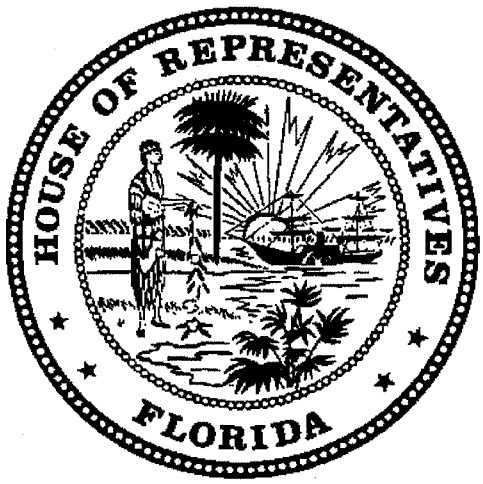

Healthcare Council

Thursday, March 27, 2008
10:30 AM – 12:30 PM
Reed Hall

Marco Rubio
Speaker

Aaron Bean
Chair

Council Meeting Notice

HOUSE OF REPRESENTATIVES

Speaker Marco Rubio

Healthcare Council

Start Date and Time:	Thursday, March 27, 2008 10:30 am
End Date and Time:	Thursday, March 27, 2008 12:30 pm
Location:	Reed Hall (102 HOB)
Duration:	2.00 hrs

Review and Discussion of Chair's Recommendations for FY 2008-09 Budget

Review and Discussion of Proposed Conforming Bills

NOTICE FINALIZED on 03/25/2008 16:13 by BAI

Review and Discussion of
Chair's Recommendations
for FY 2008-09

ROW	ISSUE	ISSUE TITLE	FTE	RATE	GR	NR GR	TB	NR TB	OTHER TF	TOTAL FUNDS	COMMENTS	ROW
1	AGENCY/HEALTH CARE ADMIN											1
2	1100000	Startup (Recurring Law And Policy) - Operating	1,707.50	74,760,487	4,722,752,671		170,164,108		11,233,404,665	16,126,321,444	Base Budget	2
3	1600330	Realign Prepaid Health Plan Categories - Add			1,095,427,999				1,381,490,616	2,476,918,615	Technical Issue to realign prepaid health plan categories.	3
4	1600340	Realign Prepaid Health Plan Categories - Deduct			(1,095,427,999)				(1,381,490,616)	(2,476,918,615)	Technical Issue to realign prepaid health plan categories.	4
5	1601440	Transfer From Qualified Expenditure Category To Operating Category - Deduct			(2,242,800)				(5,423,398)	(7,666,198)	Technical issue to realign funding for the Florida Kidcare program.	5
6	1601450	Transfer From Qualified Expenditure Category To Operating Category - Add			2,242,800				5,423,398	7,666,198	Technical issue to realign funding for the Florida Kidcare program.	6
7	1602000	Agency For Health Care Research And Quality Grant							165,600	165,600	Continuation of FY 2007-08 approved budget amendment.	7
8	1604500	Reallocation Of Human Resources Outsourcing			(628)				(2,343)	(2,971)	Statewide reallocation of Human Resources Outsourcing contractual funding.	8
9	1700200	Transfer Home And Community Based Services Waiver Funding To Medicaid State Plan Services			9,100,292				11,331,437	20,431,729	Transfer of funding from APD to AHCA. AHCA will provide Personal Care Assistance to waiver clients under age 21 through the Medicaid State Plan effective July 1, 2008. Currently these services are provided through waivers in APD.	9
10	1700800	Transfer Workers' Compensation Medical Service Program To Department Of Financial Services	(15.00)	(692,509)					(1,038,103)	(1,038,103)	Transfer of positions and funding to the DFS for the Workers' Compensation Medical Services Program. The majority of the functions related to the Medical Services Unit impact regulatory responsibilities of the Division of Workers' Compensation. The positions are currently housed at DFS.	10
11	1800400	Hospice Room & Board Funding To Nursing Home Care-Add			116,862,034				145,542,502	262,404,536	Transfer of funding for Room and Board payments from the Hospice category to the Nursing Home Care Line item due to the elimination of the hospice program. See Issue Code 33V5860.	11
12	1800450	Hospice Room & Board Funding To Nursing Home Care-Deduct			(116,862,034)				(145,542,502)	(262,404,536)	Transfer of funding for Room and Board payments from the Hospice category to the Nursing Home Care Line item due to the elimination of the hospice program. See Issue Code 33V5860.	12
13	1801080	Transfer Positions From Health Care Regulation To The Florida Center For Adverse Incident Reports - Deduct	(3.00)	(109,547)					(182,841)	(182,841)	Transfer positions responsible for intake and evaluation of hospital and ambulatory surgery center adverse incidents reports from Health Care Regulation Division to Center for Health Information and Policy Analysis to assist the Agency's efforts to redirect analysis and use of Code 15 reports from regulatory/punitive purpose to a patient safety improvement use.	13

ROW	ISSUE	ISSUE TITLE	FTE	RATE	GR	NR GR	TB	NR TB	OTHER TF	TOTAL FUNDS	COMMENTS	ROW
14	1801090	Transfer Positions From Health Care Regulation To The Florida Center For Adverse Incident Reports - Add	3.00	109,547					182,841	182,841	Transfer positions responsible for intake and evaluation of hospital and ambulatory surgery center adverse incidents reports from Health Care Regulation Division to Center for Health Information and Policy Analysis to assist the Agency's efforts to redirect analysis and use of Code 15 reports from regulatory/punitive purpose to a patient safety improvement use.	14
15	2301510	Institutional And Prescribed Drug Providers			183,602,243				256,294,881	439,897,124	Medicaid price level adjustment as agreed upon at the February 2008 Social Services Estimating Conference.	15
16	2503080	Direct Billing For Administrative Hearings			(37,371)				(563,193)	(600,564)	Statewide issue allocating funding for administrative hearings process.	16
17	3001400	Pharmaceutical Expense Assistance			(152,135)					(152,135)	Reduction in funding based on usage of program. This program assists cancer and transplant patients with the 20% co-insurance on their Medicare Part B-covered medications related to those therapies.	17
18	3001780	Children's Special Health Care			12,695,502		737,734		15,334,721	28,767,957	Funding for increase caseload and cost adjustments for the Florida Kidcare Program. Funding for an additional 38,417 slots over the estimated June 20, 2008 enrollment estimates.	18
19	3004500	Medicaid Services			154,861,302				(190,138,810)	(35,277,508)	Medicaid workload adjustment as agreed upon at the February 2008 Social Services Estimating Conference. $175.2 of the increased state funding is due to the change in the FMAP rate.	19
20	33B1200	Eliminate Contract With Teaching Nursing Home			(625,000)					(625,000)	Eliminates state funding for the Teaching Nursing Home Program. Currently, the Miami Jewish Home and Hospital for the Aged, Inc. serves as the only official teaching nursing home in Florida. Since Fiscal Year 2000-01 the program has received $5.2 million in state funding.	20
21	33B1300	Eliminate Contract With The Patient Safety Corporation			(750,000)					(750,000)	Eliminates state funding for the Patient Safety Corporation. Since Fiscal Year 2004-05 the program has received $2.9 million in state funding.	21
22	33B1700	Eliminate Expenditures For The Family Cafe			(100,000)				(100,000)	(200,000)	Eliminates AHCA contribution towards the Family Café annual conference.	22

ROW	ISSUE	ISSUE TITLE	FTE	RATE	GR	NR GR	TB	NR TB	OTHER TF	TOTAL FUNDS	COMMENTS	ROW
23	33B1900	Limit Travel For Surveys In Plans And Construction							(55,000)	(55,000)	Reduces the 80% complete on-site construction inspection for new and renovated facilities. Projects will still be inspected that are 100% complete. Will save approximately 25% of the annual travel spent for construction reviews. Will require rule revisions.	23
24	33B2350	Expand Prior Authorization Of Inpatient Hospital To Include Elective Cesarean Sections			(1,602,126)				(1,660,489)	(3,262,615)	Prior authorization of elective C-Section procedures. Emergency C-Sections would not require prior authorization.	24
25	33V0030	Eliminate Exemption From Hospital Inpatient Reimbursement Ceiling Funding			(5,168,859)				(6,660,254)	(11,829,113)	Eliminates funding for special inpatient hospital per diem adjustments as described in s. 409.905(5)(c), F.S. Five hospitals currently receive funding-Health Central, Lake Wales, Winter Haven, New Port Richey and Larkin Community.	25
26	33V0100	Medicaid Choice Counseling Consolidation Of Funding			(3,252,500)				(3,252,500)	(6,505,000)	Eliminates duplicative funding for Medicaid Choice Counseling Funding. This function will continue to be provided through the Medicaid Fiscal Agent appropriation.	26
27	33V0110	Eliminate Payment For Preventable Hospital Errors			(96,179)				(119,468)	(215,647)	Eliminates payments to hospitals for preventable hospital errors based federal CMS program.	27
28	33V0150	Nursing Home Diversion Expansion			(9,970,297)				(12,414,743)	(22,385,040)	Expands Nursing Home Diversion program by 3,000 slots funded by a reduction in the Nursing Home Care appropriation.	28
29	33V0170	Freeze Florida Healthy Kids Corporation Capitation Rates			(4,840,546)				(10,664,086)	(15,504,632)	Freezes the per member per month capitation payments at the June 30, 2008 levels for the FHK component of Kidcare.	29
30	33V0182	Pharmacy Program Reduction			(4,343,431)				(5,395,197)	(9,738,628)	Reduced reimbursement for prescribed drugs from AWP minus 15.4% to AWP minus 16.4%; and WAC plus 5.75% to WAC plus 4.75%.	30
31	33V0410	Positions Vacant Greater Than 365 Days	(2.00)	(78,043)	(97,674)				(33,221)	(130,895)	Elimination of Agency positions vacant greater than 365 days.	31
32	33V0900	Statewide Advocacy Council	(13.00)	(577,127)	(955,051)					(955,051)	Eliminates funding for the Statewide and Local Advocacy Councils.	32
33	33V4000	Eliminate Chiropractic And Podiatric Coverage			(1,288,113)				(1,630,816)	(2,918,929)	Eliminates chiropractic and podiatric coverage from optional Medicaid services effective October 1, 2008. 29,908 individuals utilized these services during the 2006-07 fiscal year.	33
34	33V4230	Reduce MediPass Case Management Fee			(4,436,712)				(5,561,142)	(9,997,854)	Reduces MediPass Case Management fee from $3 per member per month to $1.50 per member per month effective September 1, 2008.	34

ROW	ISSUE	ISSUE TITLE	FTE	RATE	GR	NR GR	TB	NR TB	OTHER TF	TOTAL FUNDS	COMMENTS	ROW
35	33V4270	Reduce Prepaid Mental Health Plan Service Contract Rates			(4,249,132)				(5,290,903)	(9,540,035)	Reduces funding for prepaid mental health plan service contract rates by 4%.	35
36	33V4290	Reduce Clinic Services Reimbursement Rates			(24,478,992)				(31,381,008)	(55,860,000)	Reduces reimbursement for County Health Department Medicaid reimbursements from 100% of cost to 61% of cost. See Issue 4101800.	36
37	33V5140	Eliminate Non-Ambulatory Coverage For The Medically Needy Program			(75,550,150)				(94,072,997)	(169,623,147)	Eliminates Hospital Inpatient Services from the Medically Needy program effective October 1, 2008. There are currently 19,509 individuals served through the Medically Needy program. Children and Pregnant women will continue to receive inpatient services.	37
38	33V5850	Exclude Retroactive Eligibility Payments From Home Rates			(8,616,281)				(10,728,760)	(19,345,041)	Eliminates retroactive eligible claims from the calculation of managed care rates since managed care plans do not cover these costs through their plans. Effective September 1, 2008.	38
39	33V5860	Eliminate Hospice Coverage			(23,372,406)				(29,108,501)	(52,480,907)	Eliminates the optional Medicaid Hospice program effective October 1, 2008. 7,668 individuals would lose hospice coverage, however, 5,751 are currently served in nursing homes and would continue to receive skilled nursing care services in nursing homes.	39
40	33V6100	Eliminate Adult Dental, Visual And Hearing Services			(14,014,532)				(17,757,897)	(31,772,429)	Eliminates the optional adult dental, vision and hearings services from the Medicaid program effective October 1, 2008. 145,659 Individuals accessed these services during the 2006-07 fiscal year. Children under the age of 21 will continue to receive these services. Includes impact to HMO rates.	40
41	33V6500	Autoimmune Center - University Of Florida			(450,000)					(450,000)	Eliminates funding for the UF Center for Orphan Auto Immune Disorder Contract. Since Fiscal Year 2001-02, this contract has received $3.2 million in state funds.	41
42	33V7010	Nursing Home Rate Reduction			(123,822,408)				(154,180,304)	(278,002,712)	10% reduction in Nursing Home reimbursement based on anticipated 2008-09 spend for this category.	42
43	33V7020	Hospital Outpatient Rate Reduction			(32,116,188)				(40,314,876)	(72,431,064)	10% reduction in Hospital Outpatient reimbursement based on anticipated 2008-09 spend for this category. Includes impact to HMO rates.	43

ROW	ISSUE	ISSUE TITLE	FTE	RATE	GR	NR GR	TB	NR TB	OTHER TF	TOTAL FUNDS	COMMENTS	ROW
44	33V7030	Hospital Inpatient Rate Reduction			(113,815,778)				(142,194,510)	(256,010,288)	10% reduction in Hospital Inpatient reimbursement based on anticipated 2008-09 spend for this category. Includes impact to HMO rates.	44
45	33V7040	Health Maintenance Organization Rate Reduction			(42,321,340)				(53,901,758)	(96,223,098)	10% reduction in Prepaid Health Plan reimbursement based on anticipated 2008-09 spend for this category. Amount adjusted for impacts from other categorical reductions.	45
46	33V7050	Intermediate Care Facility For The Developmentally Disabled (ICF-DD) Rate Reduction			(11,300,197)				(14,070,699)	(25,370,896)	8% reduction in Private ICF-DD reimbursement based on anticipated 2008-09 spend for this category.	46
47	33V7060	Non Emergency Transportation Rate Reduction			(1,308,095)				(1,628,805)	(2,936,900)	4% reduction in non-emergency transportation reimbursement.	47
48	3300100	Delete Unfunded Budget							(86,643,368)	(86,643,368)	Elimination of budget not funded by a cash source.	48
49	34F0100	Transfer The Health Care Trust Fund To The Medical Care Trust Fund - Deduct							(691,503)	(691,503)	Technical Issue to realign agency trust funds in accordance with s. 215.32 Florida Statutes.	49
50	34F0200	Transfer The Health Care Trust Fund To The Medical Care Trust Fund - Add							691,503	691,503	Technical Issue to realign agency trust funds in accordance with s. 215.32 Florida Statutes.	50
51	34F0300	Transfer The Administrative Trust Fund To The Health Care Trust Fund - Deduct							(5,186,655)	(5,186,655)	Technical Issue to realign agency trust funds in accordance with s. 215.32 Florida Statutes.	51
52	34F0400	Transfer The Administrative Trust Fund To The Health Care Trust Fund - Add							5,186,655	5,186,655	Technical Issue to realign agency trust funds in accordance with s. 215.32 Florida Statutes.	52
53	34F0500	Transfer The Fl Organ Donor Educ & Proc Trust Fund To The Health Care Trust Fund - Deduct							(384,518)	(384,518)	Technical Issue to realign agency trust funds in accordance with s. 215.32 Florida Statutes.	53
54	34F0600	Transfer The Fl Organ Donor Educ & Proc Trust Fund To The Health Care Trust Fund - Add							384,518	384,518	Technical Issue to realign agency trust funds in accordance with s. 215.32 Florida Statutes.	54
55	34F0700	Transfer The Resident Protection Trust Fund To The Health Care Trust Fund - Deduct							(776,720)	(776,720)	Technical Issue to realign agency trust funds in accordance with s. 215.32 Florida Statutes.	55
56	34F0800	Transfer The Resident Protection Trust Fund To The Health Care Trust Fund - Add							776,720	776,720	Technical Issue to realign agency trust funds in accordance with s. 215.32 Florida Statutes.	56
57	34F0900	Transfer The Health Care Trust Fund To The Administrative Trust Fund - Deduct							(17,674,068)	(17,674,068)	Technical Issue to realign agency trust funds in accordance with s. 215.32 Florida Statutes.	57
58	34F1000	Transfer The Health Care Trust Fund To The Administrative Trust Fund - Add							17,674,068	17,674,068	Technical Issue to realign agency trust funds in accordance with s. 215.32 Florida Statutes.	58

ROW	ISSUE	ISSUE TITLE	FTE	RATE	GR	NR GR	TB	NR TB	OTHER TF	TOTAL FUNDS	COMMENTS	ROW
59	34F1100	Transfer Administrative Trust Fund To Medical Care Trust Fund - Deduct							(154,085,782)	(154,085,782)	Technical Issue to realign agency trust funds in accordance with s. 215.32 Florida Statutes.	59
60	34F1200	Transfer Administrative Trust Fund To Medical Care Trust Fund - Add							154,085,782	154,085,782	Technical Issue to realign agency trust funds in accordance with s. 215.32 Florida Statutes.	60
61	3400300	Public Medical Assistance Trust Fund to General Revenue - Deduct							(11,781,471)	(11,781,471)	Technical issue to realign general revenue funds and public medical assistance trust funds between categories.	61
62	3400400	Public Medical Assistance Trust Fund to General Revenue - Add			11,781,471					11,781,471	Technical issue to realign general revenue funds and public medical assistance trust funds between categories.	62
63	3400500	General Revenue to Public Medical Assistance Trust Fund -Add							11,781,471	11,781,471	Technical issue to realign general revenue funds and public medical assistance trust funds between categories.	63
64	3400600	General Revenue to Public Medical Assistance Trust Fund -Deduct			(11,781,471)					(11,781,471)	Technical issue to realign general revenue funds and public medical assistance trust funds between categories.	64
65	3401700	Increased Third Party Liability - Deduct			(10,000,000)					(10,000,000)	Fund Shift based on increased collections in Third Party Liability Recoveries.	65
66	3401800	Increased Third Party Liability - Add							10,000,000	10,000,000	Fund Shift based on increased collections in Third Party Liability Recoveries.	66
67	3402700	Leasehold Licensee Fees For Nursing Home Overpayments - Add							1,781,600	1,781,600	Utilizes nursing home leasehold licensee fess to repay nursing home Medicaid overpayments in accordance with s. 400.179 F.S.	67
68	3402800	Leasehold Licensee Fees For Nursing Home Overpayments - Deduct			(1,781,600)					(1,781,600)	Utilizes nursing home leasehold licensee fess to repay nursing home Medicaid overpayments in accordance with s. 400.179 F.S.	68
69	4100060	Personal Care Assistance Rate Adjustment			2,748,342				3,422,161	6,170,503	Increase in funding to raise the personal care assistance hourly rate from an average of $9.63 hour to $15.00 per hour. New rate will be consistent with the proposed rate for the APD waivers.	69
70	4101760	Low Income Pool							114,613,299	114,613,299	Additional authority for LIP model at the $1 billion level.	70
71	4101780	Hospital Ceiling Exemptions							66,200,746	66,200,746	Additional trust fund authority for hospital exemption program supported by intergovernmental transfers.	71

ROW	ISSUE	ISSUE TITLE	FTE	RATE	GR	NR GR	TB	NR TB	OTHER TF	TOTAL FUNDS	COMMENTS	ROW
72	4101800	Restructure Medicaid Clinic Services Reimbursement							55,860,000	55,860,000	Enables County Health Department to use county cash contributions as Medicaid match toward the cost of their Medicaid reimbursement in lieu of state funding. This will protect their ability to draw federal matching funds. Similar to the program used for hospital rebasing. See issue 33V4290.	72
73	4105210	Increase Medicaid Rates For Physicians							21,082,444	21,082,444	3.75% Fee Increase for family care, internal medicine, OB GYN, pediatric, cardiology and pulmonary physicians.	73
74	4106020	Dental Services Fee Increase							2,111,363	2,111,363	3.75% fee increase for pediatric dentists.	74
75	4109050	Medicaid Cost Sharing Obligation For Qualified Medicare Beneficiary Services			7,714,941				9,606,468	17,321,409	Funding to expand Medicare cost sharing obligations for Qualified Medicare Beneficiaries for services Medicaid is not currently covering per a federal compliance directive.	75
76	4206250	Reduce Freestanding Dialysis Centers			(865,130)				(1,080,880)	(1,946,010)	Reduces reimbursement for dialysis services from $125 per visit to $95 per visit.	76
77	54R0000	Casualty Insurance Premium Adjustment			(15,088)				(41,597)	(56,685)	Statewide Issue allocating state casualty insurance premium costs.	77
78	**AGENCY/HEALTH CARE ADMIN Total**		**1,677.50**	**73,412,808**	**4,567,681,354**	**0**	**170,901,842**	**0**	**10,879,523,157**	**15,618,106,353**		78
79												79
80	**AGENCY/PERSONS WITH DISABL**											80
81	1100000	Startup (Recurring Law And Policy) - Operating	3,703.00	116,478,542	499,659,238				627,098,612	1,126,757,850	Base Budget	81
82	160S100	Correct Funding Source Identifier - Add			381,886				9,808,785	10,190,671	Technical Issue realigning funding identifiers.	82
83	160S200	Correct Funding Source Identifier - Deduct			(381,886)				(9,808,785)	(10,190,671)	Technical Issue realigning funding identifiers.	83
84	1600650	Consumer Directed Care Plus Administrative Resources - Deduct	(9.00)	(394,123)	(656,964)				(656,964)	(1,313,928)	Continuation of FY 2007-08 approved budget amendment.	84
85	1600660	Consumer Directed Care Plus Administrative Resources - Add	9.00	394,123	656,964				656,964	1,313,928	Continuation of FY 2007-08 approved budget amendment.	85
86	1600670	Realignment Of Federal Grant Awards - Add							201,867	201,867	Technical movement of federal grant funding within the agency.	86
87	1600680	Realignment Of Federal Grant Awards - Deduct							(201,867)	(201,867)	Technical movement of federal grant funding within the agency.	87
88	1600870	Criminal Justice Incentive Pay (CJIP) - Deduct		(21,221)	(25,000)					(25,000)	Technical issue transferring funds from the salary category to the Salary Incentive Payments category to pay criminal justice incentive payments in the Forensic Institutions as specified in s. 943.22 F.S.	88

ROW	ISSUE	ISSUE TITLE	FTE	RATE	GR	NR GR	TB	NR TB	OTHER TF	TOTAL FUNDS	COMMENTS	ROW
89	1600890	Criminal Justice Incentive Pay (CJIP) - Add			25,000					25,000	Technical issue transferring funds from the salary category to the Salary Incentive Payments category to pay criminal justice incentive payments in the Forensic Institutions as specified in s. 943.22 F.S.	89
90	1604500	Reallocation Of Human Resources Outsourcing			(13,004)				(10,599)	(23,603)	Statewide reallocation of Human Resources Outsourcing contractual funding.	90
91	1700200	Transfer Home And Community Based Services Waiver Funding To Medicaid State Plan Services			(9,100,292)				(11,331,437)	(20,431,729)	Transfer of funding from APD to AHCA. AHCA will provide Personal Care Assistance to waiver clients under age 21 through the Medicaid State Plan effective July 1, 2008. Currently these services are provided through waivers in APD.	91
92	1700750	Transfer Positions From Department Of Children And Families To The Agency For Persons With Disabilities (APD) - Add	9.00	341,212	495,929					495,929	Transfer of positions and funding from DCF to APD for legal and administrative work.	92
93	1800310	Transfer To Serve Additional Clients In The Community (Brown V Bush) - Add			1,135,770				1,414,230	2,550,000	Transfer of funding from APD Institutions to community waiver categories in accordance with the Brown v. Bush Settlement.	93
94	1800330	Transfer To Serve Additional Clients In The Community (Brown V Bush) - Deduct			(1,135,770)				(1,414,230)	(2,550,000)	Transfer of funding from APD Institutions to community waiver categories in accordance with the Brown v. Bush Settlement.	94
95	1800850	Administrative Budget Realignment- Deduct			(337,196)					(337,196)	Realignment of agency budget to enable cost saving from an agency contractual service reduction. See Issue Code 33V8040.	95
96	1800860	Administrative Budget Realignment - Add		137,508	337,196					337,196	Realignment of agency budget to enable cost saving from an agency contractual service reduction. See Issue Code 33V8040.	96
97	2503080	Direct Billing For Administrative Hearings			670,519					670,519	Statewide issue allocating funding for administrative hearings process.	97
98	33V0200	Provider Rate Reduction			(10,421,034)				(12,975,989)	(23,397,023)	3% rate reduction in waiver services excluding personal care assistance.	98
99	33V6000	Personal Care Assistance Rate Adjustment			(5,525,522)				(6,880,230)	(12,405,752)	Reduction in personal care assistance hourly rate from average of $17.12 per hour to $15.00 per hour.	99
100	33V8010	Reduction In Administration	(1.00)	(38,809)	(27,310)				(27,311)	(54,621)	Administrative FTE reduction. Base budget review recommendation.	100
101	33V8020	Start-Up Funds/Group Homes Category Reduction			(70,041)					(70,041)	Elimination of loan program for group/foster homes due to reduction in usage. Currently there are approximately 1,800 vacant group home beds. Base budget review recommendation.	101

ROW	ISSUE	ISSUE TITLE	FTE	RATE	GR	NR GR	TB	NR TB	OTHER TF	TOTAL FUNDS	COMMENTS	ROW
102	33V8030	Grant And Aid Community Development Category Reduction			(55,261)				(35,799)	(91,060)	Elimination of funding for community development projects due to reduction in usage. Base budget review recommendation.	102
103	33V8040	Contract Reductions			(728,539)				(962,500)	(1,691,039)	Contractual service reduction due to rebid of prior service authorization contracts and reduction of Web Based competency training program. Base budget review recommendation.	103
104	3401470	Changes To Federal Financial Participation Rate - State			14,626,319					14,626,319	Fund shift due to change in federal matching percentage rate (FMAP).	104
105	3401480	Changes To Federal Financial Participation Rate - Federal							(14,626,319)	(14,626,319)	Fund shift due to change in federal matching percentage rate (FMAP).	105
106	36206C0	Staff Augmentation							1,148,770	1,148,770	Contractual service funding for staff augmentation and IT support.	106
107	4001140	Serving Persons With Disabilities			14,281,380	14,281,380	10,000,000	10,000,000	30,234,516	54,515,896	Waiver service funding restoration on a non-recurring basis.	107
108	4008040	Additional Federal Grants Trust Fund							417,074	417,074	Additional trust fund authority due to increase in federal grant awards.	108
109	4008060	Establish Community Dental Service Pilot							581,000	581,000	Trust fund authority to enable the department to serve DD clients through institutional dental providers due to a shortage of these providers in communities.	109
110	54R0000	Casualty Insurance Premium Adjustment			(546,842)				(414,511)	(961,353)	Statewide Issue allocating state casualty insurance premium costs.	110
111	**AGENCY/PERSONS WITH DISABL Total**		**3,711.00**	**116,897,232**	**503,245,540**	**14,281,380**	**10,000,000**	**10,000,000**	**612,215,277**	**1,125,460,817**		111
112												112
113	**CHILDREN & FAMILY SERVICES**											113
114	1100000	Startup (Recurring Law And Policy) - Operating	13,525.00	516,433,697	1,532,986,901		147,651,883		1,210,347,600	2,890,986,384		114
115	160D010	Guaranteed Energy Performance Savings Contracts - Add			295,619					295,619	Shifts budget between categories to undertake energy efficient improvements in state mental health facility.	115
116	160D020	Guaranteed Energy Performance Savings Contracts - Deduct			(295,619)					(295,619)	Shifts budget between categories to undertake energy efficient improvements in state mental health facility.	116
117	160E120	Realignment Of Budget To Expenditures Between Contracted Services And Expenses - Add			31,105				68,245	99,350	Shift of budget between contracted services and expenses categories.	117
118	160E130	Realignment Of Budget To Expenditures Between Contracted Services And Expenses - Deduct			(31,105)				(68,245)	(99,350)	Shift of budget between contracted services and expenses categories.	118
119	160E140	Realignment Of Contractual Services Budget From Expense To Special Category Pursuant To Senate Bill 2610 - Add			2,275				625	2,900	Shift of budget between contracted services and expenses categories.	119
120	160E150	Realignment Of Contractual Services Budget From Expense To Special Category Pursuant To Senate Bill 2610 - Deduct			(2,275)				(625)	(2,900)	Shift of budget between contracted services and expenses categories.	120

ROW	ISSUE	ISSUE TITLE	FTE	RATE	GR	NR GR	TB	NR TB	OTHER TF	TOTAL FUNDS	COMMENTS	ROW
121	160F620	Transfer Rate And Budget From Violent Sexual Predator Program To The Executive Direction And Support Services Entity - Add		28,666	33,772					33,772	Shift of budget between budget entities.	121
122	160F630	Transfer Rate And Budget From Violent Sexual Predator Program To The Executive Direction And Support Services Entity - Deduct		(28,666)	(33,772)					(33,772)	Shift of budget between budget entities.	122
123	160F660	Transfer Funds To Support The Medicaid And Medicare Cost Reporting Contract - Add							8,371	8,371	Continuation of FY 2007-08 approved budget amendment.	123
124	160F670	Transfer Funds To Support The Medicaid And Medicare Cost Reporting Contract - Deduct		(7,105)					(8,371)	(8,371)	Continuation of FY 2007-08 approved budget amendment.	124
125	160F680	Transfer Funds For Winewood Renovation Project - Add			16,683					16,683	Continuation of FY 2007-08 approved budget amendment.	125
126	160F690	Transfer Funds For Winewood Renovation Project - Deduct		(14,161)	(16,683)					(16,683)	Continuation of FY 2007-08 approved budget amendment.	126
127	1600150	Transfer To Other Personal Services From Child Protection - Add			25,326				17,743	43,069	Continuation of FY 2007-08 approved budget amendment.	127
128	1600160	Transfer To Other Personal Services From Child Protection - Deduct			(25,326)				(17,743)	(43,069)	Continuation of FY 2007-08 approved budget amendment.	128
129	1600620	Transfer Budget From The Assistant Secretary For Administration To The Executive Direction And Support Services - Add		12,258	14,441					14,441	Continuation of FY 2007-08 approved budget amendment.	129
130	1600630	Transfer Budget From The Assistant Secretary For Administration To The Executive Direction And Support Services - Deduct		(12,258)	(14,441)					(14,441)	Continuation of FY 2007-08 approved budget amendment.	130
131	1600660	Transfer Budget To District Administration To Create The Other Personnel Services Category - Add			1,000				1,000	2,000	Technical issue to shift budget between categories.	131
132	1600670	Transfer Budget To District Administration To Create The Other Personnel Services Category - Deduct			(1,000)				(1,000)	(2,000)	Technical issue to shift budget between categories.	132
133	1600700	Financial Assistance Payments / Refugee / Entrant Program Budget Authority							2,465,487	2,465,487	Continuation of FY 2007-08 approved budget amendment.	133
134	1601840	Transfer Of Expenses To Contracted Services For Centers Of Excellence Contract - Add			76,569				323,431	400,000	Continuation of FY 2007-08 approved budget amendment.	134
135	1601860	Transfer Of Expenses To Contracted Services For Centers Of Excellence Contract - Deduct			(76,569)				(323,431)	(400,000)	Continuation of FY 2007-08 approved budget amendment.	135
136	1604500	Reallocation Of Human Resources Outsourcing			(92,013)				(10,197)	(102,210)	Statewide issue regarding human resources outsourcing costs.	136
137	1608320	Replace Federal Grants Trust Fund Budget With Alcohol, Drug Abuse And Mental Health Trust Fund Budget - Add							935,390	935,390	Continuation of FY 2007-08 approved budget amendment.	137
138	1608330	Replace Federal Grants Trust Fund Budget With Alcohol, Drug Abuse And Mental Health Trust Fund Budget - Deduct							(935,390)	(935,390)	Continuation of FY 2007-08 approved budget amendment.	138

ROW	ISSUE	ISSUE TITLE	FTE	RATE	GR	NR GR	TB	NR TB	OTHER TF	TOTAL FUNDS	COMMENTS	ROW
139	1701400	Transfer Positions And Related Funding Between The Department Of Children And Families To Agency For Persons With Disabilities - Deduct	(9.00)	(341,212)	(495,929)					(495,929)	Moves positions from DCF to APD to handle responsibilities related to the transfer of duties to the new agency when APD was created.	139
140	1800570	Transfer Child Care Positions From Family Safety Program To Child Care Program - Add	18.00	824,896	983,445				193,260	1,176,705	Technical issue to appropriately align positions within the organization.	140
141	1800580	Transfer Child Care Positions From Family Safety Program To Child Care Program - Deduct	(18.00)	(824,896)	(983,445)				(193,260)	(1,176,705)	Technical issue to appropriately align positions within the organization.	141
142	1801020	Transfer Child Location Specialist Positions From District Administration To Family Safety - Add	5.00							0	Technical issue to appropriately align positions within the organization.	142
143	1801030	Transfer Child Location Specialist Positions From District Administration To Family Safety - Deduct	(5.00)							0	Technical issue to appropriately align positions within the organization.	143
144	1801040	Transfer Director Of Criminal Justice Position District Administration To Family Safety - Add	1.00	90,346	147,320					147,320	Technical issue to appropriately align positions within the organization.	144
145	1801050	Transfer Director Of Criminal Justice Position District Administration To Family Safety - Deduct	(1.00)	(90,346)	(147,320)					(147,320)	Technical issue to appropriately align positions within the organization.	145
146	25020C0	Continue Current Data Processing Applications							(1,887,732)	(1,887,732)	Technical issue to balance budget in DCF data center.	146
147	2503080	Direct Billing For Administrative Hearings			65,987					65,987	Statewide issue relating to costs of administrative hearings.	147
148	3000020	Adjustment For Temporary Assistance For Needy Families (TANF) Estimating Conference							17,802,207	17,802,207	Temporary Cash Assistance Need based on January Social Services Estimating Conference.	148
149	3007820	Establish Positions To Address Workload Increase Of The Office Of The Appeals Hearings Office	5.00	183,045	158,233	12,142			158,233	316,466	This issue funds five positions in the Inspector General's Office of Appeal Hearings to meet increasing workload demands and to ensure the unit's ability to meet the federally-mandated time standard to conduct and complete fair hearings.	149
150	33B2050	Family Safety Contracts - Unobligated Funds			(631,463)					(631,463)	Reduces funding associated with unobligated contracts in Family Safety.	150
151	33B2200	Optional State Supplementation Due To Surplus			(3,353,986)					(3,353,986)	This reduces the Optional State Supplemental category which has budget surplus to program needs. This program provides payments to supplement the income of indigent elderly and disabled individuals, and all eligible persons are receiving their payments without DCF fully expending the allocated budget.	151
152	33B2400	Cover Prescribed Drug Increase With Salary Lapse In Mental Health Treatment Facilities			(5,420,351)					(5,420,351)	Reduces the Prescribed Medication and Drugs category of the state-operated mental health treatment facilities and maintains a five percent lapse in the salary category to generate funds to transfer to cover drug costs.	152

ROW	ISSUE	ISSUE TITLE	FTE	RATE	GR	NR GR	TB	NR TB	OTHER TF	TOTAL FUNDS	COMMENTS	ROW
153	33B2500	Department Administration Critical Processes	(95.50)	(4,710,613)	(3,765,216)				(3,222,112)	(6,987,328)	Reduction in administrative entities, including Executive Direction, Assistant Secretary for Administration (including IT), and District Administration, to be taken in each office based on eliminating or reducing critical processes and staff. Positions eliminated in the issue totals 95.5. Adjusted for 4% holdback. This issue reduces the Temporary Assistance for Needy Families (TANF) Maintenance of Effort (MOE) by $693,368.	153
154	33B2510	Adult Protection Program - Administration	(2.00)	(126,821)	(175,409)				(58,212)	(233,621)	Reduction in Adult Services program management, resulting in eliminating 2 positions and associated expense budget. Adjusted for 4% holdback.	154
155	33B2520	Child Protection & Permanency Central Office Contracts By 5%			(253,107)				(102,943)	(356,050)	Reduce current contracts by 5% as part of an efficiency reduction. Adjusted for 4% holdback. This issue reduces the Temporary Assistance for Needy Families (TANF) Maintenance of Effort (MOE) by $652.	155
156	33B2530	Hotline Administration - Eliminate Oversight And Training For The Abuse Hotline Certification Program	(1.00)	(23,514)	(35,559)					(35,559)	Eliminate staff position that provides oversight and training for the Abuse Hotline Certification Program.	156
157	33B2540	Child Care Administration By 5% Phase 1		(21,370)	(33,888)					(33,888)	Reduction in administration in the Child Care Program office budget.	157
158	33B2550	Family Safety Program Office By 5% Phase 1		(739,232)	(1,257,609)				(217,957)	(1,475,566)	Reduce the Family Safety Program Management and Compliance entity general revenue by 5%. Adjusted for 4% holdback. This issue reduces the Temporary Assistance for Needy Families (TANF) Maintenance of Effort (MOE) by $612,734.	158
159	33B2560	Mental Health Program Office By 5% Phase 1			(149,413)				(14,538)	(163,951)	Reduction in salary, OCO, expenses, and OPS. This issue reduces the Temporary Assistance for Needy Families (TANF) Maintenance of Effort (MOE) by $146,061.	159
160	33B2570	Access Program Office - Administration	(12.00)	(473,102)	(115,096)				(223,992)	(339,088)	Reduction in administrative funding in the Automated Community Connection to Economic Self-Sufficiency program office and eliminates 12 FTEs. This issue reduces the Temporary Assistance for Needy Families (TANF) Maintenance of Effort (MOE) by $11,810.	160
161	33B2580	Mental Health Treatment Facility Headquarters Administration Phase 1	(1.00)	(14,646)	(79,737)					(79,737)	Reduction in salaries and one position in the Mental Health Treatment Facilities Headquarters Office.	161

ROW	ISSUE	ISSUE TITLE	FTE	RATE	GR	NR GR	TB	NR TB	OTHER TF	TOTAL FUNDS	COMMENTS	ROW
162	33B2650	Expenses By Eliminating Empty Lease Space			(961,143)					(961,143)	Reduce unoccupied leased space and not renew leases as their expiration dates come due.	162
163	33B2700	Expenses By Hoteling Of Protective Investigator Staff			(3,406,847)				(156,866)	(3,563,713)	Reduce leased space statewide by hoteling Adult Protective Investigators and Child Protective Investigators. These positions can share office space since they spend a great deal of their time out of the office visiting clients.	163
164	33B2750	Special Projects Department-Wide			(8,030,279)		(90,000)		(2,182,897)	(10,303,176)	Eliminates 50% of each of the special projects appropriated with recurring funds over the years. This issue impacts the Mental Health and Substance Abuse Maintenance of Effort (MOE) requirement. At the 50% level, it would reduce approximately $9.5 million from the MOE.	164
165	33B2800	Department Administration - Major Critical Processes	(56.00)	(2,503,607)	(5,315,457)				(2,764,298)	(8,079,755)	Reductions in administrative entities and elimination of 56 FTEs. This is an additional five percent on top of a ten percent administrative reduction in issue number 33B2500. Adjusted for 4% holdback.	165
166	33B2850	Mental Health Contract Administration By 10%			(2,253,976)				(57,896)	(2,311,872)	Reduces funding in the children and adult mental health services category and is based on an estimated administrative rate of 7% of the total contract amount to determine the administrative cost - this amount was reduced by 10%. This issue impacts the Mental Health Maintenance of Effort requirement by approximately $2.3 million.	166
167	33B2900	Community Based Care Administration By 10%			(2,461,476)				(928,894)	(3,390,370)	Reduce Community-Based Care (CBC) providers' administrative funds by 10%, which includes costs for executive officers, personnel administration, information technology, and accounting.	167
168	33B2950	Sheriff's Protective Investigations Contract Administration By 10%			(358,105)					(358,105)	Reduction of funds to go to the Sheriffs, requiring each office to review their organizations for efficiencies which can be gained by streamlining administrative functions. This issue reduces the Temporary Assistance for Needy Families (TANF) Maintenance of Effort (MOE) by $291,546.	168
169	33B3000	Outsourced Child Welfare Legal Services Contract Administration By 10%			(45,400)				(29,837)	(75,237)	Reduction in administrative support of the Child Welfare Legal Services contracts with the Attorney General's Office and State Attorney's office.	169

ROW	ISSUE	ISSUE TITLE	FTE	RATE	GR	NR GR	TB	NR TB	OTHER TF	TOTAL FUNDS	COMMENTS	ROW
170	33B3050	Healthy Families Contract Administration By 10%			(198,774)					(198,774)	Reduction in funds for administrative functions carried out by the Ounce of Prevention in the Healthy Families program; 10% reduction of administrative funding. Adjusted for 4% holdback. This issue reduces the Temporary Assistance for Needy Families (TANF) Maintenance of Effort (MOE) by $198,774.	170
171	33B3100	Hospital Administration Contracts By 10%			(719,989)				(115,260)	(835,249)	Provides for a 10% reduction in administrative costs at the five privately operated mental health treatment facilities: South Florida State Hospital; South Florida Evaluation and Treatment Center; SFETC Annex; Treasure Coast Forensic Treatment Center; and the Florida Civil Commitment Center.	171
172	33B3150	Mental Health Treatment Facilities Administration - Phase 1			(1,770,900)				(348,439)	(2,119,339)	Proposal to reduce administrative costs at the state operated-mental health treatment facilities, Florida State Hospital, Northeast Florida State Hospital, North Florida Evaluation and Treatment Center, and Headquarters. These expense reductions include delay in maintenance projects, travel for staff training and facility reviews, and purchase of supplies.	172
173	33B3200	Adult Protection Program - Quality Assurance	(2.00)	(156,568)	(179,071)				(59,565)	(238,636)	5% reduction in program management of adult protective services -- eliminating 2 positions from the regional offices. Adjusted for 4% holdback.	173
174	33B3210	Child Protection & Permanency Central Office Contracts By 5%			(253,107)				(102,943)	(356,050)	An additional 5% reduction in central office contracts, bringing total reduction to 10%. These are support contracts that do not provide direct services to clients.	174
175	33B3220	Hotline Administration - Travel And Equipment			(35,559)					(35,559)	Reduce travel for administrative staff and delay purchase of equipment in the Florida Abuse Hotline budget entity.	175
176	33B3230	Child Care Administration By 5% Phase 2	(1.00)	(21,370)	(33,888)					(33,888)	Additional 5% administrative reduction, bringing total to 10%, deleting one position.	176
177	33B3240	Family Safety Program Office By 5% Phase 2	(6.00)	(739,232)	(1,291,168)				(188,697)	(1,479,865)	Additional reduction bringing administrative cut to 10%, in salaries, expense, and OPS and elimination of 6 FTEs. Adjusted for 4% holdback. This issue reduces the Temporary Assistance for Needy Families (TANF) Maintenance of Effort (MOE) by $654,938.	177

ROW	ISSUE	ISSUE TITLE	FTE	RATE	GR	NR GR	TB	NR TB	OTHER TF	TOTAL FUNDS	COMMENTS	ROW
178	33B3250	Mental Health Program Office By 5% Phase 2	(7.00)	(306,348)	(610,862)				(14,538)	(625,400)	An additional 5% reduction in the program office. Adjusted for 4% holdback. This issue impacts the Mental Health Maintenance of Effort requirement by $610,862. Deletes 7 FTEs.	178
179	33B3260	Access Program Office - Eliminate Quality Control	(39.00)	(473,102)	(1,132,080)				(924,617)	(2,056,697)	Eliminate quality control functions in the Automated Community Connection to Economic Self-Sufficiency program required by federal regulations. This issue reduces the Temporary Assistance for Needy Families (TANF) Maintenance of Effort (MOE) by $128,048 and eliminates 39 FTEs.	179
180	33B3270	Mental Health Treatment Facility Headquarters Administration Phase 2	(1.00)	(14,646)	(79,737)					(79,737)	Deletion of an additional staff position in the Mental Health Treatment Facilities Headquarters Office.	180
181	33B3300	Eliminate South Florida State Hospital Cost Of Living Increase			(1,008,725)					(1,008,725)	Provides for a 3% reduction in overall operational costs at South Florida State Hospital. This was a cost-of-living adjustment provided in Fiscal Year 2007-2008.	181
182	33B3400	Marriage And Family Support Initiatives - Ounce Of Prevention Commission On Marriage			(250,000)					(250,000)	Elimination of contract for this function which supports the Commission on Marriage.	182
183	33B3420	Contract Administration Additional 5% - Mental Health			(1,126,991)				(28,948)	(1,155,939)	Reduction in child and adult mental health services categories; calculated based on an estimated administrative rate of 7% of the total contract amount to determine the administrative cost and then this amount was reduced by 10%. This issue impacts the Mental Health Block Grant Maintenance of Effort requirement by $1,126,991.	183
184	33B3450	Contract Administration Additional 5% - Community Based Care			(1,489,289)				(463,431)	(1,952,720)	5% Reduction of CBC administration - based on 10% of the contract amounts inclusive of administrative functions.	184
185	33B3500	Contract Administration Additional 5% - Sheriff's Protective Investigations			(179,054)					(179,054)	Additional 5% reduction in Sheriff's contracts to handle protective investigations. This issue reduces the Temporary Assistance for Needy Families (TANF) Maintenance of Effort (MOE) by $145,773.	185
186	33B3550	Outsourced Child Welfare Legal Services Contract Administration Additional 5%			(22,701)				(14,919)	(37,620)	Administrative reduction in support of contracts with Attorney General's Office and State Attorney's Office for dependency court cases.	186

ROW	ISSUE	ISSUE TITLE	FTE	RATE	GR	NR GR	TB	NR TB	OTHER TF	TOTAL FUNDS	COMMENTS	ROW
187	33B3600	Contract Administration Additional 5% - Healthy Families			(99,388)					(99,388)	Additional 5% reduction in Ounce of Prevention contract for Healthy Families. Adjusted for 4% holdback. This issue reduces the Temporary Assistance for Needy Families (TANF) Maintenance of Effort (MOE) by $76,651.	187
188	33B3650	Hospital Administration Additional 5% - Contracts			(359,894)				(57,731)	(417,625)	Additional 5% reduction to the administrative costs of the privately operated mental health treatment facilities; includes South Florida State Hospital, South Florida Evaluation and treatment Center, SFETC Annex, Treasure Coast Forensic Treatment Center, and the Florida Civil Commitment Center.	188
189	33B3700	Mental Health Treatment Facilities Administration - Phase 2			(764,012)					(764,012)	Reduce administration in state-operated civil mental health treatment facilities.	189
190	33B3710	Adult Protection Program Administration	(2.00)	(156,413)	(179,071)				(59,565)	(238,636)	5% reduction in program management in the Adult Protection Program Office and elimination of 2 FTEs. Adjusted for 4% holdback.	190
191	33B3720	Child Protection & Permanency Central Office Contracts By 5%			(253,107)				(102,943)	(356,050)	Reduction in support contracts in the program office; these contracts do not provide direct support to clients. Adjusted for 4% holdback. This issue reduces the Temporary Assistance for Needy Families (TANF) Maintenance of Effort (MOE) by $649.	191
192	33B3730	Hotline Administration By 5%			(35,559)					(35,559)	Additional Hotline reduction, including limiting travel and delaying equipment purchases.	192
193	33B3740	Child Care Administration By 5% Phase 3	(1.00)	(21,370)	(33,888)					(33,888)	Additional reduction of 5% in child care program administration and elimination of one position.	193
194	33B3750	Family Safety Program Office By 5% Phase 3	(6.00)	(739,232)	(1,291,168)				(188,697)	(1,479,865)	Reduce an additional 5% in the Family Safety Program Office - for a total reduction of 15% when including other issues in the Schedule VIIIB. Adjusted for 4% holdback. This issue reduces the Temporary Assistance for Needy Families (TANF) Maintenance of Effort (MOE) by $654,938. Deletes 6 FTEs.	194
195	33B3760	Mental Health Program Office By 5% Phase 3	(7.00)	(306,348)	(610,862)				(14,538)	(625,400)	Additional 5% reduction in program office. Adjusted for 4% holdback. This issue impacts the Mental Health Maintenance of Effort requirement by $594,101. Deletes 7 FTEs.	195

ROW	ISSUE	ISSUE TITLE	FTE	RATE	GR	NR GR	TB	NR TB	OTHER TF	TOTAL FUNDS	COMMENTS	ROW
196	33B3770	Access Program Office - Limit Quality Assurance	(45.00)	(473,102)	(1,132,080)				(924,617)	(2,056,697)	Reduction in quality assurance functions required by federal regulations. Adjusted for 4% holdback. This issue reduces the Temporary Assistance for Needy Families (TANF) Maintenance of Effort (MOE) by $128,048. Deletes 45 FTEs.	196
197	33B3780	Mental Health Treatment Facility Headquarters Administration Phase 3	(1.00)	(14,646)	(79,737)					(79,737)	Additional reduction of one position related to mental health institution central office supervision.	197
198	33B3790	Eliminate Additional Recurring SACWIS Funding			(2,009,823)				(2,009,823)	(4,019,646)	Reduces recurring SACWIS funding by 75%, which will reduce available funds as the Florida Safe Family Network (FSFN) development is completed.	198
199	33B3800	Eliminate Mental Health Forensic Facility			(6,614,874)					(6,614,874)	This proposal closes the 100-bed South Florida Evaluation and Treatment Center Annex and transfers one-half of the operating costs to the community to provide community forensic services.	199
200	33B3850	Additional Hospital Salary Lapse	(62.00)	(2,052,975)	(2,768,140)					(2,768,140)	Reduction in salary budget and 62 positions in state-operated mental health treatment facilities. Would result in reduction of 30 beds.	200
201	33B4150	Department Protective Investigators	(71.00)	(3,159,671)	(4,094,925)					(4,094,925)	Reduce Child Protective Investigations salaries, benefits, expenses and contracts. The majority of this reduction will occur through the elimination of 71 FTEs. Adjusted for 4% holdback. This issue reduces the Temporary Assistance for Needy Families (TANF) Maintenance of Effort (MOE) by $2,426,381.	201
202	33B4200	Sheriff's Protective Investigators By 5%			(2,378,827)					(2,378,827)	Additional 5% reduction in Sheriff's protective investigation funding. This issue reduces the Temporary Assistance for Needy Families (TANF) Maintenance of Effort (MOE) by $1,936,689.	202
203	33B4300	Child Welfare Legal Services Staff By 5%	(19.00)	(846,162)	(928,731)				(483,005)	(1,411,736)	Reduce Child Welfare Legal Services in salaries and expense funding. Adjusted for 4% holdback. This issue reduces the Temporary Assistance for Needy Families (TANF) Maintenance of Effort (MOE) by $52,488. Deletes 19 positions.	203

ROW	ISSUE	ISSUE TITLE	FTE	RATE	GR	NR GR	TB	NR TB	OTHER TF	TOTAL FUNDS	COMMENTS	ROW
204	33B4350	Community Based Care Services By Maximum Net Of Administrative Reduction - About 4.4% Of Services			(18,978,151)					(18,978,151)	Reduces Community Based Care Services. This reduction is based on a DCF Schedule VIIIB issue which totaled $30,766,646, representing approximately 4.4% of services, after taking an administrative reduction. The amount contained in the House proposal is approximately 62% of that amount, having adjusted the amount to avoid a federal Maintenance of Effort (MOE) required by the Title IVE grant to the state for the child welfare program. Therefore, the reduction in services should be about 2.7%. The original issue has been adjusted down by $11,788,495 to avoid the federal Title IVE MOE problem.	204
205	33B4400	Healthy Families Services 5%			(1,320,429)					(1,320,429)	Reduction of Healthy Families services by 5%. Adjusted for 4% holdback. This issue reduces the Temporary Assistance for Needy Families (TANF) Maintenance of Effort (MOE) by $1,320,429.	205
206	33B4750	Temporary Assistance For Needy Families Funded Substance Abuse Services							(9,750,000)	(9,750,000)	Reduces TANF-funded adult substance abuse services, from the current level of $13.8 million.	206
207	33B4850	Automated Community Connection To Economic Self-Sufficiency (Access) 5%	(205.00)	(6,260,017)	(6,405,751)				(4,330,298)	(10,736,049)	Issue reduces salary and benefit funding by 5%,including 205 direct service positions performing eligibility determination work. Adjusted for 4% holdback. This issue reduces the Temporary Assistance for Needy Families (TANF) Maintenance of Effort (MOE) by $268,116.	207
208	33V0525	Reduce Independent Living Program			(7,000,000)					(7,000,000)	This issue reduces the Independent Living Program by $7,000,000. The total program is just over $27 million from General Revenue, Tobacco Settlement Trust Fund, and Federal Grants Trust Fund. This program assists children in foster care with life skills needed when they leave the child welfare system.	208
209	3300100	Delete Unfunded Positions	(57.50)	(63,570)						0	Eliminates unfunded positions where funds were previously moved to the Community Based Care organizations.	209
210	3301010	Eliminate Unfunded Budget							(20,330,318)	(20,330,318)	This issue eliminates unfunded budget in the Mental Health Institutions budget entity.	210

ROW	ISSUE	ISSUE TITLE	FTE	RATE	GR	NR GR	TB	NR TB	OTHER TF	TOTAL FUNDS	COMMENTS	ROW
211	3400140	Transfer Child Advocacy Funding To Grants And Donations Trust Fund - Add							130,000	130,000	Transfers Child Advocacy Trust Fund to Grants and Donations Trust Fund, as the Child Advocacy Trust fund is scheduled to be deleted effective July 1, 2008.	211
212	3400150	Transfer Child Advocacy Funding To Grants And Donations Trust Fund - Deduct							(130,000)	(130,000)	Companion to issue # 3400140. Transfers Child Advocacy Trust Fund to Grants and Donations Trust Fund, as the Child Advocacy Trust fund is scheduled to be deleted effective July 1, 2008.	212
213	3401070	Shift Alcohol, Drug Abuse And Mental Health Block Grant Trust Fund To Federal Grants And Grants And Donations Trust Funds - Add							34,239	34,239	Shifts budget authority to appropriately align with functions.	213
214	3401080	Shift Alcohol, Drug Abuse And Mental Health Block Grant Trust Fund To Federal Grants And Grants And Donations Trust Funds - Deduct							(34,239)	(34,239)	Shifts budget authority to appropriately align with functions.	214
215	3401470	Changes To Federal Financial Participation Rate - State			910,959					910,959	This issue covers the cost of the change in the Medicaid Federal Medical Assistance Percentage (FMAP) rate which requires the state to provide additional general revenue.	215
216	3401480	Changes To Federal Financial Participation Rate - Federal							(910,959)	(910,959)	This issue covers the cost of the change in the Medicaid Federal Medical Assistance Percentage (FMAP) rate which requires the state to provide additional general revenue.	216
217	3402010	Institutional Fees - Add							1,000,000	1,000,000	Uses available fee revenue in place of general revenue in mental health hospitals.	217
218	3402020	Institutional Fees - Deduct			(1,000,000)					(1,000,000)	Uses available fee revenue in place of general revenue in mental health hospitals.	218
219	36302C0	Budget Authority To Reimburse The Department Of Management Services For The Child Care Information System							277,000	277,000	This issue includes $277,000 from the Operations and Maintenance Trust Fund for the Child Care Information System. This system provides support to the child care industry and families seeking quality child care services and system is maintained by the Department of Management Services (DMS). The rate structure established by DMS changed during FY2005-2006 and resulted in an unanticipated increase to the Child Care Program.	219
220	4000530	Change In Medicaid Federal Medical Assistance Percentage (FMAP)			1,281,215					1,281,215	This issue covers the cost of the change in the Medicaid Federal Medical Assistance Percentage (FMAP) rate which requires the state to provide additional general revenue.	220

ROW	ISSUE	ISSUE TITLE	FTE	RATE	GR	NR GR	TB	NR TB	OTHER TF	TOTAL FUNDS	COMMENTS	ROW
221	4000570	Annual Increase For Title IV-E Demonstration Waiver							4,445,919	4,445,919	This issue includes $4,445,919 from the Federal Grants Trust Fund for the annual 3 percent increase in federal funding for the Title IV-E foster care waiver. The waiver allows federal IV-E foster care funds to be used for any child welfare purpose rather than be restricted to out-of-home care, which is normally the case under federal law.	221
222	4000660	Community Based Care Risk Pool							7,500,000	7,500,000	This issue includes $7,500,000 from the Federal Grants Trust Fund to fund the risk pool for community based care (CBC) agencies. This funding will allow the CBCs that experience shortfalls through no act of their own to continue providing foster care and related services.	222
223	4006000	Expansion Of Services For Community Mental Health							10,529,348	10,529,348	This issue reflects $21,058,696 in nonrecurring funds that were earned through the Medicaid Administrative Claiming (MAC) program, which enables community mental health and substance abuse agencies to receive Medicaid reimbursement for expenses incurred in support of the administration of a state's Medicaid program. This issue uses 50% of these additional funds to mitigate reductions to mental/substance abuse reductions.	223
224	4006100	Continuation Of Expansion Of Services For Community Mental Health	1.00	48,043	(5,400,000)				14,045,794	8,645,794	This issue fund shifts $5.4 million from General Revenue to federal funds and adds $8,645,794 in mental health services based on Community Based Medicaid Administrative claiming, which enables the drawdown of additional federal dollars which can be used fto mitigate reductions in mental health/substance abuse services.	224
225	4006150	Transforming Florida's Mental Health System			8,000,000	8,000,000				8,000,000	This issue provides funding to begin to implement recommendations to transform Florida's mental health system made by the Florida Supreme Court's Mental Health Subcommittee of the Steering Committee on Families and Children in the Court.	225
226	4006700	Casey Family Foundation Grant							506,163	506,163	Budget authority for additional grant funds.	226
227	54R0000	Casualty Insurance Premium Adjustment			(353,134)				(231,470)	(584,604)		227
228	**CHILDREN & FAMILY SERVICES Total**		**12,822.00**	**491,884,630**	**1,430,238,390**	**8,012,142**	**147,561,883**	**0**	**1,215,564,059**	**2,793,364,332**		228
229												229
230	**ELDER AFFAIRS, DEPT OF**											230
231	1100000	Startup (Recurring Law And Policy) - Operating	411.50	16,944,505	134,832,480		24,770,633		219,432,145	379,035,258	Base budget	231

ROW	ISSUE	ISSUE TITLE	FTE	RATE	GR	NR GR	TB	NR TB	OTHER TF	TOTAL FUNDS	COMMENTS	ROW
232	160E100	Realignment Of Contractual Services Budget - Add			3,600				15,128	18,728	Technical issue to realign contractual services budget	232
233	160E110	Realignment Of Contractual Services Budget - Deduct			(3,600)				(15,128)	(18,728)	Technical issue to realign contractual services budget	233
234	1600050	Realignment Of Contracted Services To OPS And Expenses Categories - Add			102,300					102,300	Technical issue to realign contracted services.	234
235	1600060	Realignment Of Contracted Services To OPS And Expenses Categories - Deduct			(102,300)					(102,300)	Technical issue to realign contracted services.	235
236	1604500	Reallocation Of Human Resources Outsourcing			(500)				(1,112)	(1,612)	Statewide reallocation of Human Resources Outsourcing contractual funding.	236
237	1700100	Transfer Johnnie B. Byrd, Sr. Alzheimer's Center And Research Institute To University Of South Florida			(3,750,000)					(3,750,000)	Transfers funding of Byrd Alzheimer's Center from DOEA to the University of South Florida.	237
238	3201010	Eliminate Unfunded Budget							(56,753)	(56,753)	Realigns federal waiver authority to actual receipts.	238
239	33B0300	Home Care For The Elderly			(952,946)					(952,946)	10% reduction to expenditures for Home Care for the Elderly. Home Care for the Elderly is a stipend paid to caregivers to enable the elder to stay at home.	239
240	33B0500	Contracted Services			(244,545)					(244,545)	10% reduction to contracted services.	240
241	33B0600	Community Care For The Elderly			(3,065,350)					(3,065,350)	10% reduction to expenditures for Community Care for the Elderly. Community Care for the Elderly are Medicaid-like services for those not eligible for Medicaid or awaiting eligibility determination.	241
242	33B0700	Alzheimer's Disease Initiative			(1,362,402)					(1,362,402)	Reduces spending for memory disorder clinics and other projects by 10%.	242
243	33B0900	J. Byrd Alzheimer's Center And Research Institute			(9,750,000)				(9,750,000)	(19,500,000)	Reduces funding to the Byrd Alzheimer's Center by $11.25 million (including the $1.5 million cut during Special Session C) to a total annual recurring GR appropriation of $3.75 million.	243
244	33V0100	Telehealth Support Project			(250,000)					(250,000)	Eliminates recurring GR funding to AlzOnline Caregivers Telehealth Support Project.	244
245	33V0300	Sunshine For Seniors Program			(158,000)					(158,000)	Eliminates recurring GR funding for the Sunshine for Seniors Prescription Assistance Program.	245
246	3300010	Delete Unfunded Budget							(3,750,000)	(3,750,000)	Removes double-budget created by transferring budget for Byrd Alzheimer's Center to the University of South Florida.	246
247	3401470	Changes To Federal Participation Rate - State Expenses			1,871,510					1,871,510	Fund shift due to change in federal matching percentage rate (FMAP).	247
248	3401480	Changes To Federal Participation Rate - Federal Expenses							(1,871,510)	(1,871,510)	Fund shift due to change in federal matching percentage rate (FMAP).	248
249	54R0000	Casualty Insurance Premium Adjustment			(81,567)				(10,255)	(91,822)	Statewide Issue allocating state casualty insurance premium costs.	249

ROW	ISSUE	ISSUE TITLE	FTE	RATE	GR	NR GR	TB	NR TB	OTHER TF	TOTAL FUNDS	COMMENTS	ROW
250	ELDER AFFAIRS, DEPT OF Total		411.50	16,944,505	117,088,680	0	24,770,633	0	203,992,515	345,851,828		250
251												251
252	HEALTH, DEPT OF											252
253	1100000	Startup (Recurring Law And Policy) - Operating	3,175.50	128,434,145	565,710,781		105,136,259		2,062,227,208	2,733,074,248	Base Budget	253
254	160E030	Realignment Of Contractual Services Budget - Deduct Category Reapproval Of Amendments			50,000				49,203	99,203	Technical issue to realign contractual services budget	254
255	160E040	Realignment Of Contractual Services Budget - Add To Special Category Reapproval Of Amendments			(50,000)				(49,203)	(99,203)	Technical issue to realign contractual services budget	255
256	160F110	Realignment Of Contractual Services Budget - Deduct To Expenses							(40,000)	(40,000)	Continuation of FY 2007-08 approved budget amendment.	256
257	160F120	Realignment Of Contractual Services Budget - Add To Special Category							40,000	40,000	Continuation of FY 2007-08 approved budget amendment.	257
258	160F230	Transfer Between Categories - United States Trust Fund - Deduct							(1,200,000)	(1,200,000)	Continuation of FY 2007-08 approved budget amendment.	258
259	160F240	Transfer Between Categories - United States Trust Fund - Add							1,200,000	1,200,000	Continuation of FY 2007-08 approved budget amendment.	259
260	160F740	Transfer Between Categories Federal Grants Trust Fund - Deduct							(250,000)	(250,000)	Continuation of FY 2007-08 approved budget amendment.	260
261	160F750	Transfer Between Categories Federal Grants Trust Fund - Add							250,000	250,000	Continuation of FY 2007-08 approved budget amendment.	261
262	160P030	Program Component Correction For Children's Medical Services-Deduct			(130,511)					(130,511)	Technical issue that realigns program components within CMS	262
263	160P040	Program Component Correction For Children's Medical Services-Add			130,511					130,511	Technical issue that realigns program components within CMS	263
264	160P050	Healthy Start Adjustment - Add			578,753					578,753	Technical issue that move funding within program components; aligns with another issue that creates special Medicaid Waiver categories	264
265	160P060	Healthy Start Adjustment - Deduct			(578,753)					(578,753)	Technical issue that move funding within program components; aligns with another issue that creates special Medicaid Waiver categories	265
266	160S190	Adjustment To Funding Source Identifier - Deduct			(704,987)					(704,987)	Technical issue that realigns budget authority with revenue sources	266
267	160S200	Adjustment To Funding Source Identifier - Add			704,987					704,987	Technical issue that realigns budget authority with revenue sources	267
268	1604500	Reallocation Of Human Resources Outsourcing			(1,174)				81,674	80,500	Statewide reallocation of Human Resources Outsourcing contractual funding	268
269	1800370	Transfer Medicaid Waiver Funds To A Special Category - Deduct			(16,155,050)				(30,365,927)	(46,520,977)	Moves Medicaid Waiver funding into a special appropriation category to assist in calculating FMAP changes	269
270	1800380	Transfer Medicaid Waiver Funds To A Special Category - Add			16,155,050				31,314,221	47,469,271	Moves Medicaid Waiver funding into a special appropriation category to assist in calculating FMAP changes	270

ROW	ISSUE	ISSUE TITLE	FTE	RATE	GR	NR GR	TB	NR TB	OTHER TF	TOTAL FUNDS	COMMENTS	ROW
271	1800480	Collapse Program Components In The Family Health Services Budget Entity - Add			(14)				(26)	(40)	Combines programs such as school health services, and chronic disease services within Family Health into one program component	271
272	1800550	Realign Funding In The Medical Quality Assurance Budget Entity - Deduct							(1,226,559)	(1,226,559)	Moves unspent funding from Unlicensed Activities to contracted services to convert voluminous licensing data to electronic media storage, and processing licensure revenue; to conduct inspections of surgical facilities; expert witness fees for medical professionals to support MQA actions; mailing and shipping costs; information technology application support; and credit card processing fees	272
273	1800560	Realign Funding In The Medical Quality Assurance Budget Entity - Add							1,226,559	1,226,559	Companion to issue #1800550	273
274	1800810	Realignment Of Contracted Services - Add			586,550					586,550	Realigns hospital reimbursement with contractual services category for cancer registry	274
275	1800820	Realignment Of Contracted Services - Deduct			(586,550)					(586,550)	Realigns hospital reimbursement with contractual services category for cancer registry	275
276	1800910	Realignment Of Transfer To DMS - Human Resources Services - Add			14				26	40	Statewide issue allocating funding for Human Resources	276
277	1800920	Realignment Of Transfer To DMS - Human Resources Services - Deduct			(14)				(26)	(40)	Statewide issue allocating funding for Human Resources	277
278	2503080	Direct Billing For Administrative Hearings							(16,718)	(16,718)	Statewide issue allocating funding for administrative hearings process.	278
279	33V0010	Reduction/Elimination Of Special Projects			(5,399,235)					(5,399,235)	Reduction or elimination of community budget request issues	279
280	33V0410	Positions Vacant Greater Than 365 Days	(23.50)	(825,258)	(2,877,575)				(2,731,984)	(5,609,559)	Removes department positions that are vacant over 365 days	280
281	3300070	Executive Direction			(855,661)					(855,661)	Reduction to the Division of Executive Direction and Support	281
282	3300080	Information Technology			(815,948)					(815,948)	Reduction to the Division of Information Technology	282
283	3300090	Family Health			(10,561,975)					(10,561,975)	Reduction to the Division of Family Health Services that will impact client services such as primary care , family planning, epilepsy program, ounce of prevention, and Healthy Start Coalitions.	283

ROW	ISSUE	ISSUE TITLE	FTE	RATE	GR	NR GR	TB	NR TB	OTHER TF	TOTAL FUNDS	COMMENTS	ROW
284	3300100	Infectious Disease Control			(3,721,916)		(619,849)		(2,615,711)	(6,957,476)	Reduction to the Division of Infectious Disease Control that will impact AG Holley, Bureau of Immunization, Bureau of HIV/IAIDS, Bureau of Sexually Transmitted Diseases, Bureau of TB & Refugee Health, and Bureau of Epidemiology	284
285	3300110	Environmental Health Services			(1,398,608)					(1,398,608)	Reduction to the Division of Environmental Health Services that will impact the birth registry program, cesspools, beach monitoring, and indoor air quality.	285
286	3300130	Statewide Public Health Support			(3,070,000)		(14,035)		(23,946)	(3,107,981)	Reduction to the Division of Statewide Public Health that will impact the Bureau of Laboratories, Division of Emergency Medical Operations, Florida Center for Nursing, and the Office of Planning and Evaluation	286
287	3300140	Children's Special Health Care			(13,019,162)					(13,019,162)	Reduction to the Division of Children's Medical Services that will impact client services such as: cleft lip/palate; regional genetics; sickle cell education and screening; primary care; master contracts and contracted services; infant/toddler stepdown program; kidney disease program, and pediatric AIDS network	287
288	3300150	Community Health Resources			(7,281,438)					(7,281,438)	Reduction to the Division of Community Health Resources that will impact the Area Health Education Centers and the Florida Indoor Air Act.	288
289	3400320	Transfer Program Funding Between Funds - Deduct							(1,981,086)	(1,981,086)	Corrects a technical error in the FY 07-08 GAA; aligns funds for the Healthy Start Coalitions	289
290	3400330	Transfer Program Funding Between Funds - Add							1,981,086	1,981,086	Corrects a technical error in the FY 07-08 GAA; aligns funds for the Healthy Start Coalitions	290
291	3401470	Changes To Federal Financial Participation Rate - State			1,112,188				52,025	1,164,213	Fund shift due to change in federal matching percentage rate (FMAP).	291
292	3401480	Changes To Federal Financial Participation Rate - Federal							(1,112,188)	(1,112,188)	Fund shift due to change in federal matching percentage rate (FMAP).	292
293	4000530	Change In Medicaid Federal Medical Assistance Percentage (FMAP)			45,371					45,371	Fund shift due to change in federal matching percentage rate (FMAP).	293
294	4100060	Additional Federal Funding For The Early Steps Program							3,045,423	3,045,423	Fund shift due to change in federal matching percentage rate (FMAP).	294
295	4300150	Brain & Spinal Cord Injury Research							500,000	500,000	Project to cure paralysis	295

ROW	ISSUE	ISSUE TITLE	FTE	RATE	GR	NR GR	TB	NR TB	OTHER TF	TOTAL FUNDS	COMMENTS	ROW
296	4309000	Tobacco Constitutional Amendment					6,563,267	5,000,000		6,563,267	Reflects the consumer Price Index increase and replaces nonrecurring funds appropriated last year to Implement the constitutionally mandated Tobacco Education and Use Prevention Program	296
297	4800020	Child Nutrition Program							12,378,909	12,378,909	Provides additional budget authority to spend federal dollars for the Child Nutrition Program	297
298	4800060	Additional Funding For March Of Dimes Grants							50,000	50,000	Provides budget authority to facilitate a grant received from the March of Dimes; the department is to develop a preconception website and a statewide plan for preconception health activities	298
299	4807000	Women, Infant And Children (WIC) Program							35,617,617	35,617,617	Provides additional budget authority to spend federal dollars for the Women, Infant and Children Program	299
300	54R0000	Casualty Insurance Premium Adjustment			356,133				85,396	441,529	Statewide Issue allocating state casualty insurance premium costs.	300
301	5800010	Additional Funding To Support Current Environmental Health Initiatives							474,181	474,181	Provides budget authority to support recurring federal grants to conduct three projects: Radon, Harmful Algal Bloom, and Water Quality	301
302	5800070	Additional Funding To Support State Grant Awards							80,000	80,000	Provides budget authority to support a recurring state award from the Fish and Wildlife Conservation Commission to support Aquatic Toxins Hotline	302
303	6400100	Provide Temporary Assistance To Needy Families (TANF) Funding							6,600,000	6,600,000	Temporary Cash Assistance Need based on January Social Services Estimating Conference.	303
304	6500000	Access To Health Care			30,000,000					30,000,000	Restores nonrecurring funding for hospital services to Medicaid recipients and low-income individuals	304
305	990S000	Special Purpose							15,296,600	15,296,600	Provides budget authority for fixed capital outlay projects for the following CHDs: Flagler; Hillsborough; Palm Beach; and Broward. These CHDs have provided their own cash but need the authority to spend from the Legislature.	305
306	**HEALTH, DEPT OF Total**		**3,152.00**	**127,608,887**	**548,221,767**	**0**	**111,065,642**	**5,000,000**	**2,130,936,754**	**2,790,224,163**		306
307												307
308	**VETERANS' AFFAIRS, DEPT OF**											308
309	1100000	Startup (Recurring Law And Policy) - Operating	668.50	21,237,678	13,930,987				44,627,716	58,558,703	Base budget	309
310	1604500	Reallocation Of Human Resources Outsourcing			356				1,064	1,420	Statewide reallocation of Human Resources Outsourcing contractual funding.	310

ROW	ISSUE	ISSUE TITLE	FTE	RATE	GR	NR GR	TB	NR TB	OTHER TF	TOTAL FUNDS	COMMENTS	ROW
311	1800130	Transfer Legislative Affairs Director To Executive Direction - Add	1.00	83,512	107,410					107,410	Technical issue to transfer the Legislative Affairs Director position to Executive Direction.	311
312	1800140	Transfer Legislative Affairs Director To Executive Direction - Deduct	(1.00)	(83,512)	(107,410)					(107,410)	Technical issue to transfer the Legislative Affairs Director position to Executive Direction.	312
313	2401700	State Nursing Home Replacement Equipment - Operating Capital Outlay (OCO) Category							64,100	64,100	Departmental purchase of certain replacement equipment.	313
314	2402100	State Nursing Home Additional Equipment - Operating Capital Outlay (OCO) Category							66,600	66,600	Departmental purchase of three specialty mattresses for each of the State Veterans' Homes.	314
315	2503080	Direct Billing For Administrative Hearings			(2,007)					(2,007)	Technical issue; billing for administrative hearings.	315
316	33B2000	Department Of Veterans' Affairs Schedule VIIIB-1 Homes Program Reduction			(15,431)					(15,431)	Reduction to expenses related to CNA positions; will be absorbed by using Operations and Maintenance Trust Fund.	316
317	33B2100	Department Of Veterans' Affairs Schedule VIIIB-1 Executive Direction/Support Services Program Reduction.			(66,600)					(66,600)	Limit on out-of-state travel that is not federally-mandated.	317
318	33B2200	Department Of Veterans' Affairs Schedule VIIIB-1 Veterans' Benefits & Assistance Program Reduction.			(50,582)					(50,582)	Reduction in travel and office expenditures	318
319	33B2210	Department Of Veterans' Affairs Schedule VIIIB-1 Benefits And Assistance Reduction In OCO			(11,700)					(11,700)	Limit on new equipment purchases in division.	319
320	33V01C0	Information Technology Reductions			(119,283)					(119,283)	1 year delay to Information Technology refresh cycle.	320
321	3400300	Realignment Of Operations And Maintenance Trust Funds/General Revenue Appropriations - Add							135,947	135,947	Fund shift	321
322	3400400	Realignment Of Operations And Maintenance Trust Funds/General Revenue Appropriations - Deduct			(135,947)					(135,947)	Fund shift	322
323	3400600	EDSS Div - Reduction In Expense			(100,458)					(100,458)	Fund shift	323
324	3400700	Homes-Inc Operations Maint TF Expense							100,458	100,458	Fund shift	324
325	4109000	Initial Staffing/Start-Up Funding St. Johns County State Veterans' Nursing Home	9.00	389,250					313,885	313,885	Nine key staff members begin March 2009 to develop operational plans prior to the admission of residents July 2009.	325
326	54R0000	Casualty Insurance Premium Adjustment			(5,066)				(14,469)	(19,535)	Statewide Issue allocating state casualty insurance premium costs.	326
327	990M000	Maintenance And Repair							1,245,256	1,245,256	Capital Improvement Program to fund facility repair.	327
328	**VETERANS' AFFAIRS, DEPT OF Total**		**677.50**	**21,626,928**	**13,424,269**	**0**	**0**	**0**	**46,540,557**	**59,964,826**		328
329	**Grand Total**		**22,451.50**	**848,374,990**	**7,179,900,000**	**22,293,522**	**464,300,000**	**15,000,000**	**15,088,772,319**	**22,732,972,319**		329

Review and Discussion of Proposed Conforming Bills

Health Care

Health Care Conforming Bill

Drugs, Devices and Cosmetics

- Transfers the DOH Division of Drugs, Devices and Cosmetics to the Department of Business and Professional Regulation effective April, 2009.
    - All functions and regulatory authority transfer to DBPR
    - All FTEs transfer to DBPR

Medicaid Provider Rates

- Requires AHCA, for two years, to set rates in a manner that will ensure no increase in statewide expenditures resulting from a change in unit costs, for hospitals, nursing homes, county health departments and community intermediate care facilities for the developmentally disabled for two years.
    - This eliminates automatic, cost-based, rate increases for those providers for two years.
    - The effect of this on rates for those providers passes through to managed care rates.
    - Requires AHCA to establish work groups to look at alternative ways to reimburse nursing homes, hospitals and HMOs in future.
    - Suspends enforcement of nursing home staffing ratios during the two-year rate increase suspension.
- Reduces reimbursement to pharmacies for prescribed drugs.
- Prohibits licensure enforcement of nursing home staffing ratios by AHCA during the two years that automatic rate increases are prohibited.

Medicaid Optional Services

- Suspends coverage of certain optional services for two years:
    - Adult dental services
    - Chiropractic services
    - Hearing services
    - Hospice services

- Optometric services
- Podiatric services
- Visual services

Medicaid Special Hospital Payments

- Eliminates special hospital payments. Five hospitals currently receive such payments by meeting statutory criteria. One additional hospital currently qualifies, but funds have not been appropriated to make the payments.

Medicaid Reform

- Sets the next two demonstration sites:
  - Miami-Dade and Monroe Counties, to start enrolling by July 1, 2009.
  - Monroe, Pasco, Pinellas, Hardee, Highlands, Hillsborough, Manatee and Polk Counties, to start enrolling by July 1, 2010.

- Makes program adjustments to improve oversight and quality:
  - Requires AHCA to monitor and evaluate plans' network adequacy regularly, to ensure recipients have access to all types of providers
  - Requires AHCA to encourage provider service networks (PSNs) to develop innovative ways to perform their administrative functions, including coordination with other PSNs
  - Ensures recipients will receive accurate and current prescription drug coverage information for each plan
  - Requires the agency to set standards for prompt claims payment by plans to providers
  - Modifies the assignment processes for recipients who don't voluntarily choose a plan to ensure a more balanced enrollment between HMOs and PSN. Currently, recipients are automatically assigned to an HMO if they were enrolled in that HMO before reform.

Repeals

- Teaching nursing home pilot project – received $5.2 million over the last 8 years (approx. $650k per year); nursing homes are not using the teaching nursing home as a resource. Base budget review team recommendation.

- Statewide Advocacy Council and Local Advocacy Councils – approx. $1 million per year and 13 FTES. Some functions are redundant to other programs, such as the DOEA ombudsman program, the Advocacy Center for Persons with Disabilities and the Guardian ad Litem Program. Base budget review team recommendation.

- Florida Center for Nursing - $480 GR annually.

- Florida Patient Safety Corporation – received $2.9 million since FY '04-05 (approx. $750k per year). Base budget review team recommendation.

- Sunshine for Seniors Program – $158,000 GR. Base budget review team recommendation.

Technical Issues

- Permits AHCA to move funds for lease bond licensee issues.

- Medicaid dual eligibles - allows certain payments required by CMS for Medicaid recipients also eligible for Medicare.

- Medicaid DSH/UPL - Usual annual updates for the calculation methodology.

- Eliminates Medicaid requirement to mail explanations of medical benefits for certain services.

- Requires AHCA to notify the Legislature before seeking Medicaid state plan amendments under the federal Deficit Reduction Act.

A bill to be entitled

An act relating to health care; transferring and reassigning divisions, functions, and responsibilities, including records, personnel, property, and unexpended balances of appropriations and other resources from the Department of Health to the Department of Business and Professional Regulation; providing for the continued validity of pending judicial or administrative actions in which the Department of Health is a party; providing for the continued validity of lawful orders issued by the Department of Health; transferring rules created by the Department of Health to the Department of Business and Professional Regulation; providing for the continued validity of permits and certifications issued by the Department of Health; amending s. 400.179, F.S.; authorizing transfer of funds; amending s. 400.141, F.S.; prohibiting enforcement of certain nursing facility deficiencies for two fiscal years; amending s. 400.23, F.S.; prohibiting enforcement of certain nursing facility deficiencies for two fiscal years; providing a sunset date for the prohibition against enforcement of certain nursing facility deficiencies; amending s. 409.905, F.S.; eliminating authority for certain hospital inpatient per diem rate adjustment; amending s. 409.906, F.S.; prohibiting payment for Medicaid adult dental services, chiropractic services, hearing services, hospice services, optometric services, podiatric services, and visual services for two fiscal years; authorizing the agency to

pay for Medicaid services provided by an anesthesiologist assistant; providing for reimbursement; amending s. 409.908, F.S.; deleting provision prohibiting Medicaid from making payment toward deductibles and coinsurance for services not covered by Medicaid; requiring the agency to continue collecting but suspend the use of cost data to set reimbursement rates for hospitals, nursing facilities, county health departments and community intermediate care facilities for two fiscal years; requiring the agency to apply the effect of the suspension of the use of cost data to set certain rates to managed care plans and nursing home diversion programs; requiring the agency to establish work groups to evaluate alternative payment methodologies for hospitals, nursing facilities, and managed care plans; requiring a report; providing a sunset date for the suspension of the use of cost data to set certain rates; amending s. 409.911, F.S.; revising the share data used to calculate the disproportionate share payments to hospitals; amending s. 409.9112, F.S.; revising the time period during which the agency is prohibited from distributing disproportionate share payments to regional perinatal intensive care centers; amending s. 409.9113, F.S.; requiring the agency to distribute moneys provided in the General Appropriations Act to statutorily defined teaching hospitals and family practice teaching hospitals under the teaching hospital disproportionate share program for the 2008-2009 fiscal year; amending s. 409.9117, F.S.; prohibiting the agency from distributing moneys under the

primary care disproportionate share program for the 2008-2009 fiscal year; amending s. 409.912, F.S.; amending reimbursement to pharmacies for Medicaid prescribed drugs; requiring the agency to notify the Legislature before seeking an amendment to the state plan in order to implement programs authorized by the Deficit Reduction Act of 2005; amending s. 409.91211, F.S.; providing for expansion of the Medicaid managed care pilot program to Miami-Dade, Monroe, Pasco, Pinellas, Hardee, Highlands, Hillsborough, Manatee and Polk Counties; requiring the agency to encourage cost-effective administration by provider service networks; requiring quarterly monitoring and annual evaluation of plan network adequacy; requiring that Medicaid recipients receive prescription drug coverage information for each plan; requiring the agency to set standards for prompt claims payment; modifying assignment processes for certain recipients; amending s. 409.9124, F.S.; revising the methodology used by the agency to reimburse managed care plans; amending s. 409.913, F.S.; prohibiting the explanation of certain Medicaid benefits from being mailed; repealing s. 381.0271, F.S., relating to the Florida Patient Safety Corporation; repealing s. 381.0273, F.S., relating to public records exemption for patient safety data; repealing s. 402.164, F.S., relating to the Florida Statewide Advocacy Council and the Florida local advocacy councils; repealing s. 402.165, F.S., relating to the Florida Statewide Advocacy Council; repealing s. 402.166,

F.S., relating to Florida local advocacy councils; repealing s. 402.167, F.S., relating to the Florida Statewide Advocacy Council and the Florida local advocacy councils; repealing s. 409.9061, F.S., relating to authority for a statewide laboratory services contract; repealing s. 430.80, F.S., relating to implementation of a teaching nursing home pilot project; repealing s. 430.83, F.S., relating to the Sunshine for Seniors Program; repealing s. 464.0195, F.S., relating to the Florida Center for Nursing; goals; repealing s. 464.0196, F.S., relating to the Florida Center for Nursing; board of directors; repealing s. 464.0197, F.S., relating to the Florida Center for Nursing; state budget support; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. (1) Effective April 1, 2009, all of the statutory powers, duties and functions, records, personnel, property, and unexpended balances of appropriations, allocations, or other funds for the administration of part I of chapter 499, Florida Statutes, related to Drugs, Devices, Cosmetics, and Household Products, shall be transferred by a type two transfer, as defined in s. 20.06(2), Florida Statutes, from the Department of Health to the Department of Business and Professional Regulation.

(2) The transfer of regulatory authority under part I of chapter 499, Florida Statutes, provided by this act shall not

affect the validity of any judicial or administrative action pending as of 11:59 p.m. on the day before the effective date of this act, to which action the Department of Health is at that time a party, and the Department of Business and Professional Regulation shall be substituted as a party in interest in any such action.

(3) All lawful orders issued by the Department of Health implementing or enforcing or otherwise in regard to any provision of part I of chapter 499, Florida Statutes, issued prior to the effective date of this act, shall remain in effect and be enforceable after the effective date of this act, unless thereafter modified in accordance with law.

(4) The rules of the Department of Health relating to the implementation of part I of chapter 499, Florida Statutes, that were in effect at 11:59 p.m. on the day prior to this act taking effect shall become the rules of the Department of Business and Professional Regulation and shall remain in effect until amended or repealed in the manner provided by law.

(5) Notwithstanding the transfer of regulatory authority over part I of chapter 499, Florida Statutes, provided by this act, persons and entities holding in good standing any permit under part I of chapter 499, Florida Statutes, as of 11:59 p.m. on the day prior to the effective date of this act, shall be deemed to hold in good standing a permit.

(6) Notwithstanding the transfer of regulatory authority over part I of chapter 499, Florida Statutes, provided by this act, persons holding in good standing any certification under part I of chapter 499, Florida Statutes, as of 11:59 p.m. on the

day prior to the effective date of this act, shall as of the effective date of this act be deemed to be certified in the same capacity in which they were formerly certified.

Section 2. Paragraph (d) of subsection (2) of section 400.179, Florida Statutes, is amended to read:

400.179 Liability for Medicaid underpayments and overpayments.--

(2) Because any transfer of a nursing facility may expose the fact that Medicaid may have underpaid or overpaid the transferor, and because in most instances, any such underpayment or overpayment can only be determined following a formal field audit, the liabilities for any such underpayments or overpayments shall be as follows:

(d) Where the transfer involves a facility that has been leased by the transferor:

1. The transferee shall, as a condition to being issued a license by the agency, acquire, maintain, and provide proof to the agency of a bond with a term of 30 months, renewable annually, in an amount not less than the total of 3 months' Medicaid payments to the facility computed on the basis of the preceding 12-month average Medicaid payments to the facility.

2. A leasehold licensee may meet the requirements of subparagraph 1. by payment of a nonrefundable fee, paid at initial licensure, paid at the time of any subsequent change of ownership, and paid annually thereafter, in the amount of 1 percent of the total of 3 months' Medicaid payments to the facility computed on the basis of the preceding 12-month average Medicaid payments to the facility. If a preceding 12-month

average is not available, projected Medicaid payments may be used. 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. The agency is authorized to transfer funds to the Grants and Donations Trust Fund for such repayments. Payment of this fee shall not release the licensee from any liability for any Medicaid overpayments, nor shall payment bar the agency from seeking to recoup overpayments from the licensee and any other liable party. As a condition of exercising this lease bond alternative, licensees paying this fee must maintain an existing lease bond through the end of the 30-month term period of that bond. The agency is herein granted specific authority to promulgate all rules pertaining to the administration and management of this account, including withdrawals from the account, subject to federal review and approval. This provision shall take effect upon becoming law and shall apply to any leasehold license application. The financial viability of the Medicaid nursing home overpayment account shall be determined by the agency through annual review of the account balance and the amount of total outstanding, unpaid Medicaid overpayments owing from leasehold licensees to the agency as determined by final agency audits.

3. The leasehold licensee may meet the bond requirement through other arrangements acceptable to the agency. The agency is herein granted specific authority to promulgate rules pertaining to lease bond arrangements.

4. All existing nursing facility licensees, operating the facility as a leasehold, shall acquire, maintain, and provide proof to the agency of the 30-month bond required in subparagraph 1., above, on and after July 1, 1993, for each license renewal.

5. It shall be the responsibility of all nursing facility operators, operating the facility as a leasehold, to renew the 30-month bond and to provide proof of such renewal to the agency annually.

6. Any failure of the nursing facility operator to acquire, maintain, renew annually, or provide proof to the agency shall be grounds for the agency to deny, revoke, and suspend the facility license to operate such facility and to take any further action, including, but not limited to, enjoining the facility, asserting a moratorium pursuant to part II of chapter 408, or applying for a receiver, deemed necessary to ensure compliance with this section and to safeguard and protect the health, safety, and welfare of the facility's residents. A lease agreement required as a condition of bond financing or refinancing under s. 154.213 by a health facilities authority or required under s. 159.30 by a county or municipality is not a leasehold for purposes of this paragraph and is not subject to the bond requirement of this paragraph.

Section 3. Subsection (15) of section 400.141, Florida Statutes, is amended to read:

400.141 Administration and management of nursing home facilities.--Every licensed facility shall comply with all applicable standards and rules of the agency and shall:

(15) Submit semiannually to the agency, or more frequently if requested by the agency, information regarding facility staff-to-resident ratios, staff turnover, and staff stability, including information regarding certified nursing assistants, licensed nurses, the director of nursing, and the facility administrator. For purposes of this reporting:

(a) Staff-to-resident ratios must be reported in the categories specified in s. 400.23(3)(a) and applicable rules. The ratio must be reported as an average for the most recent calendar quarter.

(b) Staff turnover must be reported for the most recent 12-month period ending on the last workday of the most recent calendar quarter prior to the date the information is submitted. The turnover rate must be computed quarterly, with the annual rate being the cumulative sum of the quarterly rates. The turnover rate is the total number of terminations or separations experienced during the quarter, excluding any employee terminated during a probationary period of 3 months or less, divided by the total number of staff employed at the end of the period for which the rate is computed, and expressed as a percentage.

(c) The formula for determining staff stability is the total number of employees that have been employed for more than 12 months, divided by the total number of employees employed at the end of the most recent calendar quarter, and expressed as a percentage.

(d) A nursing facility that has failed to comply with state minimum-staffing requirements for 2 consecutive days is

prohibited from accepting new admissions until the facility has achieved the minimum-staffing requirements for a period of 6 consecutive days. For the purposes of this paragraph, any person who was a resident of the facility and was absent from the facility for the purpose of receiving medical care at a separate location or was on a leave of absence is not considered a new admission. Failure to impose such an admissions moratorium constitutes a class II deficiency. The agency may not enforce the requirements of this paragraph for deficiencies occurring after June 30, 2008 and before July 1, 2010. This prohibition on enforcement shall sunset on June 30, 2010.

(e) A nursing facility which does not have a conditional license may be cited for failure to comply with the standards in s. 400.23(3)(a)1.a. only if it has failed to meet those standards on 2 consecutive days or if it has failed to meet at least 97 percent of those standards on any one day.

(f) A facility which has a conditional license must be in compliance with the standards in s. 400.23(3)(a) at all times.

Nothing in this section shall limit the agency's ability to impose a deficiency or take other actions if a facility does not have enough staff to meet the residents' needs.

Facilities that have been awarded a Gold Seal under the program established in s. 400.235 may develop a plan to provide certified nursing assistant training as prescribed by federal regulations and state rules and may apply to the agency for approval of their program.

Section 4. Subsection (11) is added to section 400.23, Florida Statutes, to read:

400.23 Rules; evaluation and deficiencies; licensure status.--

(11) The agency may not enforce the requirements of subparagraph (3)(a)1. for deficiencies occurring after June 30, 2008 and before July 1, 2010. This subsection shall sunset on June 30, 2010.

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

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

(5) HOSPITAL INPATIENT SERVICES.--The agency shall pay for all covered services provided for the medical care and treatment of a recipient who is admitted as an inpatient by a licensed

physician or dentist to a hospital licensed under part I of chapter 395. However, the agency shall limit the payment for inpatient hospital services for a Medicaid recipient 21 years of age or older to 45 days or the number of days necessary to comply with the General Appropriations Act.

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

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

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

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

~~No later than October 1 of each year, the agency must provide estimated costs for any adjustment in a hospital inpatient per diem pursuant to this paragraph to the Executive Office of the Governor, the House of Representatives General Appropriations Committee, and the Senate Appropriations Committee. Before the agency implements a change in a hospital's inpatient per diem~~

~~rate pursuant to this paragraph, the Legislature must have specifically appropriated sufficient funds in the General Appropriations Act to support the increase in cost as estimated by the agency.~~

Section 6. Section 409.906, Florida Statutes, is amended to read:

409.906 Optional Medicaid services.--Subject to specific appropriations, the agency may make payments for services which are optional to the state under Title XIX of the Social Security Act and are furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any optional service that is provided shall be provided only when medically necessary and in accordance with state and federal law. Optional services rendered by providers in mobile units to Medicaid recipients may be restricted or prohibited by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. If necessary to safeguard the state's systems of providing services to elderly and disabled persons and subject to the notice and review provisions of s. 216.177, the Governor may direct the Agency for Health Care Administration to amend the Medicaid state plan to delete the optional Medicaid service known as "Intermediate Care Facilities for the Developmentally Disabled." Optional services may include:

(1) ADULT DENTAL SERVICES.--For two fiscal years beginning July 1, 2008, and ending June 30, 2010, the agency may not pay for adult dental services.

~~(a) The agency may pay for medically necessary, emergency dental procedures to alleviate pain or infection. Emergency dental care shall be limited to emergency oral examinations, necessary radiographs, extractions, and incision and drainage of abscess, for a recipient who is 21 years of age or older.~~

~~(b) Beginning July 1, 2006, the agency may pay for full or partial dentures, the procedures required to seat full or partial dentures, and the repair and reline of full or partial dentures, provided by or under the direction of a licensed dentist, for a recipient who is 21 years of age or older.~~

~~(c) However, Medicaid will not provide reimbursement for dental services provided in a mobile dental unit, except for a mobile dental unit:~~

~~1. Owned by, operated by, or having a contractual agreement with the Department of Health and complying with Medicaid's county health department clinic services program specifications as a county health department clinic services provider.~~

~~2. Owned by, operated by, or having a contractual arrangement with a federally qualified health center and complying with Medicaid's federally qualified health center specifications as a federally qualified health center provider.~~

~~3. Rendering dental services to Medicaid recipients, 21 years of age and older, at nursing facilities.~~

~~4. Owned by, operated by, or having a contractual agreement with a state-approved dental educational institution.~~

(2) ADULT HEALTH SCREENING SERVICES.--The agency may pay for an annual routine physical examination, conducted by or under the direction of a licensed physician, for a recipient age 21 or older, without regard to medical necessity, in order to detect and prevent disease, disability, or other health condition or its progression.

(3) AMBULATORY SURGICAL CENTER SERVICES.--The agency may pay for services provided to a recipient in an ambulatory surgical center licensed under part I of chapter 395, by or under the direction of a licensed physician or dentist.

(4) BIRTH CENTER SERVICES.--The agency may pay for examinations and delivery, recovery, and newborn assessment, and related services, provided in a licensed birth center staffed with licensed physicians, certified nurse midwives, and midwives licensed in accordance with chapter 467, to a recipient expected to experience a low-risk pregnancy and delivery.

(5) CASE MANAGEMENT SERVICES.--The agency may pay for primary care case management services rendered to a recipient pursuant to a federally approved waiver, and targeted case management services for specific groups of targeted recipients, for which funding has been provided and which are rendered pursuant to federal guidelines. The agency is authorized to limit reimbursement for targeted case management services in order to comply with any limitations or directions provided for in the General Appropriations Act.

(6) CHILDREN'S DENTAL SERVICES.--The agency may pay for diagnostic, preventive, or corrective procedures, including orthodontia in severe cases, provided to a recipient under age 21, by or under the supervision of a licensed dentist. Services provided under this program include treatment of the teeth and associated structures of the oral cavity, as well as treatment of disease, injury, or impairment that may affect the oral or general health of the individual. However, Medicaid will not provide reimbursement for dental services provided in a mobile dental unit, except for a mobile dental unit:

(a) Owned by, operated by, or having a contractual agreement with the Department of Health and complying with Medicaid's county health department clinic services program specifications as a county health department clinic services provider.

(b) Owned by, operated by, or having a contractual arrangement with a federally qualified health center and complying with Medicaid's federally qualified health center specifications as a federally qualified health center provider.

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

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

(7) CHIROPRACTIC SERVICES.-- For two fiscal years beginning July 1, 2008, and ending June 30, 2010, the agency may not pay for chiropractic services. ~~The agency may pay for manual manipulation of the spine and initial services, screening, and X~~

~~rays provided to a recipient by a licensed chiropractic physician.~~

(8) COMMUNITY MENTAL HEALTH SERVICES.--

(a) The agency may pay for rehabilitative services provided to a recipient by a mental health or substance abuse provider under contract with the agency or the Department of Children and Family Services to provide such services. Those services which are psychiatric in nature shall be rendered or recommended by a psychiatrist, and those services which are medical in nature shall be rendered or recommended by a physician or psychiatrist. The agency must develop a provider enrollment process for community mental health providers which bases provider enrollment on an assessment of service need. The provider enrollment process shall be designed to control costs, prevent fraud and abuse, consider provider expertise and capacity, and assess provider success in managing utilization of care and measuring treatment outcomes. Providers will be selected through a competitive procurement or selective contracting process. In addition to other community mental health providers, the agency shall consider for enrollment mental health programs licensed under chapter 395 and group practices licensed under chapter 458, chapter 459, chapter 490, or chapter 491. The agency is also authorized to continue operation of its behavioral health utilization management program and may develop new services if these actions are necessary to ensure savings from the implementation of the utilization management system. The agency shall coordinate the implementation of this enrollment process with the Department of

Children and Family Services and the Department of Juvenile Justice. The agency is authorized to utilize diagnostic criteria in setting reimbursement rates, to preauthorize certain high-cost or highly utilized services, to limit or eliminate coverage for certain services, or to make any other adjustments necessary to comply with any limitations or directions provided for in the General Appropriations Act.

(b) The agency is authorized to implement reimbursement and use management reforms in order to comply with any limitations or directions in the General Appropriations Act, which may include, but are not limited to: prior authorization of treatment and service plans; prior authorization of services; enhanced use review programs for highly used services; and limits on services for those determined to be abusing their benefit coverages.

(9) DIALYSIS FACILITY SERVICES.--Subject to specific appropriations being provided for this purpose, the agency may pay a dialysis facility that is approved as a dialysis facility in accordance with Title XVIII of the Social Security Act, for dialysis services that are provided to a Medicaid recipient under the direction of a physician licensed to practice medicine or osteopathic medicine in this state, including dialysis services provided in the recipient's home by a hospital-based or freestanding dialysis facility.

(10) DURABLE MEDICAL EQUIPMENT.--The agency may authorize and pay for certain durable medical equipment and supplies provided to a Medicaid recipient as medically necessary.

(11) HEALTHY START SERVICES.--The agency may pay for a continuum of risk-appropriate medical and psychosocial services for the Healthy Start program in accordance with a federal waiver. The agency may not implement the federal waiver unless the waiver permits the state to limit enrollment or the amount, duration, and scope of services to ensure that expenditures will not exceed funds appropriated by the Legislature or available from local sources. If the Health Care Financing Administration does not approve a federal waiver for Healthy Start services, the agency, in consultation with the Department of Health and the Florida Association of Healthy Start Coalitions, is authorized to establish a Medicaid certified-match program for Healthy Start services. Participation in the Healthy Start certified-match program shall be voluntary, and reimbursement shall be limited to the federal Medicaid share to Medicaid-enrolled Healthy Start coalitions for services provided to Medicaid recipients. The agency shall take no action to implement a certified-match program without ensuring that the amendment and review requirements of ss. 216.177 and 216.181 have been met.

(12) HEARING SERVICES.-- For two fiscal years beginning July 1, 2008, and ending June 30, 2010, the agency may not pay for hearing services.~~The agency may pay for hearing and related services, including hearing evaluations, hearing aid devices, dispensing of the hearing aid, and related repairs, if provided to a recipient by a licensed hearing aid specialist, otolaryngologist, otologist, audiologist, or physician.~~

(13) HOME AND COMMUNITY-BASED SERVICES.--

(a) The agency may pay for home-based or community-based services that are rendered to a recipient in accordance with a federally approved waiver program. The agency may limit or eliminate coverage for certain services, preauthorize high-cost or highly utilized services, or make any other adjustments necessary to comply with any limitations or directions provided for in the General Appropriations Act.

(b) The agency may consolidate types of services offered in the Aged and Disabled Waiver, the Channeling Waiver, the Project AIDS Care Waiver, and the Traumatic Brain and Spinal Cord Injury Waiver programs in order to group similar services under a single service, or continue a service upon evidence of the need for including a particular service type in a particular waiver. The agency is authorized to seek a Medicaid state plan amendment or federal waiver approval to implement this policy.

(c) The agency may implement a utilization management program designed to prior-authorize home and community-based service plans and includes, but is not limited to, assessing proposed quantity and duration of services and monitoring ongoing service use by participants in the program. The agency is authorized to competitively procure a qualified organization to provide utilization management of home and community-based services. The agency is authorized to seek any federal waivers to implement this initiative.

(14) HOSPICE CARE SERVICES.-- For two fiscal years beginning July 1, 2008, and ending June 30, 2010, the agency may not pay for hospice services. ~~The agency may pay for all reasonable and necessary services for the palliation or~~

~~management of a recipient's terminal illness, if the services are provided by a hospice that is licensed under part IV of chapter 400 and meets Medicare certification requirements.~~

(15) INTERMEDIATE CARE FACILITY FOR THE DEVELOPMENTALLY DISABLED SERVICES.--The agency may pay for health-related care and services provided on a 24-hour-a-day basis by a facility licensed and certified as a Medicaid Intermediate Care Facility for the Developmentally Disabled, for a recipient who needs such care because of a developmental disability. Payment shall not include bed-hold days except in facilities with occupancy rates of 95 percent or greater. The agency is authorized to seek any federal waiver approvals to implement this policy.

(16) INTERMEDIATE CARE SERVICES.--The agency may pay for 24-hour-a-day intermediate care nursing and rehabilitation services rendered to a recipient in a nursing facility licensed under part II of chapter 400, if the services are ordered by and provided under the direction of a physician.

(17) OPTOMETRIC SERVICES.-- For two fiscal years beginning July 1, 2008, and ending June 30, 2010, the agency may not pay for optometric services.~~The agency may pay for services provided to a recipient, including examination, diagnosis, treatment, and management, related to ocular pathology, if the services are provided by a licensed optometrist or physician.~~

(18) PHYSICIAN ASSISTANT SERVICES.--The agency may pay for all services provided to a recipient by a physician assistant licensed under s. 458.347 or s. 459.022. Reimbursement for such services must be not less than 80 percent of the reimbursement

that would be paid to a physician who provided the same services.

(19) PODIATRIC SERVICES.-- For two fiscal years beginning July 1, 2008, and ending June 30, 2010, the agency may not pay for podiatric services. ~~The agency may pay for services, including diagnosis and medical, surgical, palliative, and mechanical treatment, related to ailments of the human foot and lower leg, if provided to a recipient by a podiatric physician licensed under state law.~~

(20) PRESCRIBED DRUG SERVICES.--The agency may pay for medications that are prescribed for a recipient by a physician or other licensed practitioner of the healing arts authorized to prescribe medications and that are dispensed to the recipient by a licensed pharmacist or physician in accordance with applicable state and federal law.

(21) REGISTERED NURSE FIRST ASSISTANT SERVICES.--The agency may pay for all services provided to a recipient by a registered nurse first assistant as described in s. 464.027. Reimbursement for such services may not be less than 80 percent of the reimbursement that would be paid to a physician providing the same services.

(22) STATE HOSPITAL SERVICES.--The agency may pay for all-inclusive psychiatric inpatient hospital care provided to a recipient age 65 or older in a state mental hospital.

(23) VISUAL SERVICES.-- For two fiscal years beginning July 1, 2008, and ending June 30, 2010, the agency may not pay for visual services. ~~The agency may pay for visual examinations, eyeglasses, and eyeglass repairs for a recipient if they are~~

~~prescribed by a licensed physician specializing in diseases of the eye or by a licensed optometrist. Eyeglasses for adult recipients shall be limited to two pairs per year per recipient, except a third pair may be provided after prior authorization.~~

(24) CHILD-WELFARE-TARGETED CASE MANAGEMENT.--The Agency for Health Care Administration, in consultation with the Department of Children and Family Services, may establish a targeted case-management project in those counties identified by the Department of Children and Family Services and for all counties with a community-based child welfare project, as authorized under s. 409.1671, which have been specifically approved by the department. Results of targeted case management projects shall be reported to the Social Services Estimating Conference established under s. 216.136. The covered group of individuals who are eligible to receive targeted case management include children who are eligible for Medicaid; who are between the ages of birth through 21; and who are under protective supervision or postplacement supervision, under foster-care supervision, or in shelter care or foster care. The number of individuals who are eligible to receive targeted case management shall be limited to the number for whom the Department of Children and Family Services has available matching funds to cover the costs. The general revenue funds required to match the funds for services provided by the community-based child welfare projects are limited to funds available for services described under s. 409.1671. The Department of Children and Family Services may transfer the general revenue matching funds as billed by the Agency for Health Care Administration.

(25) ASSISTIVE-CARE SERVICES.--The agency may pay for assistive-care services provided to recipients with functional or cognitive impairments residing in assisted living facilities, adult family-care homes, or residential treatment facilities. These services may include health support, assistance with the activities of daily living and the instrumental acts of daily living, assistance with medication administration, and arrangements for health care.

(26) ANESTHESIOLOGIST ASSISTANT SERVICES.--The agency may pay for all services provided to a recipient by an anesthesiologist assistant licensed under s. 458.3475 or s. 459.023. Reimbursement for such services must be not less than 80 percent of the reimbursement that would be paid to a physician who provided the same services.

Section 7. Subsection (13) of section 409.908, Florida Statutes, is amended and subsection (23) is added to read:

409.908 Reimbursement of Medicaid providers.--Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. If a provider is reimbursed based on cost reporting and submits a cost report late and that cost report would have been used to set a lower reimbursement rate

for a rate semester, then the provider's rate for that semester shall be retroactively calculated using the new cost report, and full payment at the recalculated rate shall be effected retroactively. Medicare-granted extensions for filing cost reports, if applicable, shall also apply to Medicaid cost reports. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

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

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

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

(b) ~~(c)~~ Medicaid will pay no portion of Medicare deductibles and coinsurance when payment that Medicare has made for the service equals or exceeds what Medicaid would have paid if it had been the sole payor. The combined payment of Medicare and Medicaid shall not exceed the amount Medicaid would have paid had it been the sole payor. The Legislature finds that there has been confusion regarding the reimbursement for services rendered to dually eligible Medicare beneficiaries. Accordingly, the Legislature clarifies that it has always been the intent of the Legislature before and after 1991 that, in reimbursing in accordance with fees established by Title XVIII for premiums, deductibles, and coinsurance for Medicare services rendered by physicians to Medicaid eligible persons, physicians be reimbursed at the lesser of the amount billed by the physician or the Medicaid maximum allowable fee established by the Agency for Health Care Administration, as is permitted by federal law. It has never been the intent of the Legislature with regard to such services rendered by physicians that Medicaid be required to provide any payment for deductibles, coinsurance, or copayments for Medicare cost sharing, or any expenses incurred relating thereto, in excess of the payment amount provided for under the State Medicaid plan for such service. This payment methodology is applicable even in those situations in which the payment for Medicare cost sharing for a qualified Medicare beneficiary with respect to an item or service is reduced or eliminated. This expression of the Legislature is in clarification of existing law and shall apply to payment for, and with respect to provider agreements with

respect to, items or services furnished on or after the effective date of this act. This paragraph applies to payment by Medicaid for items and services furnished before the effective date of this act if such payment is the subject of a lawsuit that is based on the provisions of this section, and that is pending as of, or is initiated after, the effective date of this act.

(c) ~~(d)~~ Notwithstanding paragraphs (a) - (b) ~~(a) - (c)~~:

1. Medicaid payments for Nursing Home Medicare part A coinsurance shall be limited to the Medicaid nursing home per diem rate less any amounts paid by Medicare, but only up to the amount of Medicare coinsurance. The Medicaid per diem rate shall be the rate in effect for the dates of service of the crossover claims and may not be subsequently adjusted due to subsequent per diem rate adjustments.

2. Medicaid shall pay all deductibles and coinsurance for Medicare-eligible recipients receiving freestanding end stage renal dialysis center services.

3. Medicaid payments for general hospital inpatient services shall be limited to the Medicare deductible per spell of illness and coinsurance. Medicaid payments for hospital Medicare Part A coinsurance shall be limited to the Medicaid hospital per diem rate less any amounts paid by Medicare, but only up to the amount of Medicare coinsurance. Medicaid payments for coinsurance shall be limited to the Medicaid per diem rate in effect for the dates of service of the crossover claims and may not be subsequently adjusted due to subsequent per diem

adjustments. ~~Medicaid shall make no payment toward coinsurance for Medicare general hospital inpatient services.~~

4. Medicaid shall pay all deductibles and coinsurance for Medicare emergency transportation services provided by ambulances licensed pursuant to chapter 401.

(23)(a) The agency shall establish rates at a level that ensures no increase in statewide expenditures resulting from a change in unit costs, for two fiscal years effective July 1, 2008. Reimbursement rates for the two fiscal years shall be as provided in the General Appropriation Act.

(b) This subsection applies to the following provider types:

1. Inpatient hospitals;

2. Outpatient hospitals;

3. Nursing homes;

4. County health departments; and

5. Community intermediate care facilities for the developmentally disabled.

The agency shall apply the effect of this subsection to the reimbursement rates for managed care plans and nursing home diversion programs.

(c) The agency shall create a work group on hospital reimbursement, a work group on nursing facility reimbursement, and a work group on managed care plan payment. The work groups shall evaluate alternative reimbursement and payment methodologies for hospitals, nursing facilities, and managed care plans, including prospective payment methodologies for hospitals and nursing facilities. The nursing facility work

group shall also consider price-based methodologies for indirect care and acuity adjustments for direct care. The agency shall submit a report on the evaluated alternative reimbursement methodologies to the relevant committees of the Senate and the House of Representatives by November 1, 2009.

(d) This subsection shall sunset June 30, 2010.

Section 8. Subsection (2) of section 409.911, Florida Statutes, is amended to read:

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 2002, 2003, and 2004~~2000, 2001, and 2002~~ audited disproportionate share data to determine each hospital's Medicaid days and charity care for the 2008-2009~~2006-2007~~ state fiscal year.

(b) If the Agency for Health Care Administration does not have the prescribed 3 years of audited disproportionate share

data as noted in paragraph (a) for a hospital, the agency shall use the average of the years of the audited disproportionate share data as noted in paragraph (a) which is available.

(c) In accordance with s. 1923(b) of the Social Security Act, a hospital with a Medicaid inpatient utilization rate greater than one standard deviation above the statewide mean or a hospital with a low-income utilization rate of 25 percent or greater shall qualify for reimbursement.

Section 9. Subsection (1) of section 409.9112, Florida Statutes, is amended to read:

409.9112 Disproportionate share program for regional perinatal intensive care centers.--In addition to the payments made under s. 409.911, the Agency for Health Care Administration shall design and implement a system of making disproportionate share payments to those hospitals that participate in the regional perinatal intensive care center program established pursuant to chapter 383. 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 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. For the state fiscal year 2008-2009~~2005-2006~~, the agency shall not distribute moneys under the regional perinatal intensive care centers disproportionate share program.

(1) The following formula shall be used by the agency to calculate the total amount earned for hospitals that participate in the regional perinatal intensive care center program:

TAE = HDSP/THDSP

Where:

TAE = total amount earned by a regional perinatal intensive care center.

HDSP = the prior state fiscal year regional perinatal intensive care center disproportionate share payment to the individual hospital.

THDSP = the prior state fiscal year total regional perinatal intensive care center disproportionate share payments to all hospitals.

Section 10. 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 state fiscal year 2008-2009~~2006-2007~~, the agency shall distribute the moneys provided in the General Appropriations Act to statutorily defined teaching hospitals and family practice teaching hospitals under the teaching hospital disproportionate share program. The funds provided for statutorily defined teaching hospitals shall be distributed in the same proportion as the state fiscal year 2003-2004 teaching hospital disproportionate share funds were distributed, or as otherwise provided in the General Appropriations Act. The funds provided for family practice teaching hospitals shall be distributed equally among family practice teaching hospitals.

Section 11. Section 409.9117, Florida Statutes, is amended to read:

409.9117 Primary care disproportionate share program.--For the state fiscal year 2008-2009~~2006-2007~~, the agency shall not distribute moneys under the primary care disproportionate share program.

(1) If federal funds are available for disproportionate share programs in addition to those otherwise provided by law, there shall be created a primary care disproportionate share program.

Section 12. Subsection (39) of section 409.912, Florida Statutes, is amended, and subsection (53) is added, to read:

409.912 Cost-effective purchasing of health care.--The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery

of quality medical care. To ensure that medical services are effectively utilized, the agency may, in any case, require a confirmation or second physician's opinion of the correct diagnosis for purposes of authorizing future services under the Medicaid program. This section does not restrict access to emergency services or poststabilization care services as defined in 42 C.F.R. part 438.114. Such confirmation or second opinion shall be rendered in a manner approved by the agency. The agency shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services. The agency shall contract with a vendor to monitor and evaluate the clinical practice patterns of providers in order to identify trends that are outside the normal practice patterns of a provider's professional peers or the national guidelines of a provider's professional association. The vendor must be able to provide information and counseling to a provider whose practice patterns are outside the norms, in consultation with the agency, to improve patient care and reduce inappropriate utilization. The agency may mandate prior authorization, drug therapy management, or disease management participation for certain populations of Medicaid beneficiaries, certain drug classes, or

particular drugs to prevent fraud, abuse, overuse, and possible dangerous drug interactions. The Pharmaceutical and Therapeutics Committee shall make recommendations to the agency on drugs for which prior authorization is required. The agency shall inform the Pharmaceutical and Therapeutics Committee of its decisions regarding drugs subject to prior authorization. The agency is authorized to limit the entities it contracts with or enrolls as Medicaid providers by developing a provider network through provider credentialing. The agency may competitively bid single-source-provider contracts if procurement of goods or services results in demonstrated cost savings to the state without limiting access to care. The agency may limit its network based on the assessment of beneficiary access to care, provider availability, provider quality standards, time and distance standards for access to care, the cultural competence of the provider network, demographic characteristics of Medicaid beneficiaries, practice and provider-to-beneficiary standards, appointment wait times, beneficiary use of services, provider turnover, provider profiling, provider licensure history, previous program integrity investigations and findings, peer review, provider Medicaid policy and billing compliance records, clinical and medical record audits, and other factors. Providers shall not be entitled to enrollment in the Medicaid provider network. The agency shall determine instances in which allowing Medicaid beneficiaries to purchase durable medical equipment and other goods is less expensive to the Medicaid program than long-term rental of the equipment or goods. The agency may establish rules to facilitate purchases in lieu of long-term rentals in

order to protect against fraud and abuse in the Medicaid program as defined in s. 409.913. The agency may seek federal waivers necessary to administer these policies.

(39)(a) The agency shall implement a Medicaid prescribed-drug spending-control program that includes the following components:

1. A Medicaid preferred drug list, which shall be a listing of cost-effective therapeutic options recommended by the Medicaid Pharmacy and Therapeutics Committee established pursuant to s. 409.91195 and adopted by the agency for each therapeutic class on the preferred drug list. At the discretion of the committee, and when feasible, the preferred drug list should include at least two products in a therapeutic class. The agency may post the preferred drug list and updates to the preferred drug list on an Internet website without following the rulemaking procedures of chapter 120. Antiretroviral agents are excluded from the preferred drug list. The agency shall also limit the amount of a prescribed drug dispensed to no more than a 34-day supply unless the drug products' smallest marketed package is greater than a 34-day supply, or the drug is determined by the agency to be a maintenance drug in which case a 100-day maximum supply may be authorized. The agency is authorized to seek any federal waivers necessary to implement these cost-control programs and to continue participation in the federal Medicaid rebate program, or alternatively to negotiate state-only manufacturer rebates. The agency may adopt rules to implement this subparagraph. The agency shall continue to

provide unlimited contraceptive drugs and items. The agency must establish procedures to ensure that:

a. There will be a response to a request for prior consultation by telephone or other telecommunication device within 24 hours after receipt of a request for prior consultation; and

b. A 72-hour supply of the drug prescribed will be provided in an emergency or when the agency does not provide a response within 24 hours as required by sub-subparagraph a.

2. Reimbursement to pharmacies for Medicaid prescribed drugs shall be set at the lesser of: the average wholesale price (AWP) minus 16.4~~15.4~~ percent, the wholesaler acquisition cost (WAC) plus 4.75~~5.75~~ percent, the federal upper limit (FUL), the state maximum allowable cost (SMAC), or the usual and customary (UAC) charge billed by the provider.

(53) Before seeking an amendment to the state plan for purposes of implementing programs authorized by the Deficit Reduction Act of 2005, the agency shall notify the Legislature.

Section 13. Section 409.91211, Florida Statutes, is amended to read:

409.91211 Medicaid managed care pilot program.--

(1)(a) The agency is authorized to seek and implement experimental, pilot, or demonstration project waivers, pursuant to s. 1115 of the Social Security Act, to create a statewide initiative to provide for a more efficient and effective service delivery system that enhances quality of care and client outcomes in the Florida Medicaid program pursuant to this section. Phase one of the demonstration shall be implemented in

two geographic areas. One demonstration site shall include only Broward County. A second demonstration site shall initially include Duval County and shall be expanded to include Baker, Clay, and Nassau Counties within 1 year after the Duval County program becomes operational. A third demonstration site shall include Miami-Dade and Monroe Counties. The agency shall begin enrolling recipients in the third demonstration site by July, 2009. A fourth demonstration site shall include Pasco, Pinellas, Hardee, Highlands, Hillsborough, Manatee and Polk Counties. The agency shall begin enrolling recipients in the fourth demonstration site by July, 2010. The agency shall implement expansion of the program to include the remaining counties of the state and remaining eligibility groups in accordance with the process specified in the federally approved special terms and conditions numbered 11-W-00206/4, as approved by the federal Centers for Medicare and Medicaid Services on October 19, 2005, with a goal of full statewide implementation by June 30, 2011.

(b) This waiver authority is contingent upon federal approval to preserve the upper-payment-limit funding mechanism for hospitals, including a guarantee of a reasonable growth factor, a methodology to allow the use of a portion of these funds to serve as a risk pool for demonstration sites, provisions to preserve the state's ability to use intergovernmental transfers, and provisions to protect the disproportionate share program authorized pursuant to this chapter. Upon completion of the evaluation conducted under s. 3, ch. 2005-133, Laws of Florida, the agency may request statewide expansion of the demonstration projects. Statewide phase-in to

additional counties shall be contingent upon review and approval by the Legislature. Under the upper-payment-limit program, or the low-income pool as implemented by the Agency for Health Care Administration pursuant to federal waiver, the state matching funds required for the program shall be provided by local governmental entities through intergovernmental transfers in accordance with published federal statutes and regulations. The Agency for Health Care Administration shall distribute upper-payment-limit, disproportionate share hospital, and low-income pool funds according to published federal statutes, regulations, and waivers and the low-income pool methodology approved by the federal Centers for Medicare and Medicaid Services.

(c) It is the intent of the Legislature that the low-income pool plan required by the terms and conditions of the Medicaid reform waiver and submitted to the federal Centers for Medicare and Medicaid Services propose the distribution of the above-mentioned program funds based on the following objectives:

1. Assure a broad and fair distribution of available funds based on the access provided by Medicaid participating hospitals, regardless of their ownership status, through their delivery of inpatient or outpatient care for Medicaid beneficiaries and uninsured and underinsured individuals;

2. Assure accessible emergency inpatient and outpatient care for Medicaid beneficiaries and uninsured and underinsured individuals;

3. Enhance primary, preventive, and other ambulatory care coverages for uninsured individuals;

4. Promote teaching and specialty hospital programs;

5. Promote the stability and viability of statutorily defined rural hospitals and hospitals that serve as sole community hospitals;

6. Recognize the extent of hospital uncompensated care costs;

7. Maintain and enhance essential community hospital care;

8. Maintain incentives for local governmental entities to contribute to the cost of uncompensated care;

9. Promote measures to avoid preventable hospitalizations;

10. Account for hospital efficiency; and

11. Contribute to a community's overall health system.

(2) The Legislature intends for the capitated managed care pilot program to:

(a) Provide recipients in Medicaid fee-for-service or the MediPass program a comprehensive and coordinated capitated managed care system for all health care services specified in ss. 409.905 and 409.906.

(b) Stabilize Medicaid expenditures under the pilot program compared to Medicaid expenditures in the pilot area for the 3 years before implementation of the pilot program, while ensuring:

1. Consumer education and choice.

2. Access to medically necessary services.

3. Coordination of preventative, acute, and long-term care.

4. Reductions in unnecessary service utilization.

(c) Provide an opportunity to evaluate the feasibility of statewide implementation of capitated managed care networks as a

replacement for the current Medicaid fee-for-service and MediPass systems.

(3) The agency shall have the following powers, duties, and responsibilities with respect to the pilot program:

(a) To implement a system to deliver all mandatory services specified in s. 409.905 and optional services specified in s. 409.906, as approved by the Centers for Medicare and Medicaid Services and the Legislature in the waiver pursuant to this section. Services to recipients under plan benefits shall include emergency services provided under s. 409.9128.

(b) To implement a pilot program, including Medicaid eligibility categories specified in ss. 409.903 and 409.904, as authorized in an approved federal waiver.

(c) To implement the managed care pilot program that maximizes all available state and federal funds, including those obtained through intergovernmental transfers, the low-income pool, supplemental Medicaid payments, and the disproportionate share program. Within the parameters allowed by federal statute and rule, the agency may seek options for making direct payments to hospitals and physicians employed by or under contract with the state's medical schools for the costs associated with graduate medical education under Medicaid reform.

(d) To implement actuarially sound, risk-adjusted capitation rates for Medicaid recipients in the pilot program which cover comprehensive care, enhanced services, and catastrophic care.

(e) To implement policies and guidelines for phasing in financial risk for approved provider service networks over a 3-

year period. These policies and guidelines must include an option for a provider service network to be paid fee-for-service rates. For any provider service network established in a managed care pilot area, the option to be paid fee-for-service rates shall include a savings-settlement mechanism that is consistent with s. 409.912(44). This model shall be converted to a risk-adjusted capitated rate no later than the beginning of the fourth year of operation, and may be converted earlier at the option of the provider service network. Federally qualified health centers may be offered an opportunity to accept or decline a contract to participate in any provider network for prepaid primary care services. The agency shall encourage the development of innovative methods by provider service networks to perform administrative functions in a cost-effective manner, including coordination and consolidation of such functions between provider service networks and across demonstration sites.

(f) To implement stop-loss requirements and the transfer of excess cost to catastrophic coverage that accommodates the risks associated with the development of the pilot program.

(g) To recommend a process to be used by the Social Services Estimating Conference to determine and validate the rate of growth of the per-member costs of providing Medicaid services under the managed care pilot program.

(h) To implement program standards and credentialing requirements for capitated managed care networks to participate in the pilot program, including those related to fiscal solvency, quality of care, and adequacy of access to health care

providers. The agency shall monitor quarterly and evaluate annually each plan based on the program standards and credentialing requirements for adequacy of access to health care providers to ensure consistent compliance. It is the intent of the Legislature that, to the extent possible, any pilot program authorized by the state under this section include any federally qualified health center, federally qualified rural health clinic, county health department, the Children's Medical Services Network within the Department of Health, or other federally, state, or locally funded entity that serves the geographic areas within the boundaries of the pilot program that requests to participate. This paragraph does not relieve an entity that qualifies as a capitated managed care network under this section from any other licensure or regulatory requirements contained in state or federal law which would otherwise apply to the entity. The standards and credentialing requirements shall be based upon, but are not limited to:

1. Compliance with the accreditation requirements as provided in s. 641.512.

2. Compliance with early and periodic screening, diagnosis, and treatment screening requirements under federal law.

3. The percentage of voluntary disenrollments.

4. Immunization rates.

5. Standards of the National Committee for Quality Assurance and other approved accrediting bodies.

6. Recommendations of other authoritative bodies.

7. Specific requirements of the Medicaid program, or standards designed to specifically meet the unique needs of Medicaid recipients.

8. Compliance with the health quality improvement system as established by the agency, which incorporates standards and guidelines developed by the Centers for Medicare and Medicaid Services as part of the quality assurance reform initiative.

9. The network's infrastructure capacity to manage financial transactions, recordkeeping, data collection, and other administrative functions.

10. The network's ability to submit any financial, programmatic, or patient-encounter data or other information required by the agency to determine the actual services provided and the cost of administering the plan.

(i) To implement a mechanism for providing information to Medicaid recipients for the purpose of selecting a capitated managed care plan. For each plan available to a recipient, the agency, at a minimum, shall ensure that the recipient is provided with:

1. A list and description of the benefits provided.

2. Information about cost sharing.

3. Plan performance data, if available.

4. An explanation of benefit limitations.

5. Contact information, including identification of providers participating in the network, geographic locations, and transportation limitations.

6. <u>Specific information about covered prescription drugs for each plan.</u>

7. Any other information the agency determines would facilitate a recipient's understanding of the plan or insurance that would best meet his or her needs.

(j) To implement a system to ensure that there is a record of recipient acknowledgment that choice counseling has been provided.

(k) To implement a choice counseling system to ensure that the choice counseling process and related material are designed to provide counseling through face-to-face interaction, by telephone, and in writing and through other forms of relevant media. Materials shall be written at the fourth-grade reading level and available in a language other than English when 5 percent of the county speaks a language other than English. Choice counseling shall also use language lines and other services for impaired recipients, such as TTD/TTY.

(l) To implement a system that prohibits capitated managed care plans, their representatives, and providers employed by or contracted with the capitated managed care plans from recruiting persons eligible for or enrolled in Medicaid, from providing inducements to Medicaid recipients to select a particular capitated managed care plan, and from prejudicing Medicaid recipients against other capitated managed care plans. The system shall require the entity performing choice counseling to determine if the recipient has made a choice of a plan or has opted out because of duress, threats, payment to the recipient, or incentives promised to the recipient by a third party. If the choice counseling entity determines that the decision to choose a plan was unlawfully influenced or a plan violated any of the

provisions of s. 409.912(21), the choice counseling entity shall immediately report the violation to the agency's program integrity section for investigation. Verification of choice counseling by the recipient shall include a stipulation that the recipient acknowledges the provisions of this subsection.

(m) To implement a choice counseling system that promotes health literacy and provides information aimed to reduce minority health disparities through outreach activities for Medicaid recipients.

(n) To contract with entities to perform choice counseling. The agency may establish standards and performance contracts, including standards requiring the contractor to hire choice counselors who are representative of the state's diverse population and to train choice counselors in working with culturally diverse populations.

(o) To implement eligibility assignment processes to facilitate client choice while ensuring pilot programs of adequate enrollment levels. These processes shall ensure that pilot sites have sufficient levels of enrollment to conduct a valid test of the managed care pilot program within a 2-year timeframe.

(p) To implement standards for plan compliance, including, but not limited to, standards for quality assurance and performance improvement, standards for peer or professional reviews, grievance policies, and policies for maintaining program integrity. The agency shall set reasonable standards for prompt payment of provider claims. The agency shall develop a data-reporting system, seek input from managed care plans in

order to establish requirements for patient-encounter reporting, and ensure that the data reported is accurate and complete.

1. In performing the duties required under this section, the agency shall work with managed care plans to establish a uniform system to measure and monitor outcomes for a recipient of Medicaid services.

2. The system shall use financial, clinical, and other criteria based on pharmacy, medical services, and other data that is related to the provision of Medicaid services, including, but not limited to:

a. The Health Plan Employer Data and Information Set (HEDIS) or measures that are similar to HEDIS.

b. Member satisfaction.

c. Provider satisfaction.

d. Report cards on plan performance and best practices.

e. Compliance with the requirements for prompt payment of claims under ss. 627.613, 641.3155, and 641.513.

f. Utilization and quality data for the purpose of ensuring access to medically necessary services, including underutilization or inappropriate denial of services.

3. The agency shall require the managed care plans that have contracted with the agency to establish a quality assurance system that incorporates the provisions of s. 409.912(27) and any standards, rules, and guidelines developed by the agency.

4. The agency shall establish an encounter database in order to compile data on health services rendered by health care practitioners who provide services to patients enrolled in

managed care plans in the demonstration sites. The encounter database shall:

a. Collect the following for each type of patient encounter with a health care practitioner or facility, including:

(I) The demographic characteristics of the patient.

(II) The principal, secondary, and tertiary diagnosis.

(III) The procedure performed.

(IV) The date and location where the procedure was performed.

(V) The payment for the procedure, if any.

(VI) If applicable, the health care practitioner's universal identification number.

(VII) If the health care practitioner rendering the service is a dependent practitioner, the modifiers appropriate to indicate that the service was delivered by the dependent practitioner.

b. Collect appropriate information relating to prescription drugs for each type of patient encounter.

c. Collect appropriate information related to health care costs and utilization from managed care plans participating in the demonstration sites.

5. To the extent practicable, when collecting the data the agency shall use a standardized claim form or electronic transfer system that is used by health care practitioners, facilities, and payors.

6. Health care practitioners and facilities in the demonstration sites shall electronically submit, and managed

care plans participating in the demonstration sites shall electronically receive, information concerning claims payments and any other information reasonably related to the encounter database using a standard format as required by the agency.

7. The agency shall establish reasonable deadlines for phasing in the electronic transmittal of full encounter data.

8. The system must ensure that the data reported is accurate and complete.

(q) To implement a grievance resolution process for Medicaid recipients enrolled in a capitated managed care network under the pilot program modeled after the subscriber assistance panel, as created in s. 408.7056. This process shall include a mechanism for an expedited review of no greater than 24 hours after notification of a grievance if the life of a Medicaid recipient is in imminent and emergent jeopardy.

(r) To implement a grievance resolution process for health care providers employed by or contracted with a capitated managed care network under the pilot program in order to settle disputes among the provider and the managed care network or the provider and the agency.

(s) To implement criteria in an approved federal waiver to designate health care providers as eligible to participate in the pilot program. These criteria must include at a minimum those criteria specified in s. 409.907.

(t) To use health care provider agreements for participation in the pilot program.

(u) To require that all health care providers under contract with the pilot program be duly licensed in the state,

if such licensure is available, and meet other criteria as may be established by the agency. These criteria shall include at a minimum those criteria specified in s. 409.907.

(v) To ensure that managed care organizations work collaboratively with other state or local governmental programs or institutions for the coordination of health care to eligible individuals receiving services from such programs or institutions.

(w) To implement procedures to minimize the risk of Medicaid fraud and abuse in all plans operating in the Medicaid managed care pilot program authorized in this section.

1. The agency shall ensure that applicable provisions of this chapter and chapters 414, 626, 641, and 932 which relate to Medicaid fraud and abuse are applied and enforced at the demonstration project sites.

2. Providers must have the certification, license, and credentials that are required by law and waiver requirements.

3. The agency shall ensure that the plan is in compliance with s. 409.912(21) and (22).

4. The agency shall require that each plan establish functions and activities governing program integrity in order to reduce the incidence of fraud and abuse. Plans must report instances of fraud and abuse pursuant to chapter 641.

5. The plan shall have written administrative and management arrangements or procedures, including a mandatory compliance plan, which are designed to guard against fraud and abuse. The plan shall designate a compliance officer who has sufficient experience in health care.

6.a. The agency shall require all managed care plan contractors in the pilot program to report all instances of suspected fraud and abuse. A failure to report instances of suspected fraud and abuse is a violation of law and subject to the penalties provided by law.

b. An instance of fraud and abuse in the managed care plan, including, but not limited to, defrauding the state health care benefit program by misrepresentation of fact in reports, claims, certifications, enrollment claims, demographic statistics, or patient-encounter data; misrepresentation of the qualifications of persons rendering health care and ancillary services; bribery and false statements relating to the delivery of health care; unfair and deceptive marketing practices; and false claims actions in the provision of managed care, is a violation of law and subject to the penalties provided by law.

c. The agency shall require that all contractors make all files and relevant billing and claims data accessible to state regulators and investigators and that all such data is linked into a unified system to ensure consistent reviews and investigations.

(x) To develop and provide actuarial and benefit design analyses that indicate the effect on capitation rates and benefits offered in the pilot program over a prospective 5-year period based on the following assumptions:

1. Growth in capitation rates which is limited to the estimated growth rate in general revenue.

2. Growth in capitation rates which is limited to the average growth rate over the last 3 years in per-recipient Medicaid expenditures.

3. Growth in capitation rates which is limited to the growth rate of aggregate Medicaid expenditures between the 2003-2004 fiscal year and the 2004-2005 fiscal year.

(y) To develop a mechanism to require capitated managed care plans to reimburse qualified emergency service providers, including, but not limited to, ambulance services, in accordance with ss. 409.908 and 409.9128. The pilot program must include a provision for continuing fee-for-service payments for emergency services, including, but not limited to, individuals who access ambulance services or emergency departments and who are subsequently determined to be eligible for Medicaid services.

(z) To ensure that school districts participating in the certified school match program pursuant to ss. 409.908(21) and 1011.70 shall be reimbursed by Medicaid, subject to the limitations of s. 1011.70(1), for a Medicaid-eligible child participating in the services as authorized in s. 1011.70, as provided for in s. 409.9071, regardless of whether the child is enrolled in a capitated managed care network. Capitated managed care networks must make a good faith effort to execute agreements with school districts regarding the coordinated provision of services authorized under s. 1011.70. County health departments and federally qualified health centers delivering school-based services pursuant to ss. 381.0056 and 381.0057 must be reimbursed by Medicaid for the federal share for a Medicaid-eligible child who receives Medicaid-covered services in a

school setting, regardless of whether the child is enrolled in a capitated managed care network. Capitated managed care networks must make a good faith effort to execute agreements with county health departments and federally qualified health centers regarding the coordinated provision of services to a Medicaid-eligible child. To ensure continuity of care for Medicaid patients, the agency, the Department of Health, and the Department of Education shall develop procedures for ensuring that a student's capitated managed care network provider receives information relating to services provided in accordance with ss. 381.0056, 381.0057, 409.9071, and 1011.70.

(aa) To implement a mechanism whereby Medicaid recipients who are already enrolled in a managed care plan or the MediPass program in the pilot areas shall be offered the opportunity to change to capitated managed care plans on a staggered basis, as defined by the agency. All Medicaid recipients shall have 30 days in which to make a choice of capitated managed care plans. Those Medicaid recipients who do not make a choice shall be assigned to a capitated managed care plan in accordance with paragraph (4)(a) and shall be exempt from s. 409.9122. To facilitate continuity of care for a Medicaid recipient who is also a recipient of Supplemental Security Income (SSI), prior to assigning the SSI recipient to a capitated managed care plan, the agency shall determine whether the SSI recipient has an ongoing relationship with a provider or capitated managed care plan, and, if so, the agency shall assign the SSI recipient to that provider or capitated managed care plan where feasible. Those SSI recipients who do not have such a provider

relationship shall be assigned to a capitated managed care plan provider in accordance with paragraph (4)(a) and shall be exempt from s. 409.9122.

(bb) To develop and recommend a service delivery alternative for children having chronic medical conditions which establishes a medical home project to provide primary care services to this population. The project shall provide community-based primary care services that are integrated with other subspecialties to meet the medical, developmental, and emotional needs for children and their families. This project shall include an evaluation component to determine impacts on hospitalizations, length of stays, emergency room visits, costs, and access to care, including specialty care and patient and family satisfaction.

(cc) To develop and recommend service delivery mechanisms within capitated managed care plans to provide Medicaid services as specified in ss. 409.905 and 409.906 to persons with developmental disabilities sufficient to meet the medical, developmental, and emotional needs of these persons.

(dd) To implement service delivery mechanisms within capitated managed care plans to provide Medicaid services as specified in ss. 409.905 and 409.906 to Medicaid-eligible children whose cases are open for child welfare services in the HomeSafeNet system. These services must be coordinated with community-based care providers as specified in s. 409.1671, where available, and be sufficient to meet the medical, developmental, behavioral, and emotional needs of these children. These service delivery mechanisms must be implemented

no later than July 1, 2008, in AHCA area 10 in order for the children in AHCA area 10 to remain exempt from the statewide plan under s. 409.912(4)(b)8.

(4)(a) A Medicaid recipient in the pilot area who is not currently enrolled in a capitated managed care plan upon implementation is not eligible for services as specified in ss. 409.905 and 409.906, for the amount of time that the recipient does not enroll in a capitated managed care network. If a Medicaid recipient has not enrolled in a capitated managed care plan within 30 days after eligibility, the agency shall assign the Medicaid recipient to a provider service network. The agency shall assign such recipients to provider service networks for the first 5 years of implementation of each demonstration site, or until the number of recipients enrolled in provider service networks in that demonstration site reaches 10 percent of the total number of participating Medicaid recipients in that demonstration site, whichever is first. After that time, if a Medicaid recipient has not enrolled in a capitated managed care plan within 30 days after eligibility, the agency shall assign the Medicaid recipient to a capitated managed care plan based on the assessed needs of the recipient as determined by the agency and the recipient shall be exempt from s. 409.9122. When making such assignments, the agency shall take into account the following criteria:

1. A capitated managed care network has sufficient network capacity to meet the needs of members.

2. The capitated managed care network has previously enrolled the recipient as a member, or one of the capitated

managed care network's primary care 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 capitated managed care network as indicated by Medicaid fee-for-service claims data, but has failed to make a choice.

4. The capitated managed care network's primary care providers are geographically accessible to the recipient's residence.

(b) When more than one capitated managed care network provider meets the criteria specified in paragraph (3)(h), the agency shall make recipient assignments consecutively by family unit.

(c) If a recipient is currently enrolled with a Medicaid managed care organization that also operates an approved reform plan within a demonstration area and the recipient fails to choose a plan during the reform enrollment process or during redetermination of eligibility, the recipient shall be automatically assigned by the agency into a provider service network. The agency shall assign such recipients to provider service networks for the first 5 years of implementation of each demonstration site, or until the number of recipients enrolled in provider service networks in that demonstration site reaches 10 percent of the total number of participating Medicaid recipients in that demonstration site, whichever is first. After that time, ~~the most appropriate reform plan operated by the recipient's current Medicaid managed care plan. If the recipient's current managed care plan does not operate a reform~~

~~plan in the demonstration area which adequately meets the needs of the Medicaid recipient,~~ the agency shall use the automatic assignment process as prescribed in the special terms and conditions numbered 11-W-00206/4. All enrollment and choice counseling materials provided by the agency must contain an explanation of the provisions of this paragraph for current managed care recipients.

(d) The agency may not engage in practices that are designed to favor one capitated managed care plan over another or that are designed to influence Medicaid recipients to enroll in a particular capitated managed care network in order to strengthen its particular fiscal viability.

(e) After a recipient has made a selection or has been enrolled in a capitated managed care network, the recipient shall have 90 days in which to voluntarily disenroll and select another capitated managed care network. After 90 days, no further changes may be made except for cause. Cause shall include, but not be limited to, poor quality of care, lack of access to necessary specialty services, an unreasonable delay or denial of service, inordinate or inappropriate changes of primary care providers, service access impairments due to significant changes in the geographic location of services, or fraudulent enrollment. The agency may require a recipient to use the capitated managed care network's grievance process as specified in paragraph (3)(q) prior to the agency's determination of cause, except in cases in which immediate risk of permanent damage to the recipient's health is alleged. The grievance process, when used, must be completed in time to

permit the recipient to disenroll no later than the first day of the second month after the month the disenrollment request was made. If the capitated managed care network, as a result of the grievance process, approves an enrollee's request to disenroll, the agency is not required to make a determination in the case. The agency must make a determination and take final action on a recipient's request so that disenrollment occurs no later than the first day of the second month after the month the request was made. If the agency fails to act within the specified timeframe, the recipient's request to disenroll is deemed to be approved as of the date agency action was required. Recipients who disagree with the agency's finding that cause does not exist for disenrollment shall be advised of their right to pursue a Medicaid fair hearing to dispute the agency's finding.

(f) The agency shall apply for federal waivers from the Centers for Medicare and Medicaid Services to lock eligible Medicaid recipients into a capitated managed care network for 12 months after an open enrollment period. After 12 months of enrollment, a recipient may select another capitated managed care network. However, nothing shall prevent a Medicaid recipient from changing primary care providers within the capitated managed care network during the 12-month period.

(g) The agency shall apply for federal waivers from the Centers for Medicare and Medicaid Services to allow recipients to purchase health care coverage through an employer-sponsored health insurance plan instead of through a Medicaid-certified plan. This provision shall be known as the opt-out option.

1. A recipient who chooses the Medicaid opt-out option shall have an opportunity for a specified period of time, as authorized under a waiver granted by the Centers for Medicare and Medicaid Services, to select and enroll in a Medicaid-certified plan. If the recipient remains in the employer-sponsored plan after the specified period, the recipient shall remain in the opt-out program for at least 1 year or until the recipient no longer has access to employer-sponsored coverage, until the employer's open enrollment period for a person who opts out in order to participate in employer-sponsored coverage, or until the person is no longer eligible for Medicaid, whichever time period is shorter.

2. Notwithstanding any other provision of this section, coverage, cost sharing, and any other component of employer-sponsored health insurance shall be governed by applicable state and federal laws.

(5) This section does not authorize the agency to implement any provision of s. 1115 of the Social Security Act experimental, pilot, or demonstration project waiver to reform the state Medicaid program in any part of the state other than the two geographic areas specified in this section unless approved by the Legislature.

(6) The agency shall develop and submit for approval applications for waivers of applicable federal laws and regulations as necessary to implement the managed care pilot project as defined in this section. The agency shall post all waiver applications under this section on its Internet website 30 days before submitting the applications to the United States

Centers for Medicare and Medicaid Services. All waiver applications shall be provided for review and comment to the appropriate committees of the Senate and House of Representatives for at least 10 working days prior to submission. All waivers submitted to and approved by the United States Centers for Medicare and Medicaid Services under this section must be approved by the Legislature. Federally approved waivers must be submitted to the President of the Senate and the Speaker of the House of Representatives for referral to the appropriate legislative committees. The appropriate committees shall recommend whether to approve the implementation of any waivers to the Legislature as a whole. The agency shall submit a plan containing a recommended timeline for implementation of any waivers and budgetary projections of the effect of the pilot program under this section on the total Medicaid budget for the 2006-2007 through 2009-2010 state fiscal years. This implementation plan shall be submitted to the President of the Senate and the Speaker of the House of Representatives at the same time any waivers are submitted for consideration by the Legislature. The agency may implement the waiver and special terms and conditions numbered 11-W-00206/4, as approved by the federal Centers for Medicare and Medicaid Services. If the agency seeks approval by the Federal Government of any modifications to these special terms and conditions, the agency must provide written notification of its intent to modify these terms and conditions to the President of the Senate and the Speaker of the House of Representatives at least 15 days before submitting the modifications to the Federal Government for

consideration. The notification must identify all modifications being pursued and the reason the modifications are needed. Upon receiving federal approval of any modifications to the special terms and conditions, the agency shall provide a report to the Legislature describing the federally approved modifications to the special terms and conditions within 7 days after approval by the Federal Government.

(7)(a) The Secretary of Health Care Administration shall convene a technical advisory panel to advise the agency in the areas of risk-adjusted-rate setting, benefit design, and choice counseling. The panel shall include representatives from the Florida Association of Health Plans, representatives from provider-sponsored networks, a Medicaid consumer representative, and a representative from the Office of Insurance Regulation.

(b) The technical advisory panel shall advise the agency concerning:

1. The risk-adjusted rate methodology to be used by the agency, including recommendations on mechanisms to recognize the risk of all Medicaid enrollees and for the transition to a risk-adjustment system, including recommendations for phasing in risk adjustment and the use of risk corridors.

2. Implementation of an encounter data system to be used for risk-adjusted rates.

3. Administrative and implementation issues regarding the use of risk-adjusted rates, including, but not limited to, cost, simplicity, client privacy, data accuracy, and data exchange.

4. Issues of benefit design, including the actuarial equivalence and sufficiency standards to be used.

5. The implementation plan for the proposed choice-counseling system, including the information and materials to be provided to recipients, the methodologies by which recipients will be counseled regarding choice, criteria to be used to assess plan quality, the methodology to be used to assign recipients into plans if they fail to choose a managed care plan, and the standards to be used for responsiveness to recipient inquiries.

(c) The technical advisory panel shall continue in existence and advise the agency on matters outlined in this subsection.

(8) The agency must ensure, in the first two state fiscal years in which a risk-adjusted methodology is a component of rate setting, that no managed care plan providing comprehensive benefits to TANF and SSI recipients has an aggregate risk score that varies by more than 10 percent from the aggregate weighted mean of all managed care plans providing comprehensive benefits to TANF and SSI recipients in a reform area. The agency's payment to a managed care plan shall be based on such revised aggregate risk score.

(9) After any calculations of aggregate risk scores or revised aggregate risk scores in subsection (8), the capitation rates for plans participating under this section shall be phased in as follows:

(a) In the first year, the capitation rates shall be weighted so that 75 percent of each capitation rate is based on the current methodology and 25 percent is based on a new risk-adjusted capitation rate methodology.

(b) In the second year, the capitation rates shall be weighted so that 50 percent of each capitation rate is based on the current methodology and 50 percent is based on a new risk-adjusted rate methodology.

(c) In the following fiscal year, the risk-adjusted capitation methodology may be fully implemented.

(10) Subsections (8) and (9) do not apply to managed care plans offering benefits exclusively to high-risk, specialty populations. The agency may set risk-adjusted rates immediately for such plans.

(11) Before the implementation of risk-adjusted rates, the rates shall be certified by an actuary and approved by the federal Centers for Medicare and Medicaid Services.

(12) For purposes of this section, the term "capitated managed care plan" includes health insurers authorized under chapter 624, exclusive provider organizations authorized under chapter 627, health maintenance organizations authorized under chapter 641, the Children's Medical Services Network under chapter 391, and provider service networks that elect to be paid fee-for-service for up to 3 years as authorized under this section.

(13) Upon review and approval of the applications for waivers of applicable federal laws and regulations to implement the managed care pilot program by the Legislature, the agency may initiate adoption of rules pursuant to ss. 120.536(1) and 120.54 to implement and administer the managed care pilot program as provided in this section.

(14) It is the intent of the Legislature that if any conflict exists between the provisions contained in this section and other provisions of this chapter which relate to the implementation of the Medicaid managed care pilot program, the provisions contained in this section shall control. The agency shall provide a written report to the Legislature by April 1, 2006, identifying any provisions of this chapter which conflict with the implementation of the Medicaid managed care pilot program created in this section. After April 1, 2006, the agency shall provide a written report to the Legislature immediately upon identifying any provisions of this chapter which conflict with the implementation of the Medicaid managed care pilot program created in this section.

Note.--Section 3, ch. 2005-133, provides that "[t]he Office of Program Policy Analysis and Government Accountability, in consultation with the Auditor General, shall comprehensively evaluate the two managed care pilot programs created under section 409.91211, Florida Statutes. The evaluation shall begin with the implementation of the managed care model in the pilot areas and continue for 24 months after the two pilot programs have enrolled Medicaid recipients and started providing health care services. The evaluation must include assessments of cost savings; consumer education, choice, and access to services; coordination of care; and quality of care by each eligibility category and managed care plan in each pilot site. The evaluation must describe administrative or legal barriers to the implementation and operation of each pilot program and include recommendations regarding statewide expansion of the managed

care pilot programs. The office shall submit an evaluation report to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than June 30, 2008."

Section 14. Subsection (2) of section 409.9124, Florida Statutes, is amended to read:

409.9124 Managed care reimbursement.--The agency shall develop and adopt by rule a methodology for reimbursing managed care plans.

(2) Each year prior to establishing new managed care rates, the agency shall review all prior year adjustments for changes in trend, and shall reduce or eliminate those adjustments which are not reasonable and which reflect policies or programs which are not in effect. In addition, the agency shall apply only those policy reductions applicable to the fiscal year for which the rates are being set, which can be accurately estimated and verified by an independent actuary, and which have been implemented prior to or will be implemented during the fiscal year. ~~The agency shall pay rates at per-member, per-month averages that do not exceed the amounts allowed for in the General Appropriations Act applicable to the fiscal year for which the rates will be in effect.~~

Section 15. Subsection (36) of section 409.913, Florida Statutes, is amended to read:

409.913 Oversight of the integrity of the Medicaid program.--The agency shall operate a program to oversee the activities of Florida Medicaid recipients, and providers and their representatives, to ensure that fraudulent and abusive

behavior and neglect of recipients occur to the minimum extent possible, and to recover overpayments and impose sanctions as appropriate. Beginning January 1, 2003, and each year thereafter, the agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs shall submit a joint report to the Legislature documenting the effectiveness of the state's efforts to control Medicaid fraud and abuse and to recover Medicaid overpayments during the previous fiscal year. The report must describe the number of cases opened and investigated each year; the sources of the cases opened; the disposition of the cases closed each year; the amount of overpayments alleged in preliminary and final audit letters; the number and amount of fines or penalties imposed; any reductions in overpayment amounts negotiated in settlement agreements or by other means; the amount of final agency determinations of overpayments; the amount deducted from federal claiming as a result of overpayments; the amount of overpayments recovered each year; the amount of cost of investigation recovered each year; the average length of time to collect from the time the case was opened until the overpayment is paid in full; the amount determined as uncollectible and the portion of the uncollectible amount subsequently reclaimed from the Federal Government; the number of providers, by type, that are terminated from participation in the Medicaid program as a result of fraud and abuse; and all costs associated with discovering and prosecuting cases of Medicaid overpayments and making recoveries in such cases. The report must also document actions taken to prevent overpayments and the number of providers prevented from

enrolling in or reenrolling in the Medicaid program as a result of documented Medicaid fraud and abuse and must recommend changes necessary to prevent or recover overpayments.

(36) The agency shall provide to each Medicaid recipient or his or her representative an explanation of benefits in the form of a letter that is mailed to the most recent address of the recipient on the record with the Department of Children and Family Services. The explanation of benefits must include the patient's name, the name of the health care provider and the address of the location where the service was provided, a description of all services billed to Medicaid in terminology that should be understood by a reasonable person, and information on how to report inappropriate or incorrect billing to the agency or other law enforcement entities for review or investigation. The explanation of benefits may not be mailed for Medicaid independent laboratory services as described in s. 409.905(7) or for Medicaid certified match services as described in ss. 409.9071 and 1011.70.

Section 16. Sections 381.0271, 381.0273, 402.164, 402.165, 402.166, 402.167, 409.9061, 430.80, 430.83, 464.0195, 464.0196, 464.0197, Florida Statutes, are repealed.

Section 17. This act shall take effect July 1, 2008.

APD

APD Conforming Bill

- Specifies that Tier 2 services are available to clients whose service needs include a licensed residential facility and who have authorization for moderate level of support for standard residential habilitation services or authorization for minimal level of support for behavior focus residential habilitation services.

- Prohibits expansion of services in the Family and Supported Living waiver (Tier 4) during FY 2008-2009. Any expansion would be unfunded.

- Phases in the reduction in the geographic differential percentage rate which is applied to Medicaid waiver service rates in Miami-Dade, Broward, Palm Beach and Monroe counties. Currently, rates in these counties have a built-in cost of living adjustment. This would reduce, but not eliminate, the adjustment.

- Allows APD to rebase cost plans to reflect actual expenditures for consumers in the previous fiscal year. This is intended to help APD control increases in service utilization in addition to the legislation passed during 2007 under SB 1124.

- Requires APD to hold fair hearings at the Department of Children and Families. These hearing are for Medicaid funded services and pursuant to federal Medicaid laws and rules. APD held these hearing at DCF until 2006 where it cost approximately $200,000 annually. Due to a court ruling APD moved the hearings to the Division of Administrative Hearings (DOAH) and the cost this year is projected to be nearly $1,000,000.

A bill to be entitled

An act relating to Agency for Persons with Disabilities; amending s. 393.0661, F.S.; establishing geographic differential payments for Miami-Dade, Broward, Palm Beach and Monroe counties providing residential habilitation services; providing effective dates for applicable geographic differential payments for Miami-Dade, Broward, Palm Beach and Monroe counties; providing rebase cost plans based on actual expenditures for individuals served by Home and Community Based Services or Family Supported Living waiver programs; amending s. 393.071, F.S.; amending s. 393.125, F.S.; providing for hearing rights of a developmental services applicant, client, or parent, guardian, guardian advocate or authorized representative; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Paragraphs (b) and (d) of subsection (3) of section 393.0661, Florida Statutes, as amended by chapter 2007-64, Laws of Florida, is amended and new subsections (4), (5) and (6) are added to that section to read:

393.0661 Home and community-based services delivery system; comprehensive redesign.--The Legislature finds that the home and community-based services delivery system for persons with developmental disabilities and the availability of appropriated funds are two of the critical elements in making services available. Therefore, it is the intent of the

Legislature that the Agency for Persons with Disabilities shall develop and implement a comprehensive redesign of the system.

(3) The Agency for Health Care Administration, in consultation with the agency, shall seek federal approval and implement a four-tiered waiver system to serve clients with developmental disabilities in the developmental disabilities and family and supported living waivers. The agency shall assign all clients receiving services through the developmental disabilities waiver to a tier based on a valid assessment instrument, client characteristics, and other appropriate assessment methods. All services covered under the current developmental disabilities waiver shall be available to all clients in all tiers where appropriate, except as otherwise provided in this subsection or in the General Appropriations Act.

(b) Tier two shall be limited to clients whose service needs include a licensed residential facility and who have authorization for moderate level of support for standard residential habilitation services or authorization for minimal level of support for behavior focus residential habilitation services ~~greater than 5 hours per day in residential habilitation services~~ or clients in supported living who receive greater than 6 hours a day of in-home support services. Total annual expenditures under tier two may not exceed $55,000 per client each year.

(d) Tier four is the family and supported living waiver. Tier four shall include, but is not limited to, clients in independent or supported living situations and clients who live

in their family home. An increase to the number of services available to clients in this tier shall not take effect prior to July 1, 2009 ~~2008~~. Total annual expenditures under tier four may not exceed $14,792 per client each year.

(4) Effective July 1, 2008, the geographic differential for Miami-Dade, Broward and Palm Beach counties for residential habilitation services shall be 7.5 percent. Effective July 1, 2009, the geographic differential for Miami-Dade, Broward and Palm Beach counties for residential habilitation services shall be 4.5 percent.

(5) Effective July 1, 2008, the geographic differential for Monroe County for residential habilitation services shall be 20 percent. Effective July 1, 2009, the geographic differential for Monroe County for residential habilitation services shall be 15 percent. Effective July 1, 2010, the geographic differential for Monroe County for residential habilitation services shall be 10 percent.

(6) Effective January 1, 2009, and except as otherwise provided herein, each individual served by the Home and Community Based Services waiver or the Family Supported Living waiver funded within the Agency for Persons with Disabilities may have their cost plans adjusted to reflect the amount of expenditures for the previous state fiscal year plus 5 percent if said amount is less than their existing cost plan. The Agency for Persons with Disabilities shall use actual paid claims for services provided during the previous fiscal year that are submitted by October 31 in calculating revised cost plan amounts. In the event that a consumer was not served for the

entire previous state fiscal year, or there was any single change in the cost plan amount of more than 5 percent during the previous state fiscal year, the agency shall set the cost plan at an estimated annualized expenditure amount plus 5 percent. The agency shall estimate the annualized expenditure amount by calculating the average of monthly expenditures beginning in the fourth month after the individual enrolled or the cost plan was changed by more than 5 percent and ending with August 2008 and multiplying the average by twelve. In the event that at least three months of actual expenditure data are not available to estimate annualized expenditures, the agency shall not rebase a cost plan pursuant to this paragraph. This subsection expires on June 30, 2009, unless reenacted by the Legislature before that date.

Section 2. Section 393.071, Florida Statutes, is amended to read:

393.071 Client fees.--The agency shall charge fees for services provided to clients in accordance with s. 402.33. All funds collected pursuant to this section shall be deposited in the Operations and Maintenance Trust Fund.

Section 3. Section 393.125, Florida Statutes, is amended and new paragraph (a) is added to read:

393.125 Hearing rights.--

(1) REVIEW OF AGENCY DECISIONS.--

(a) For Medicaid programs administered by the agency, any developmental services applicant or client, or his or her parent, guardian, guardian advocate, or authorized representative, has the right to request a hearing pursuant to

federal Medicaid laws and rules. Such hearings shall be provided by the Department of Children and Family Services under s. 409.285 F.S.

(~~a~~ b) Any other developmental services applicant or client, or his or her parent, guardian, guardian advocate, or authorized representative, who has any substantial interest determined by the agency, has the right to request an administrative hearing pursuant to ss. 120.569 and 120.57.

(~~b~~c) Notice of the right to an administrative hearing shall be given, both verbally and in writing, to the applicant or client, and his or her parent, guardian, guardian advocate, or authorized representative, at the same time that the agency gives the applicant or client notice of the agency's action. The notice shall be given, both verbally and in writing, in the language of the client or applicant and in English.

(~~c~~d) A request for a hearing under this section shall be made to the agency, in writing, within 30 days of the applicant's or client's receipt of the notice.

(2) REVIEW OF PROVIDER DECISIONS.--The agency shall adopt rules to establish uniform guidelines for the agency and service providers relevant to termination, suspension, or reduction of client services by the service provider. The rules shall ensure the due process rights of service providers and clients.

Section 4. This act shall take effect July 1, 2008.

Johnnie B. Byrd, Sr.
Alzheimer's Center

Johnnie B. Byrd, Sr., Alzheimer's Center and Research Institute

- Transfers governance of the Johnnie B. Byrd, Sr., Alzheimer's Center & Research Institute to the University of South Florida, thereby eliminating the current/independent not-for-profit corporate structure established under s. 1004.445, F.S.

- Reduces the recurring General Revenue funding provided to the institute from $13.5 million to $3.75 million.

- Encourages the institute's collaboration with public and private universities and entities to further the institute's mission and goals.

- Specifies that state funds are to be expended on developing and operating integrated data projects; providing assistance to memory disorder clinics; furthering the administration, research support, and physical plant operations of the facility; and pursuing initiatives that fulfill the institute's mission.

- Requires the center to compete for biomedical funds through the James and Ester King Biomedical Research Program.

- Provides for administration of the institute by a chief executive officer, who shall appoint faculty and staff, actively seek grant moneys and donations, and prepare an annual report detailing the institute's expenditure of funds and research endeavors.

- Establishes an Advisory Council to advise the institute and chief executive officer on research topics of highest importance and greatest opportunity for the state.

- Requires the current board of directors to provide a final independent audit of assets and an enumeration of all contracts and liabilities by June 1, 2008.

- Directs the current board of directors to transfer all assets (fixed and movable), functions, and contracts of the institute to the University of South Florida by June 30, 2008.

A bill to be entitled

An act relating to the Johnnie B. Byrd, Sr., Alzheimer's Center and Research Institute; amending s. 1004.445, F.S.; dissolving and abolishing certain entities; establishing the institute within the University of South Florida; providing a statewide mission; directing collaboration with public and private universities and entities; directing the use of state funds directly appropriated to the institute; prohibiting the use of state funds by the institute for the purpose of conducting biomedical research; encouraging the institute to seek competitive state funding for biomedical research through the James and Esther King Biomedical Research Program; providing for administration of the institute by a chief executive officer; providing duties of the chief executive officer; requiring an annual report; establishing an Advisory Council and providing duties, term limits, and manner of appointment; providing a public records exemption; providing a recurring appropriation from the General Revenue Fund; extending the sunset provisions; requiring a final independent audit of assets; transferring assets, functions, and contracts to the University of South Florida; requiring statutory certification; requiring legislative review during the 2012 Regular Session of the Legislature; providing effective dates.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 1004.445, Florida Statutes, is amended to read:

(Substantial rewording of section. See s. 1004.445, F.S., for present text.)

1004.445 Johnnie B. Byrd, Sr., Alzheimer's Center and Research Institute.-- Effective July 1, 2008, all entities created pursuant to s. 1004.445, prior to that date, including a board of directors and any for-profit and not-for-profit corporate subsidiaries, are hereby dissolved and abolished and in place of those entities the Johnnie B. Byrd, Sr., Alzheimer's Center and Research Institute is established within the University of South Florida.

(1) The Johnnie B. Byrd, Sr., Alzheimer's Center and Research Institute is established within the University of South Florida.

(a) The institute shall have a statewide mission to advance research, education, treatment, prevention, and early detection of Alzheimer's disease.

(b) The institute shall collaborate with any public and private universities and other appropriate entities within the state, and may collaborate with appropriate entities outside the state, on programs directly contributing to the mission and goals of the institute.

(2) The institute's budget shall include the moneys appropriated or donated to the institute from state, local, federal and private sources, as well as technical and professional income generated or derived from practice activities at the institute.

(a) State funds directly appropriated to the institute shall be used for programs that fulfill the mission of the institute in education, treatment, prevention, and early detection of Alzheimer's disease, developing and operating integrated data projects, providing assistance to statutorily designated memory disorder clinics, and for the administration, research support, and physical plant operations of the institute's facility on the campus of the university.

(b) The institute shall not conduct biomedical research using funds appropriated directly to the institute by the state. However, the institute is encouraged to seek competitive state funding for biomedical research through the James and Esther King Biomedical Research Program pursuant to s. 215.5602.

(3) The institute shall be administered by a chief executive officer, who shall be appointed by and serve at the pleasure of the president of the University of South Florida or his or her designee vice president.

(a) The chief executive officer shall appoint faculty and staff to carry out the research, patient care, and educational activities of the institute consistent with the compensation, benefits, and terms of service of the university.

(b) The chief executive officer shall actively seek any federal and private sources of grant money and donations for the purpose of funding and conducting Alzheimer's disease research at the institute.

(c) The chief executive officer shall prepare an annual report for the institute that describes the expenditure of all of the institute's funds and shall provide information regarding

research that has been conducted or funded by the institute, as well as the expected and actual results of the research. The chief executive officer shall provide a copy of the institute's annual report to the Governor, the President of the Senate, the Speaker of the House of Representatives, the chair of the Board of Governors, and the chair of the Board of Trustees of the University of South Florida.

(4) The Johnnie B. Byrd, Sr., Alzheimer's Center and Research Institute Advisory Council is established to advise the institute and the chief executive officer on research topics of highest importance and greatest opportunity for the state, and to advise the institute on effective ways to collaborate across institutions and entities to achieve the mission and goals of the institute.

(a) The Advisory Council shall consist of ten members who shall each serve 4-year terms subject to the pleasure of the member's appointing authority.

(b) The Governor, the President of the Senate, and the Speaker of the House of Representatives shall each appoint to the Advisory Council:

1. One researcher with significant experience in Alzheimer's disease research;

2. One licensed physician with significant experience in treating patients diagnosed with memory disorders; and

3. One person representing a not-for-profit organization whose mission is to assist persons affected by Alzheimer's disease or other similar memory disorders.

(c) The chair of the Board of Trustees of the University

of South Florida shall appoint one person who is not an employee of the university to serve as chair of the Advisory Council.

(d) For purposes of staggering the initial terms of the Advisory Council members, the Governor, the President of the Senate, and the Speaker of the House of Representatives shall each designate one appointee to serve a 2-year term, one appointee to serve a 3-year term, and one appointee to serve a 4-year term.

(5) The following information is confidential and exempt from s. 119.07(1) and s. 24, Art. I of the State Constitution:

(a) Personal identifying information relating to clients of programs created or funded through the Johnnie B. Byrd, Sr., Alzheimer's Center and Research Institute that is held by the center, the University of South Florida, the Board of Governors, or the State Board of Education;

(b) Medical or health records relating to patients held by the center;

(c) Materials that relate to methods of manufacture or production, potential trade secrets, potentially patentable material, actual trade secrets as defined in s. 688.002, or proprietary information received, generated, ascertained, or discovered during the course of research conducted by the center and business transactions resulting from such research;

(d) The personal identifying information of a donor or prospective donor to the center who wishes to remain anonymous; and

(e) Any information received by the center from a person from another state or nation or the Federal Government that is

otherwise confidential and exempt pursuant to the laws of that state or nation or pursuant to federal law.

Any governmental entity that demonstrates a need to access such confidential and exempt information in order to perform its duties and responsibilities shall have access to such information.

(6) Beginning in fiscal year 2008-2009, the sum of $3.75 million is appropriated annually from recurring funds in the General Revenue Fund to the Board of Trustees of the University of South Florida for the purposes described in this section.

(7) This section is repealed on January 1, 2013, unless reenacted by the Legislature on or before that date.

Section 2. No later than June 1, 2008, the board of directors of the Johnnie B. Byrd, Sr., Alzheimer's Center and Research Institute shall provide a final independent audit of assets and an enumeration of all contracts and liabilities, with all moneys and funds for payment of same, of the not-for-profit corporation created pursuant to s. 1004.445 to the president of the University of South Florida and the chair of the Board of Governors to assist in the transfer of the institute to the University of South Florida. The institute shall also provide a copy of any such documents to the President of the Senate and the Speaker of the House of Representatives.

Section 3. The board of directors of the Johnnie B. Byrd, Sr., Alzheimer's Center and Research Institute shall transfer all assets, fixed and moveable, and functions of the institute to the University of South Florida on or before June 30, 2008.

Section 4. All contracts held by the not-for-profit corporation and any for-profit or not-for-profit corporate subsidiaries as described in s. 1004.445 shall be transferred to the University of South Florida by June 30, 2008.

Section 5. By June 1, 2011, the Division of Statutory Revision of the Office of Legislative Services shall certify to the President of the Senate and the Speaker of the House of Representatives the language and statutory citation of this section, which is scheduled to expire January 1, 2013. The Legislature shall review during the 2012 Regular Session of the Legislature the performance, the outcomes, and the financial management of the Johnnie B. Byrd, Sr., Alzheimer's Center and Research Institute to determine the most appropriate method of funding the institute beyond June 30, 2012.

Section 6. Except as otherwise expressly provided in this act, this act shall take effect upon becoming a law.

Tobacco Conforming Bill

- Expands the media campaign component to include the use of innovative communication strategies, such as targeting specific audiences through personal communication devices and online networking environments, and using physicians and dentists to target specific audiences to provide brief advice to quit the use of tobacco.

- Expands the cessation program component to include a statewide program that uses physicians and dentists to deliver advice to quit the use of tobacco.

- Deletes the competitive-procurement exemption for core funding for the County Health Departments.

- Reduces the appropriation to the AHEC network for expanding its smoking-cessation initiative to $6 million (from $10 million).

- Requires the Department of Health to equally award contracts or grants totaling $4 million in Fiscal Year 2008-2009 to each Florida medical school to implement a tobacco-use cessation initiative.

- Requires the Department of Health to award contracts or grants, beginning in Fiscal Year 2008-2009 and continuing thereafter, for $5 million to the H. Lee Moffitt Cancer Center and Research Institute and $5 million to the University of Florida Shands Cancer Center, for the purpose of implementing chronic disease prevention, detection, and treatment programs.

- Makes numerous changes to conform the program to the 2007 CDC Best Practices, such as substituting "tobacco-use cessation" for "smoking-cessation" and combining statewide and community program components.

A bill to be entitled

An act relating to tobacco education and prevention; amending s. 381.84, F.S.; substituting the term "tobacco-use cessation" for "smoking-cessation"; providing an additional purpose in implementing the Statewide Tobacco Education and Use Prevention program; expanding the counter-marketing and advertising campaign component to include utilization of innovative communication strategies, including the use of physicians and dentists; expanding the cessations programs, counseling, and treatment component to include the use of physicians and dentists; expanding the community programs and chronic disease prevention component to include statewide programs; deleting county health department funding eligibility; specifying the use of funds under the program; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 381.84, Florida Statutes, is amended to read:

381.84 Comprehensive Statewide Tobacco Education and Use Prevention Program.--

(1) DEFINITIONS.--As used in this section and for purposes of the provisions of s. 27, Art. X of the State Constitution, the term:

(a) "AHEC network" means an area health education center network established under s. 381.0402.

(b) "CDC" means the United States Centers for Disease Control and Prevention.

(c) "Council" means the Tobacco Education and Use Prevention Advisory Council.

(d) "Department" means the Department of Health.

(e) "Tobacco" means, without limitation, tobacco itself and tobacco products that include tobacco and are intended or expected for human use or consumption, including, but not limited to, cigarettes, cigars, pipe tobacco, and smokeless tobacco.

(f) "Youth" means minors and young adults.

(2) PURPOSE, FINDINGS, AND INTENT.--It is the purpose of this section to implement s. 27, Art. X of the State Constitution. The Legislature finds that s. 27, Art. X of the State Constitution requires the funding of a statewide tobacco education and use prevention program that focuses on tobacco use by youth. The Legislature further finds that the primary goals of the program are to reduce the prevalence of tobacco use among youth, adults, and pregnant women; reduce per capita tobacco consumption; implement interventions to detect, prevent, and treat tobacco-related chronic diseases; and reduce exposure to environmental tobacco smoke. Further, it is the intent of the Legislature to base increases in funding for individual components of the program on the results of assessments and evaluations. Recognizing that some components will need to grow faster than inflation, it is the intent of the Legislature to fund portions of the program on a nonrecurring basis in the

early years so that those components that are most effective can be supported as the program matures.

(3) PROGRAM COMPONENTS AND REQUIREMENTS.--The department shall conduct a comprehensive, statewide tobacco education and use prevention program consistent with the recommendations for effective program components contained in the 1999 Best Practices for Comprehensive Tobacco Control Programs of the CDC, as amended by the CDC. The program shall include the following components, each of which shall focus on educating people, particularly youth and their parents, about the health hazards of tobacco and discouraging the use of tobacco:

(a) Counter-marketing and advertising; Internet ~~cyberspace~~ resource center.--The counter-marketing and advertising campaign shall include, at a minimum, Internet, print, radio, and television advertising and shall be funded with a minimum of one-third of the total annual appropriation required by s. 27, Art. X of the State Constitution.

1. The campaign shall include an Internet ~~A cyberspace~~ resource center for copyrighted materials and information concerning tobacco education and use prevention, including cessation~~, shall be maintained by the program~~. Such resource center must be accessible to the public, including parents, teachers, and students, at each level of public and private schools, universities, and colleges in the state and shall provide links to other relevant resources. The Internet address for the resource center must be incorporated in all advertising. The information maintained in the resource center shall be used by the other components of the program.

2. The campaign shall utilize innovative communication strategies, such as targeting specific audiences through personal communication devices and online networking environments. The campaign shall specifically employ innovative channels to disseminate the campaign message, including utilizing physicians licensed under chapters 458 and 459 and dentists licensed under chapter 466 to target specific audiences, providing brief advice to quit the use of tobacco.

(b) Cessation programs, counseling, and treatment.--This program component shall include three ~~two~~ subcomponents:

1. A statewide toll-free cessation service, which may include counseling, referrals to other local resources and support services, and treatment to the extent funds are available for treatment services; and

2. A ~~local~~ community-based program to disseminate information about tobacco-use ~~smoking~~ cessation, how tobacco-use ~~smoking~~ cessation relates to prenatal care and obesity prevention, and other chronic tobacco-related diseases.

3. A statewide program that utilizes physicians licensed under chapters 458 and 459 and dentists licensed under chapter 466 to deliver brief advice to quit the use of tobacco.

(c) Surveillance and evaluation.--The program shall conduct ongoing epidemiological surveillance and shall contract for annual independent evaluations of the effectiveness of the various components of the program in meeting the goals as set forth in subsection (2).

(d) Youth school programs.--School and after-school programs shall use current evidence-based curricula and programs

that involve youth to educate youth about the health hazards of tobacco, help youth develop skills to refuse tobacco, and demonstrate to youth how to stop using tobacco.

(e) Statewide and community programs ~~and chronic disease prevention~~.--The department shall promote and support statewide and ~~local~~ community-based partnerships that encourage and support individuals, especially youth, to make behavior choices consistent with tobacco-free norms. ~~emphasize programs involving youth,~~ In addition, the department shall promote and support statewide and community ~~including~~ programs for the prevention, detection, and treatment ~~early intervention~~ of tobacco-related ~~smoking-related~~ chronic diseases, such as cancer, chronic lung and respiratory diseases, and heart disease.

(f) Training.--The program shall include the training of health care practitioners, tobacco-use cessation ~~smoking-cessation~~ counselors, and teachers by health professional students and other tobacco-use prevention specialists who are trained in preventing tobacco use and health education. Tobacco-use cessation ~~Smoking-cessation~~ counselors shall be trained by specialists who are certified in tobacco-use cessation.

(g) Administration and management.--The department shall administer the program within the expenditure limit established in subsection (8). As part of this component, the department shall coordinate the activities of the state and local tobacco control community.~~, statewide programs, and county health departments. Each county health department is eligible to receive a portion of the annual appropriation, on a per capita basis, for coordinating tobacco education and use prevention~~

~~programs within that county. Appropriated funds may be used to improve the infrastructure of the county health department to implement the comprehensive, statewide tobacco education and use prevention program.~~ In addition, each county health department shall prominently display in all treatment rooms and waiting rooms, counter-marketing and advertisement materials in the form of wall posters, brochures, television advertising if televisions are used in the lobby or waiting room, and screensavers and Internet advertising if computer kiosks are available for use or viewing by people at the county health department.

(h) Enforcement and awareness of related laws.--In coordination with the Department of Business and Professional Regulation, the program shall monitor the enforcement of laws, rules, and policies prohibiting the sale or other provision of tobacco to minors, as well as the continued enforcement of the Clean Indoor Air Act prescribed in chapter 386. The advertisements produced in accordance with paragraph (a) may also include information designed to make the public aware of these related laws and rules. The departments may enter into interagency agreements to carry out this program component.

(i) AHEC tobacco-use cessation ~~smoking cessation~~ initiative.--For the ~~2007-2008 and~~ 2008-2009 fiscal year ~~years~~ only, the AHEC network shall expand the AHEC tobacco-use cessation ~~smoking cessation~~ initiative to each county within the state and perform other activities as determined by the department.

(4) ADVISORY COUNCIL; MEMBERS, APPOINTMENTS, AND MEETINGS.--The Tobacco Education and Use Prevention Advisory Council is created within the department.

(a) The council shall consist of 23 members, including:

1. The State Surgeon General, who shall serve as the chairperson.

2. One county health department director, appointed by the State Surgeon General.

3. Two members appointed by the Commissioner of Education, of whom one must be a school district superintendent.

4. The chief executive officer of the Florida Division of the American Cancer Society, or his or her designee.

5. The chief executive officer of the Greater Southeast Affiliate of the American Heart Association, or his or her designee.

6. The chief executive officer of the American Lung Association of Florida, or his or her designee.

7. The dean of the University of Miami School of Medicine, or his or her designee.

8. The dean of the University of Florida College of Medicine, or his or her designee.

9. The dean of the University of South Florida College of Medicine, or his or her designee.

10. The dean of the Florida State University College of Medicine, or his or her designee.

11. The dean of Nova Southeastern College of Osteopathic Medicine, or his or her designee.

12. The dean of the Lake Erie College of Osteopathic Medicine in Bradenton, Florida, or his or her designee.

13. The chief executive officer of the Campaign for Tobacco Free Kids, or his or her designee.

14. The chief executive officer of the Legacy Foundation, or his or her designee.

15. Four members appointed by the Governor, of whom two must have expertise in the field of tobacco-use prevention and education or tobacco-use ~~smoking~~ cessation and one individual who shall be between the ages of 16 and 21 at the time of his or her appointment.

16. Two members appointed by the President of the Senate, of whom one must have expertise in the field of tobacco-use prevention and education or tobacco-use ~~smoking~~ cessation.

17. Two members appointed by the Speaker of the House of Representatives, of whom one must have expertise in the field of tobacco-use prevention and education or tobacco-use ~~smoking~~ cessation.

(b) The appointments shall be for 3-year terms and shall reflect the diversity of the state's population. A vacancy shall be filled by appointment by the original appointing authority for the unexpired portion of the term.

(c) An appointed member may not serve more than two consecutive terms.

(d) The council shall meet at least quarterly and upon the call of the chairperson. Meetings may be held via teleconference or other electronic means.

(e) Members of the council shall serve without compensation, but are entitled to reimbursement for per diem and travel expenses pursuant to s. 112.061. Members who are state officers or employees or who are appointed by state officers or employees shall be reimbursed for per diem and travel expenses pursuant to s. 112.061 from the state agency through which they serve.

(f) The department shall provide council members with information and other assistance as is reasonably necessary to assist the council in carrying out its responsibilities.

(5) COUNCIL DUTIES AND RESPONSIBILITIES.--The council shall advise the State Surgeon General as to the direction and scope of the Comprehensive Statewide Tobacco Education and Use Prevention Program. The responsibilities of the council include, but are not limited to:

(a) Providing advice on program priorities and emphases.

(b) Providing advice on the overall program budget.

(c) Providing advice on copyrighted material, trademark, and future transactions as they pertain to the tobacco education and use prevention program.

(d) Reviewing broadcast material prepared for the Internet, portable media players, radio, and television as it relates to the advertising component of the tobacco education and use prevention program.

(e) Participating in periodic program evaluation.

(f) Assisting in the development of guidelines to ensure fairness, neutrality, and adherence to the principles of merit and quality in the conduct of the program.

(g) Assisting in the development of administrative procedures relating to solicitation, review, and award of contracts and grants in order to ensure an impartial, high-quality peer review system.

(h) Assisting in the development and supervision of peer review panels.

(i) Reviewing reports of peer review panels and making recommendations for contracts and grants.

(j) Reviewing the activities and evaluating the performance of the AHEC network to avoid duplicative efforts using state funds.

(k) Recommending meaningful outcome measures through a regular review of tobacco-use prevention and education strategies and programs of other states and the Federal Government.

(l) Recommending policies to encourage a coordinated response to tobacco use in this state, focusing specifically on creating partnerships within and between the public and private sectors.

(6) CONTRACT REQUIREMENTS.--Contracts or grants for the program components or subcomponents described in paragraphs (3)(a)-(f) shall be awarded by the State Surgeon General, after consultation with the council, on the basis of merit, as determined by an open, competitive, peer-reviewed process that ensures objectivity, consistency, and high quality. The department shall award such grants or contracts no later than October 1 for each fiscal year. A recipient of a contract or grant for the program component described in paragraph (3)(c) is

not eligible for a contract or grant award for any other program component described in subsection (3) in the same state fiscal year. A school or college of medicine that is represented on the council is not eligible to receive a contract or grant under this section. ~~For the 2007-2008 and 2008-2009 fiscal years only, the department shall award a contract or grant in the amount of $10 million to the AHEC network for the purpose of developing the components described in paragraph (3)(i). The AHEC network may apply for a competitive contract or grant after the 2008-2009 fiscal year.~~

(a) In order to ensure that all proposals for funding are appropriate and are evaluated fairly on the basis of merit, the State Surgeon General, in consultation with the council, shall appoint a peer review panel of independent, qualified experts in the field of tobacco control to review the content of each proposal and establish its priority score. The priority scores shall be forwarded to the council and must be considered in determining which proposals will be recommended for funding.

(b) The council and the peer review panel shall establish and follow rigorous guidelines for ethical conduct and adhere to a strict policy with regard to conflicts of interest. A member of the council or panel may not participate in any discussion or decision with respect to a research proposal by any firm, entity, or agency with which the member is associated as a member of the governing body or as an employee or with which the member has entered into a contractual arrangement. Meetings of the council and the peer review panels are subject to chapter 119, s. 286.011, and s. 24, Art. I of the State Constitution.

(c) In each contract or grant agreement, the department shall limit the use of food and promotional items to no more than 2.5 percent of the total amount of the contract or grant and limit overhead or indirect costs to no more than 7.5 percent of the total amount of the contract or grant. The department, in consultation with the Department of Financial Services, shall publish guidelines for appropriate food and promotional items.

(d) In each advertising contract, the department shall limit the total of production fees, buyer commissions, and related costs to no more than 10 percent of the total contract amount.

(e) Notwithstanding the competitive process for contracts and grants prescribed in this subsection:~~, each county health department is eligible for core funding, on a per capita basis, to implement tobacco education and use prevention activities within that county.~~

1. For the 2008-2009 fiscal year only, the department shall award a contract or grant in the amount of $6 million to the AHEC network for the purpose of developing the component described in paragraph (3)(i).

2. For the 2008-2009 fiscal year only, the department shall equally award contracts or grants totaling $4 million to each medical school in this state recognized and approved by an accrediting agency recognized by the United States Office of Education, for the purpose of implementing the component described in paragraph (3)(i).

3. Beginning with the 2008-2009 fiscal year and continuing thereafter, the department shall award contracts or grants in

the amount of $5 million to the H. Lee Moffitt Cancer Center and Research Institute and $5 million to the University of Florida Shands Cancer Center for the purpose of implementing chronic disease prevention, detection, and treatment programs in accordance with paragraph (3)(e).

(7) ANNUAL REPORT REQUIRED.--By January 31 of each year, the department shall provide to the Governor, the President of the Senate, and the Speaker of the House of Representatives a report that evaluates the program's effectiveness in reducing and preventing tobacco use and that recommends improvements to enhance the program's effectiveness. The report must contain, at a minimum, an annual survey of youth attitudes and behavior toward tobacco, as well as a description of the progress in reducing the prevalence of tobacco use among youth, adults, and pregnant women; reducing per capita tobacco consumption; and reducing exposure to environmental tobacco smoke.

(8) LIMITATION ON ADMINISTRATIVE EXPENSES.--From the total funds appropriated for the Comprehensive Statewide Tobacco Education and Use Prevention Program in the General Appropriations Act, an amount of up to 5 percent may be used by the department for administrative expenses.

(9) RULEMAKING AUTHORIZED.--~~By January 1, 2008,~~ The department shall adopt rules pursuant to ss. 120.536(1) and 120.54 to administer this section.

Section 2. This act shall take effect July 1, 2008.

A.G. Holley Hospital

A.G. Holley State Hospital Conforming Bill

- The bill removes references to A.G. Holley State Hospital in legislative findings and intent.

- The bill specifies that funding is used to support the surveillance, treatment to cure, hospitalization, and isolation for contagious cases and to provide a system of voluntary, community-oriented care.

- The bill deletes language that states that funds, such as gifts or grants, are to be used to support the construction or maintenance of Department of Health facilities.

- Additionally, the bill broadens the duties of the advisory board to review and make recommendations concerning the coordination of patient care for non-compliant tuberculosis patients statewide, and strikes language specifically relating to A.G. Holley.

A bill to be entitled

An act relating to A.G. Holley State Hospital; amending s. 392.51, F.S., relating to legislative intent; amending s. 392.69, F.S., relating to delivery of tuberculosis control services; providing that monies are to support the surveillance, treatment to cure, hospitalization, and isolation for contagious cases and to provide a system of voluntary, community-oriented care; removing requirements for the use of funds; amending duties of the advisory board; relating to providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 392.51, Florida Statutes, is amended to read:

392.51 Findings and intent.--The Legislature finds and declares that active tuberculosis is a highly contagious infection that is sometimes fatal and constitutes a serious threat to the public health. The Legislature finds that there is a significant reservoir of tuberculosis infection in this state and that there is a need to develop community programs to identify tuberculosis and to respond quickly with appropriate measures. The Legislature finds that some patients who have active tuberculosis have complex medical, social, and economic problems that make outpatient control of the disease difficult, if not impossible, without posing a threat to the public health. The Legislature finds that in order to protect the citizenry from those few persons who pose a threat to the public, it is

necessary to establish a system of mandatory contact identification, treatment to cure, hospitalization, and isolation for contagious cases and to provide a system of voluntary, community-oriented care and surveillance in all other cases. The Legislature finds that the delivery of tuberculosis control services is best accomplished by the coordinated efforts of the respective county health departments, ~~the A.G. Holley State Hospital,~~ and the private health care delivery system.

Section 2. Section 392.69, Florida Statutes, is amended to read:

392.69 Appropriation, ~~sinking,~~ and maintenance trust funds; additional powers of the department.--

(1) The Legislature ~~shall~~ may include in its annual appropriations act ~~a sufficient sum~~ funds for the purpose of carrying out the provisions of this chapter.

(2) All moneys required to be paid by the several counties and patients for the care and maintenance of patients hospitalized by the department for tuberculosis shall be paid to the department, and the department shall immediately transmit these moneys to the Chief Financial Officer, who shall deposit the moneys in the Operations and Maintenance Trust Fund, which shall contain all moneys appropriated by the Legislature or received from patients or other third parties and shall be expended to support the surveillance, treatment to cure, hospitalization, and isolation for contagious cases and to provide a system of voluntary, community-oriented care ~~operation and maintenance of the state-operated tuberculosis hospital~~.

~~(3) In the execution of its public health program functions, notwithstanding s. 216.292(2)(b)2., the department is hereby authorized to use any sums of money which it may heretofore have saved or which it may hereafter save from its regular operating appropriation, or use any sums of money acquired by gift or grant, or any sums of money it may acquire by the issuance of revenue certificates of the hospital to match or supplement any state or federal funds, or any moneys received by said department by gift or otherwise, for the construction or maintenance of additional facilities or improvement to existing facilities, as the department deems necessary.~~

(4) The department shall appoint an advisory board, which shall meet quarterly to review and make recommendations relating to coordinating ~~to~~ patient care for non-compliant tuberculosis patients ~~at A. G. Holley State Hospital~~. Members shall be appointed for terms of 3 years, with such appointments being staggered so that terms of no more than two members expire in any one year. Members shall serve without compensation, but they are entitled to be reimbursed for per diem and travel expenses under s. 112.061.

Section 3. This act shall take effect January 1, 2009.