0.050%
Madison	0.086%
Manatee	1.623%
Marion	1.630%
Martin	0.353%
Monroe	0.262%
Nassau	0.240%
Okaloosa	0.567%
Okeechobee	0.235%
Orange	6.682%
Osceola	1.613%
Palm Beach	5.899%
Pasco	2.392%
Pinellas	6.645%

796 797 798 799 800 801 802 803 804 805 806 807 808 809

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	Polk	3.643%
810	Putnam	0.417%
811	Saint Johns	0.459%
812	Saint Lucie	1.155%
813	Santa Rosa	0.462%
814	Sarasota	1.230%
815	Seminole	1.740%
816	Sumter	0.218%
817	Suwannee	0.252%
818	Taylor	0.103%
819	Union	0.075%
820	Volusia	2.298%
821	Wakulla	0.103%
822	Walton	0.229%
823	Washington	0.114%

824
825
826 (b)1. The Legislature intends to replace the county
827 percentage share provided in subparagraph (a)3. with percentage
828 shares based upon each county's proportion of the total
829 statewide amount of county billings made under this section from
830 April 1, 2012, through March 31, 2013, for which the state
831 ultimately receives payment.
832 2. By February 1 of each year and continuing until a
833 certification is made under sub-subparagraph b., the agency
834 shall report to the President of the Senate and the Speaker of
835 the House of Representatives the status of the county billings
836 made under this section from April 1, 2012, through March 31,
837 2013, by county, including:
838 a. The amounts billed to each county which remain unpaid,
839 if any; and
840 b. A certification from the agency of a final accounting of
841 the amount of funds received by the state from such billings, by
842 county, upon the expiration of all appeal rights that counties
843 may have to contest such billings.
844 3. By March 15 of the state fiscal year in which the state
845 receives the certification provided for in sub-subparagraph
846 (b)2.b., the Social Services Estimating Conference shall
847 calculate each county's percentage share of the total statewide
848 amount of county billings made under this section from April 1,
849 2012, through March 31, 2013, for which the state ultimately
850 receives payment.
851 4. Beginning in the state fiscal year following the receipt
852 by the state of the certification provided in sub-subparagraph

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853 (b)2.b., each county's percentage share under subparagraph (a)3.
854 shall be replaced by the percentage calculated under
855 subparagraph (b)3.
856 5. If the court invalidates the replacement of each
857 county's share as provided in this paragraph, the county share
858 set forth in subparagraph (a)3. shall continue to apply.
859 (4) By June 1 of each year, the Department of Revenue shall
860 notify each county of its required annual contribution. Each
861 county shall pay its contribution, by check or electronic
862 transfer, in equal monthly installments to the department by the
863 5th day of each month. If a county fails to remit the payment by
864 the 5th day of the month, the department shall reduce the
865 monthly distribution of that county pursuant to s. 218.61 and,
866 if necessary, by the amount of the monthly installment pursuant
867 to s. 218.26. The payments and the amounts by which the
868 distributions are reduced shall be transferred to the General
869 Revenue Fund.
870 ~~(1) Each county shall participate in the following items of~~
871 ~~care and service:~~
872 ~~(a) For both health maintenance members and fee-for-service~~
873 ~~beneficiaries, payments for inpatient hospitalization in excess~~
874 ~~of 10 days, but not in excess of 45 days, with the exception of~~
875 ~~pregnant women and children whose income is in excess of the~~
876 ~~federal poverty level and who do not participate in the Medicaid~~
877 ~~medically needy program, and for adult lung transplant services.~~
878 ~~(b) For both health maintenance members and fee-for-service~~
879 ~~beneficiaries, payments for nursing home or intermediate~~
880 ~~facilities care in excess of $170 per month, with the exception~~
881 ~~of skilled nursing care for children under age 21.~~

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882 ~~(2) A county's participation must be 35 percent of the~~
883 ~~total cost, or the applicable discounted cost paid by the state~~
884 ~~for Medicaid recipients enrolled in health maintenance~~
885 ~~organizations or prepaid health plans, of providing the items~~
886 ~~listed in subsection (1), except that the payments for items~~
887 ~~listed in paragraph (1)(b) may not exceed $55 per month per~~
888 ~~person.~~
889 ~~(3) Each county shall set aside sufficient funds to pay for~~
890 ~~items of care and service provided to the county's eligible~~
891 ~~recipients for which county contributions are required,~~
892 ~~regardless of where in the state the care or service is~~
893 ~~rendered.~~
894 ~~(4) Each county shall contribute its pro rata share of the~~
895 ~~total county participation based upon statements rendered by the~~
896 ~~agency. The agency shall render such statements monthly based on~~
897 ~~each county's eligible recipients. For purposes of this section,~~
898 ~~each county's eligible recipients shall be determined by the~~
899 ~~recipient's address information contained in the federally~~
900 ~~approved Medicaid eligibility system within the Department of~~
901 ~~Children and Family Services. A county may use the process~~
902 ~~developed under subsection (10) to request a refund if it~~
903 ~~determines that the statement rendered by the agency contains~~
904 ~~errors.~~
905 (5) In any county in which a special taxing district or
906 authority is located which benefits ~~will benefit~~ from the
907 Medicaid program ~~medical assistance programs covered by this~~
908 ~~section~~, the board of county commissioners may divide the
909 county's financial responsibility for this purpose
910 proportionately, and each such district or authority must

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911 furnish its share to the board of county commissioners in time
912 for the board to comply with subsection (4) ~~(3)~~. Any appeal of
913 the proration made by the board of county commissioners must be
914 made to the Department of Financial Services, which shall ~~then~~
915 set the proportionate share for ~~of~~ each party.
916 ~~(6) Counties are exempt from contributing toward the cost~~
917 ~~of new exemptions on inpatient ceilings for statutory teaching~~
918 ~~hospitals, specialty hospitals, and community hospital education~~
919 ~~program hospitals that came into effect July 1, 2000, and for~~
920 ~~special Medicaid payments that came into effect on or after July~~
921 ~~1, 2000.~~
922 (6) ~~(7)~~(a) By August 1, 2012, the agency shall certify to
923 each county the amount of such county's billings from November
924 1, 2001, through April 30, 2012, which remain unpaid. A county
925 may contest the amount certified by filing a petition under the
926 applicable provisions of chapter 120 on or before September 1,
927 2012. This procedure is the exclusive method to challenge the
928 amount certified. In order to successfully challenge the amount
929 certified, a county must show, by a preponderance of the
930 evidence, that a recipient was not an eligible recipient of that
931 county or that the amount certified was otherwise in error.
932 (b) By September 15, 2012, the agency shall certify to the
933 Department of Revenue:
934 1. For each county that files a petition on or before
935 September 1, 2012, the amount certified under paragraph (a); and
936 2. For each county that does not file a petition on or
937 before September 1, 2012, an amount equal to 85 percent of the
938 amount certified under paragraph (a).
939 (c) The filing of a petition under paragraph (a) does ~~shall~~

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940 not stay or stop the Department of Revenue from reducing
941 distributions in accordance with paragraph (b) and subsection
942 <u>(7)</u> ~~(8)~~. If a county that files a petition under paragraph (a)
943 is able to demonstrate that the amount certified should be
944 reduced, the agency shall notify the Department of Revenue of
945 the amount of the reduction. The Department of Revenue shall
946 adjust all future monthly distribution reductions under
947 subsection <u>(7)</u> ~~(8)~~ in a manner that results in the remaining
948 total distribution reduction being applied in equal monthly
949 amounts.
950 <u>(7)</u>~~(8)~~(a) Beginning with the October 2012 distribution, the
951 Department of Revenue shall reduce each county's distributions
952 pursuant to s. 218.26 by one thirty-sixth of the amount
953 certified by the agency under subsection <u>(6)</u> ~~(7)~~ for that
954 county, minus any amount required under paragraph (b). Beginning
955 with the October 2013 distribution, the Department of Revenue
956 shall reduce each county's distributions pursuant to s. 218.26
957 by one forty-eighth of two-thirds of the amount certified by the
958 agency under subsection <u>(6)</u> ~~(7)~~ for that county, minus any
959 amount required under paragraph (b). However, the amount of the
960 reduction may not exceed 50 percent of each county's
961 distribution. If, after 60 months, the reductions for any county
962 do not equal the total amount initially certified by the agency,
963 the Department of Revenue shall continue to reduce such county's
964 distribution by up to 50 percent until the total amount
965 certified is reached. The amounts by which the distributions are
966 reduced shall be transferred to the General Revenue Fund.
967 (b) As an assurance to holders of bonds issued before the
968 effective date of this act to which distributions made pursuant

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969 to s. 218.26 are pledged, or bonds issued to refund such bonds
970 which mature no later than the bonds they refunded and which
971 result in a reduction of debt service payable in each fiscal
972 year, the amount available for distribution to a county shall
973 remain as provided by law and continue to be subject to any lien
974 or claim on behalf of the bondholders. The Department of Revenue
975 must ensure, based on information provided by an affected
976 county, that any reduction in amounts distributed pursuant to
977 paragraph (a) does not reduce the amount of distribution to a
978 county below the amount necessary for the timely payment of
979 principal and interest when due on the bonds and the amount
980 necessary to comply with any covenant under the bond resolution
981 or other documents relating to the issuance of the bonds. If a
982 reduction to a county's monthly distribution must be decreased
983 in order to comply with this paragraph, the Department of
984 Revenue must notify the agency of the amount of the decrease and
985 the agency must send a bill for payment of such amount to the
986 affected county.
987 ~~(9)(a) Beginning May 1, 2012, and each month thereafter,~~
988 ~~the agency shall certify to the Department of Revenue by the 7th~~
989 ~~day of each month the amount of the monthly statement rendered~~
990 ~~to each county pursuant to subsection (4). Beginning with the~~
991 ~~May 2012 distribution, the Department of Revenue shall reduce~~
992 ~~each county's monthly distribution pursuant to s. 218.61 by the~~
993 ~~amount certified by the agency minus any amount required under~~
994 ~~paragraph (b). The amounts by which the distributions are~~
995 ~~reduced shall be transferred to the General Revenue Fund.~~
996 ~~(b) As an assurance to holders of bonds issued before the~~
997 ~~effective date of this act to which distributions made pursuant~~

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998 ~~to s. 218.61 are pledged, or bonds issued to refund such bonds~~
999 ~~which mature no later than the bonds they refunded and which~~
1000 ~~result in a reduction of debt service payable in each fiscal~~
1001 ~~year, the amount available for distribution to a county shall~~
1002 ~~remain as provided by law and continue to be subject to any lien~~
1003 ~~or claim on behalf of the bondholders. The Department of Revenue~~
1004 ~~must ensure, based on information provided by an affected~~
1005 ~~county, that any reduction in amounts distributed pursuant to~~
1006 ~~paragraph (a) does not reduce the amount of distribution to a~~
1007 ~~county below the amount necessary for the timely payment of~~
1008 ~~principal and interest when due on the bonds and the amount~~
1009 ~~necessary to comply with any covenant under the bond resolution~~
1010 ~~or other documents relating to the issuance of the bonds. If a~~
1011 ~~reduction to a county's monthly distribution must be decreased~~
1012 ~~in order to comply with this paragraph, the Department of~~
1013 ~~Revenue must notify the agency of the amount of the decrease and~~
1014 ~~the agency must send a bill for payment of such amount to the~~
1015 ~~affected county.~~
1016 ~~(10) The agency, in consultation with the Department of~~
1017 ~~Revenue and the Florida Association of Counties, shall develop a~~
1018 ~~process for refund requests which:~~
1019 ~~(a) Allows counties to submit to the agency written~~
1020 ~~requests for refunds of any amounts by which the distributions~~
1021 ~~were reduced as provided in subsection (9) and which set forth~~
1022 ~~the reasons for the refund requests.~~
1023 ~~(b) Requires the agency to make a determination as to~~
1024 ~~whether a refund request is appropriate and should be approved,~~
1025 ~~in which case the agency shall certify the amount of the refund~~
1026 ~~to the department.~~

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1027 ~~(c) Requires the department to issue the refund for the~~
1028 ~~certified amount to the county from the General Revenue Fund.~~
1029 ~~The Department of Revenue may issue the refund in the form of a~~
1030 ~~credit against reductions to be applied to subsequent monthly~~
1031 ~~distributions.~~
1032 (8)~~(11)~~ Beginning in the 2013-2014 fiscal year and each
1033 year thereafter through the 2020-2021 fiscal year, the Chief
1034 Financial Officer shall transfer from the General Revenue Fund
1035 to the Lawton Chiles Endowment Fund an amount equal to the
1036 amounts transferred to the General Revenue Fund in the previous
1037 fiscal year pursuant to subsections (4) and (7) ~~subsections (8)~~
1038 ~~and (9), reduced by the amount of refunds paid pursuant to~~
1039 ~~subsection (10),~~ which are in excess of the official estimate
1040 for medical hospital fees for such previous fiscal year adopted
1041 by the Revenue Estimating Conference on January 12, 2012, as
1042 reflected in the conference’s workpapers. By July 20 of each
1043 year, the Office of Economic and Demographic Research shall
1044 certify the amount to be transferred to the Chief Financial
1045 Officer. Such transfers must be made before July 31 of each year
1046 until the total transfers for all years equal $350 million. If
1047 ~~In the event that~~ such transfers do not total $350 million by
1048 July 1, 2021, the Legislature shall provide for the transfer of
1049 amounts necessary to total $350 million. The Office of Economic
1050 and Demographic Research shall publish the official estimates
1051 reflected in the conference’s workpapers on its website.
1052 (9)~~(12)~~ The agency may adopt rules to administer this
1053 section.
1054 Section 11. Notwithstanding s. 409.915(3) and (4), Florida
1055 Statutes, as amended by this act, the amount of each county’s

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1056 contribution during the 2013-2014 state fiscal year shall be
1057 determined and provided to the Department of Revenue by the
1058 Agency for Health Care Administration by June 15, 2013. The
1059 Department of Revenue shall notify each county of its annual
1060 contribution by June 20, 2013.
1061 Section 12. The Agency for Health Care Administration shall
1062 submit a data report by March 1 of each year to the Governor,
1063 the President of the Senate, the Speaker of the House of
1064 Representatives, and the Florida Association of Counties which
1065 includes such information as may be necessary for
1066 comprehensively evaluating the cost and utilization of health
1067 services by Medicaid enrollees by service type in each county.
1068 This section is repealed December 31, 2015.
1069 Section 13. The paragraph following Specific Appropriation
1070 195 contained in SB 1500, if adopted during the 2013 Regular
1071 Session of the Florida Legislature, is repealed and replaced
1072 with the following upon SB 1500 becoming a law:
1073
1074 From the funds in Specific Appropriations 195, 197,
1075 198, 201, 203, 215, 219, 222, and 223, $677,722,971
1076 from the Medical Care Trust Fund is provided for
1077 increased reimbursement rates for primary care
1078 services provided to eligible Medicaid recipients.
1079
1080 Section 14. This act shall take effect July 1, 2013.

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