Fiscal Council

Joe Negron, Chair
Fred Brummer, Vice Chair

December 06, 2005
9:30 a.m. – 12:00 p.m.
Morris Hall

REVISED

Allan G. Bense
Speaker

Joe Negron
Chair

Council Meeting Notice

HOUSE OF REPRESENTATIVES

Speaker Allan G. Bense

Fiscal Council

Start Date and Time:	Tuesday, December 06, 2005 09:30 am
End Date and Time:	Tuesday, December 06, 2005 12:00 pm
Location:	Morris Hall (17 HOB)
Duration:	2.50 hrs

Consideration of the following bill(s):

HB 3B CS (IF RECEIVED) -- Medicaid by Benson
HB 47B Appropriation to Compensate Wilton Dedge by Goodlette, Quinones
HB 41B Judges by Goodlette
HB 31B (IF RECEIVED) -- Specialty License Plates by Patterson
HB 15B (IF RECEIVED) -- Ad Valorem Property Tax Payment Discounts by Hasner
HB 1B (IF RECEIVED) -- Slot Machine Gaming by Business Regulation Committee

NOTICE FINALIZED on 12/05/2005 19:20 by SLB

Florida House of Representatives

Fiscal Council

Allan Bense
Speaker

Joe Negron
Chair

AGENDA
December 6, 2005
9:30 a.m. – 12:00 p.m.
Morris Hall

I. **Meeting Call to Order**

II. **Opening Remarks by Chair**

III. **Consideration of the following bill(s):**

HB 3B CS (IF RECEIVED) -- Medicaid by Benson

HB 47B Appropriation to Compensate Wilton Dedge by Goodlette, Quinones

HB 41B Judges by Goodlette

HB 31B (IF RECEIVED) -- Specialty License Plates by Patterson

HB 15B (IF RECEIVED) -- Ad Valorem Property Tax Payment Discounts by Hasner

HB 1B (IF RECEIVED) -- Slot Machine Gaming by Business Regulation Committee

IV. **Closing Remarks and Adjournment**

221 Capitol Building, 402 South Monroe Street, Tallahassee, Florida 32399-1300 (850) 488-6204

HB 3B

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 3B CS Medicaid
SPONSOR(S): Benson
TIED BILLS: **IDEN./SIM. BILLS:** SB 2B

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care Regulation Committee	6 Y, 4 N, w/CS	Mitchell	Mitchell
2) Fiscal Council		Speir	Kelly
3) Health & Families Council			
4)			
5)			

SUMMARY ANALYSIS

In the 2005 Regular Session the Legislature passed CS/CS/SB 838 (Ch. 2005-133, L.O.F.), which establishes s. 409.91211, F.S., to give the Agency for Health Care Administration (AHCA) guidance and authority to seek a federal waiver to reform Medicaid, and specified the agency could not implement the waiver until it received authority from the Legislature. On October 3, 2005, AHCA submitted the waiver to the federal Centers for Medicare and Medicaid Services (CMS) for approval, following a year of negotiation with CMS. On October 19, 2005, the federal Centers for Medicare and Medicaid Services (CMS) approved Florida's Medicaid Reform waiver application with special terms and conditions.

HB 3B with CS amends s. 409.91211, F.S., to give AHCA authority to implement Medicaid reform as required by CS/CS/SB 838, and in accordance with CMS special terms and conditions. It also amends ss. 216.346, 409.911, 409.912, 409.9122, and 641.2261, Florida Statutes and creates ss. 11.72 and 409.91212, Florida Statutes.

The bill provides an appropriation of $250,000, and an FTE to the Office of Insurance Regulation to carry out an annual review of the risk-adjusted rate methodology.

The effective date of the bill is upon becoming law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide Limited Government. The bill requires outsourcing of the administration of health care service delivery to managed care plans approved by the Agency for Health Care Administration.

B. EFFECT OF PROPOSED CHANGES:

HB 3B with CS amends s. 409.91211, F.S., to give AHCA authority to implement the reform plan as established in the waiver application and federal terms and conditions for the waiver.

The bill:

- Requires Medicaid provider service networks to comply with certain federal solvency requirements, rather than state solvency requirements for HMOs.
- Modifies the name, composition, and mission of the existing Medicaid Disproportionate Share Council.
- Establishes Low Income Pool Council objectives for the distribution of LIP funds. The revised Council will make recommendations to the Legislature regarding the Low Income Pool, which replaces the UPL funding program for safety-net hospitals.
- Allows current capitated, behavior health programs to continue in non-reform counties.
- Facilitates the establishment of PSNs by, removing the requirement that contracts for Provider Service Networks (PSNs) be competitively bid, so hospitals and other provider networks can be established to participate in Medicaid reform.
- Authorizes AHCA to begin implementing the Medicaid managed care pilot program in two sites, Broward and Duval Counties.
- Authorizes AHCA to seek options to make direct payments to state medical school hospitals and physicians.
- Requires PSNs to continue sharing savings with the state as PSNs transition to managed care reform plans.
- Allows the Department of Health's, Children's Medical Services Network, to become a reform plan.
- Establishes detailed measures that require quality assurance, patient satisfaction, and performance standard reporting by managed care reform plans.
- Establishes detailed standards for managed care plan compliance, including patient encounter reporting requirements.
- Establishes detailed requirements to minimize the risk of Medicaid fraud and abuse in all plans operating in the Medicaid managed care pilot program.
- Requires AHCA to assign Medicaid recipients who are currently in a Medicaid managed care plan and who do not make a choice of a plan at the point of eligibility redetermination into the most appropriate reform plan operated by the recipient's current managed care organization.
- Requires AHCA to notify the Legislature before proposing any changes to the terms and conditions of the waiver.
- Requires the Office of Insurance Regulation to advise AHCA and report to the Legislature on the proposed risk-adjusted rate methodology developed for Medicaid reform plans; a four year phase in of the risk-adjusted rates; limits on variation in rates based on risk, with hold harmless on plan payments; and federal approval of risk adjusted rates.

- Requires rule making for risk-adjusted rate-setting and for choice counseling of beneficiaries.
- Establishes a Joint Legislative Committee on Medicaid Reform Implementation for reviewing policy issues related to expansion.
- Establishes detailed requirements for readiness that must be met before expansion into other counties can be considered beginning in year two. At least two plans in the expansion area must meet readiness criteria.
- Mandates the assignment of Medicaid recipients in non-reform counties to a managed care plan when they fail to select a service delivery system.
- Requires AHCA to report to the Legislature by April 1, 2006, on Low Income Pool methodology and other issues related to the special terms and conditions.
- Requires AHCA to submit all CMS required quarterly and annual progress reports to the Legislature.
- Specifies legislative intent that, if any conflict exists between the statutory provisions relating to reform and other Medicaid statutes, the requirements of reform prevail. AHCA must report to the Legislature any conflicts it identifies.
- Provides an appropriation of $250,000 for the Office of Insurance Regulation to carry out the annual review of the risk-adjusted rate methodology.
- Provides an effective date of upon becoming law, so that AHCA can implement Medicaid Reform.

THE CURRENT SITUATION

Medicaid is the $15 billion state and federal program that provides health care to more than 2.1 million vulnerable, disabled, and elderly Floridians. According to AHCA, if Florida's Medicaid program continues to grow at its present rate, it would consume more than half of the state's budget by 2015.

Governor Bush's Proposal for Medicaid Reform

In 2004, Governor Bush proposed a major reform of Florida's Medicaid system, and the Agency for Health Care Administration (AHCA) began meeting with the federal Centers for Medicare and Medicaid Services (CMS) to develop concepts for the reform. The reform is referred to as a "waiver" because it seeks federal permission to waive certain federal requirements that govern the regular Medicaid program. The goals of the reform are to establish a new Medicaid system that achieves:

> Patient Choice: Participants in reformed Medicaid plans will be able to choose among a variety of benefit packages. With the help of independent choice counselors they will choose the plan that best meets their needs. They will be able to earn credits for approved health-related expenses such as co-pays, over-the-counter medications, or eyeglasses, by meeting approved healthy lifestyle changes such as meeting all well baby checkups, losing weight, and smoking cessation.
>
> Medicaid Marketplace Innovation: Provider groups will be able to design benefit plans that attract participants because of their benefit package, innovative care, convenient networks, and optional services. Competition among managed care plans will reduce fraud in Medicaid. Currently, Medicaid pays claims first and identifies fraud later. Under proposed reforms, capitated health plans have a financial incentive to aggressively guard against fraud.
>
> Better Care: Health plans can customize their benefit design to meet the needs of the target populations in the geographic areas they serve. The state will evaluate the benefits to ensure they are actuarially equivalent to historical fee-for-service benefits and are sufficient to meet the needs of the targeted populations. Rates will be risk adjusted to create incentives for more prevention and identification of chronic illnesses.

Budget Predictability: According to the Agency for Health Care Administration, by moving to a managed and capitated system, the state expects to minimize budget fluctuations driven primarily by the current fee-for-service system and improve predictions of budget growth.

2004-2005 Legislative Action on Medicaid Reform

In the Fall of 2004, both the House and Senate established Select Committees on Medicaid Reform. The Select Committees conducted five public hearings in cities around the state, including Tampa, Ft. Lauderdale, Orlando, Panama City, and Jacksonville. During the public hearings, the Select Committees heard testimony from hundreds of individuals including Medicaid recipients, providers, health maintenance organization (HMO) representatives, advocacy groups, and other interested parties on ways to improve the Medicaid program.

CS/CS/SB 838 Authorization and Requirements to Pursue a Federal Waiver

In 2005, the Legislature passed CS/CS/SB 838, which creates s. 409.91211, F.S., to authorize AHCA to continue developing a plan to pilot the Governor's proposal for a capitated managed care system to replace the current fee-for-service Medicaid system. Requirements of SB 838 include:

Continued federal funding of supplemental payment mechanisms. The law specifies that the authorization was contingent on the attainment of:

- Federal approval to preserve the Upper Payment Limit (UPL) funding 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 (IGT) as state match for federal funds.
- Provisions to protect the Disproportionate Share Hospital (DSH) program.

Components for the reform plan. The law requires AHCA to develop and recommend provisions for implementation of Medicaid reform pilot areas that include:

- Eligibility groups and two geographic areas for the pilot projects. The bill designates one pilot program in Broward County and one pilot program in Duval and surrounding Baker, Clay, and Nassau Counties. It allows the pilot in the Duval County area to be phased in over a 2-year period.
- Requirements that health care plans in Medicaid reform pilot areas include mandatory and optional Medicaid services listed in ss. 409.905 and 409.906, F.S.
- Standards and credentialing requirements for plans, including those related to fiscal solvency, quality of care, and adequacy of access to health care providers.
- Actuarially sound, risk adjusted capitation rates for coverage of Medicaid recipients separated into comprehensive and catastrophic care premium components, and a method to phase in financial risk for approved provider service networks over a 3-year period, with stop-loss requirements.
- A system to help Medicaid recipients select a managed care plan that meets their needs. Requirements for mandatory enrollment in a capitated managed care network and locking a recipient into a health plan for 12 months, unless the recipient can demonstrate cause to justify a disenrollment, and provisions for disenrollment and selection of another plan within a certain timeframe.
- A system to monitor plan performance and the provision of services, and to detect and deter fraud and abuse by health plans, providers, and recipients, including underutilization and inappropriate denial of care.

Approval of an implementation plan. Section 409.91211, F.S, requires AHCA to develop an implementation plan to be submitted to the Legislature for approval before implementation of the reform, or if the Legislature is not in session, for approval by the Legislative Budget Commission.

Evaluation of the pilots. The Legislature also requires an independent evaluation of Medicaid reform for consideration of expansion beyond the pilot areas. The Office of Program Policy Analysis and Government Accountability (OPPAGA), in consultation with the Auditor General, will evaluate the two managed care pilot projects during the first 24 months of operation. The evaluation must contain cost savings estimates and quality measures, as well as explanations of any legal or administrative barriers to implementing the pilot projects. The evaluation must be included in a report to the Governor and the Legislature no later than June 30, 2008, for consideration of statewide expansion.

Legislature approval of expansion. No additional counties beyond those specified in s. 409.91211, F.S., may be included in the managed care pilot program without legislative authority.

Federal Approval of the Waiver

The Agency for Health Care Administration (AHCA) published the waiver application for public review on August 31, 2005, and formally submitted the waiver application to the federal government for approval on October 3, 2005.

The federal Centers for Medicaid and Medicare Services (CMS) approved the waiver for reform of Florida Medicaid on October 19, 2005. The waiver covers a 5-year period, from July 1, 2006, through June 30, 2011. Fundamental elements of the reform plan include:

Beneficiary Choice from among benefit packages. With the support of choice counselors, individuals will have the flexibility to choose from a variety of benefit packages and pick the plan that best meets their needs.

Plan Variety. In addition to traditional managed care organizations, new plans will be created from existing provider networks and organizations that wish to participate. Such entities include provider service networks, federally qualified health centers, federally qualified rural health clinics, county health departments, the Division of Children's Medical Services Network within the Department of Health; and other federally, state, or locally funded entities that serve the geographic areas within the pilot program.

Risk-Adjusted Premiums for Medicaid enrollees in managed care plans. The premium will have two components, comprehensive care and catastrophic care, and will be actuarially comparable to all services covered under the current Florida Medicaid program.

A Low-Income Pool (LIP) to be established and maintained by the state to provide direct payment and distributions to safety-net providers in the state for the purpose of providing coverage to the uninsured through provider access systems.

An Employer-Sponsored Insurance (ESI) option to allow individuals to use their premiums to "opt out" of Medicaid and purchase insurance through their workplace.

Enhanced Benefits Accounts to provide incentives to Medicaid Reform enrollees for healthy behaviors that they can use to offset health-care-related costs, such as over-the-counter pharmaceuticals, vitamins, etc.

Federal Terms and Conditions
In approving the waiver, CMS attached special terms and conditions (11-W-00206/4) that set forth in detail the nature, character, and extent of federal involvement in the reform, and Florida's obligations to CMS during the life of the waiver. The terms and conditions address 120 issues in 16 areas of the reform. They require detailed accountability. The terms and conditions require compliance with current Medicaid law, regulation, and policy. They spell out limits on the scope of change in some areas, and provide for broad flexibility in others. The areas addressed by the terms and conditions include:

- General Program and Reporting Requirements.
- Implementation of Florida Medicaid Reform.
- Eligibility, Enrollment, and Choice Counseling.
- Benefit Packages and Medicaid Reform Plans.
- Employer-Sponsored Insurance.
- The Enhanced Benefits Accounts Program.
- The Low Income Pool.
- Evaluation and Monitoring of Budget Neutrality.

The primary condition of the Medicaid waiver is "budget neutrality." A federal rule requires that the costs of Medicaid services provided to recipients under the waiver must not exceed the projected costs for Medicaid services without the waiver. If expenditures exceed the budget neutrality projections, then the state will have to fund these expenditures without federal matching funds.

The terms and conditions require federal approval of amendments to the waiver before Florida can add dual eligible, hospice, and medically needy groups to the reform; and before any program or budget changes can be made to: eligibility, enrollment, benefits, employer-sponsored insurance, implementation, the Low Income Pool, Federal Financial Participation (FFP), sources of the non-Federal share, and budget neutrality.

C. SECTION DIRECTORY:

Section 1. Amends s. 641.2261(2), F.S., to require Medicaid provider service networks to comply with certain federal solvency requirements, rather than state solvency requirements for HMOs.

Section 2. Amends s. 409.911(9), F.S., to modify the name, composition, and mission of the existing Medicaid Disproportionate Share Council. The revised Council will make recommendations to the Legislature regarding the Low Income Pool, which replaces the UPL funding program for safety-net hospitals under the terms and conditions of the federal waiver.

Section 3. Amends s. 409.912, F.S., to allow current capitated, behavior health programs to continue in non-reform counties, and remove the requirement that contracts for Provider Service Networks (PSNs) be competitively bid.

Section 4. Amends s. 409.91211, F.S., to authorize AHCA to begin implementing the Medicaid managed care pilot program in two pilot sites (Broward and Duval Counties per CS/CS/SB 838, 2005). The bill specifies additional requirements related to PSN cost sharing, quality assurance, encounter data, fraud and abuse, and continuity of care; it limits implementation of risk-adjusted rate setting; and it makes technical changes to conform to requirements of the federal waiver.

Section 5. Creates s. 409.91212, F.S., to allow Medicaid reform to expand to other counties after the beginning of year two, if detailed criteria for readiness are met.

Section 6. Amends s. 409.9122, F.S., to remove the requirement of automatic assignment into Medipass of Medicaid recipients in non-reform counties who do not make a choice of plans.

Section 7. Requires AHCA to report to the Legislature by April 1, 2006, on the Low Income Pool methodology and other issues related to the federal terms and conditions requirements of the waiver.

Section 8. Requires AHCA to submit all CMS required quarterly and annual reports to the Legislature.

Section 9. Creates s. 11.72, F.S., to establish a Joint Legislative Committee on Medicaid Reform Implementation to review policy issues related to expansion of the Medicaid managed pilot program and make recommendations regarding the extent readiness criteria are met.

Section 10. Specifies legislative intent that, if any conflict exists between the statutory provisions relating to reform and other Medicaid statutes, the requirements of reform prevail. AHCA must report to the Legislature any conflicts it identifies.

Section 11. Amends s. 216.346, F.S., to allow contracts between state agencies and state colleges and universities to charge a reasonable overhead.

Section 12. Provides an appropriation of $250,000, for the Office of Insurance Regulation to carry out the annual review of the risk-adjusted rate methodology.

Section 13. Provides an effective date of upon becoming law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   See Comments below.

2. Expenditures:

   See Comments below.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Medicaid reform will change the way Medicaid services are provided to Medicaid recipients. This may have a direct impact on the fees service providers receive.

D. FISCAL COMMENTS:

<u>Administration Costs</u>

The Agency for Health Care Administration has requested $15 million ($7.5 million General Revenue) of nonrecurring funds for the administration of Medicaid reform in its Fiscal Year 2006-2007 Legislative Budget Request. The request is for the following funds.

Choice Counseling

General Revenue Fund	$3,250,000
Administrative Trust Fund	$3,250,000
Plan Evaluation/Satisfaction Survey	
General Revenue Fund	$250,000
Administrative Trust Fund	$250,000
Premium Development	
General Revenue Fund	$1,000,000
Administrative Trust Fund	$1,000,000
Enhanced Benefit Accounts	
General Revenue Fund	$1,500,000
Administrative Trust Fund	$1,500,000
Management of Employer Sponsored Insurance	
General Revenue Fund	$1,000,000
Administrative Trust Fund	$1,000,000
Infrastructure & System Modification	
General Revenue Fund	$500,000
Administrative Trust Fund	$500,000

For subsequent years, the agency states that the projects will increase in cost as the capitated managed care pilot program expands into Baker, Clay, and Nassau counties.

Medicaid Reform Benefit Costs

The agency's Florida Medicaid Reform Implementation Plan dated November 28, 2005, compares the costs of Medicaid benefits without Medicaid reform to the costs of Medicaid benefits with Medicaid reform. The comparison is below.

Benefit Costs	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11
Without reform	$8,005,381,618	$9,074,633,163	$10,317,423,381	$11,763,265,977	$13,446,859,984
With reform	$7,814,617,174	$8,747,049,308	$9,823,408,828	$11,067,673,309	$12,507,991,943
Difference	$190,764,444	$327,583,855	$494,014,553	$695,592,668	$938,868,041

The $190.7 million in savings shown above for Fiscal Year 2006-2007 is for statewide expenditures. According to the agency, the fiscal impact of moving recipients into Medicaid reform plans in only Duval and Broward counties is indeterminate at this time.

The agency estimates that the phasing in risk-adjusted rates will reduce the amount of the agency's projected cost savings.

Rate Review

This bill authorizes one full-time equivalent position and appropriates $250,000 from the General Revenue Fund for Fiscal Year 2006-2007 for the annual review of the Medicaid managed care pilot program's risk-adjusted rate setting methodology.

Assignment of Recipients to Managed Care

The bill changes the assignment of undecided enrollees. The agency estimates that this policy change would result in savings of more than $12.2 million ($4.2 million General Revenue).

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not require counties or municipalities to spend funds or take an action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

Paragraph (c) on page 40 places a duty on the agency in a subsection that grants powers to the Office of Insurance Regulation.

Subsection (8) on page 40 requires the agency to set rates based upon the "recommendation of the committee" without knowing what committee is being referenced. The language also appears to make the agency's rate setting authority subject to another entity. This may violate the single state agency requirements in federal law (See 42 CFR 431.10).

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

On December 5, 2005, the Health Care Regulation Committee adopted two amendments sponsored by Representative Garcia. The Committee Substitute differs from the original bill as filed. The Committee Substitute adds language to require: the Office of Insurance Regulation to advise AHCA, not oversee, the proposed risk-adjusted rate system; a four year phase in of the risk-adjusted rates; limits on variation in rates based on risk, with hold harmless on plan payments; federal approval of risk adjusted rates; and rule making for risk-adjusted rate-setting and for choice counseling of beneficiaries.

The bill, as amended, was reported favorably as a committee substitute.

This analysis is drafted to the committee substitute.

CHAMBER ACTION

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1 The Health Care Regulation Committee recommends the following:
2
3 **Council/Committee Substitute**
4 Remove the entire bill and insert:
5 A bill to be entitled
6 An act relating to Medicaid; amending s. 641.2261, F.S.;
7 revising the applicability of solvency requirements to
8 include Medicaid provider service networks and updating a
9 reference; amending s. 409.911, F.S.; renaming the
10 Medicaid Disproportionate Share Council; providing for
11 appointment of council members; providing responsibilities
12 of the council; amending s. 409.912, F.S.; providing an
13 exception from certain contract procurement requirements
14 for specified Medicaid managed care pilot programs and
15 Medicaid health maintenance organizations; deleting the
16 competitive procurement requirement for provider service
17 networks; requiring provider service networks to comply
18 with the solvency requirements in s. 641.2261, F.S.;
19 updating a reference; amending s. 409.91211, F.S.;
20 providing for distribution of upper payment limit,
21 hospital disproportionate share program, and low income
22 pool funds; providing legislative intent with respect to
23 distribution of said funds; providing for implementation

24 of the powers, duties, and responsibilities of the Agency
25 for Health Care Administration with respect to the pilot
26 program; including the Division of Children's Medical
27 Services Network within the Department of Health in a list
28 of state-authorized pilot programs; requiring the agency
29 to develop a data reporting system; requiring the agency
30 to implement procedures to minimize fraud and abuse;
31 providing that certain Medicaid and Supplemental Security
32 Income recipients are exempt from s. 409.9122, F.S.;
33 authorizing the agency to assign certain Medicaid
34 recipients to reform plans; authorizing the agency to
35 implement the provisions of the waiver approved by Centers
36 for Medicare and Medicaid Services and requiring the
37 agency to notify the Legislature prior to seeking federal
38 approval of modifications to said terms and conditions;
39 requiring the agency to adopt certain rules for the
40 managed care pilot program; requiring the Office of
41 Insurance Regulation to provide advisory recommendations
42 regarding the agency's rate setting methodology;
43 authorizing the office to enter into certain contracts;
44 requiring the agency to solicit input from certain
45 stakeholders regarding the agency's rate setting
46 methodology; requiring a report to the Governor and
47 Legislature; providing for implementation of adjustments
48 to risk-adjusted capitation rates by agency rule;
49 providing a schedule for the phasing in of capitation
50 rates; providing requirements for adjustments to
51 capitation rates; requiring certification of capitation

52 rates; defining the term "capitated managed care plan";
53 creating s. 409.91212, F.S.; authorizing the agency to
54 expand the Medicaid reform demonstration program;
55 providing readiness criteria; providing for public
56 meetings; requiring notice of intent to expand the
57 demonstration program; requiring the agency to request a
58 hearing by the Joint Legislative Committee on Medicaid
59 Reform Implementation; authorizing the agency to request
60 certain budget transfers; amending s. 409.9122, F.S.;
61 revising provisions relating to assignment of certain
62 Medicaid recipients to managed care plans; requiring the
63 agency to submit reports to the Legislature; specifying
64 content of reports; creating s. 11.72, F.S.; creating the
65 Joint Legislative Committee on Medicaid Reform
66 Implementation; providing for membership, powers, and
67 duties; providing for conflict between specified
68 provisions of ch. 409, F.S., and requiring a report by the
69 agency pertaining thereto; amending s. 216.346, F.S.;
70 revising provisions relating to contracts between state
71 agencies; providing an appropriation; providing an
72 effective date.
73
74 Be It Enacted by the Legislature of the State of Florida:
75
76 Section 1. Section 641.2261, Florida Statutes, is amended
77 to read:

78 641.2261 Application of federal solvency requirements to
79 provider-sponsored organizations and Medicaid provider service
80 networks.--
81 (1) The solvency requirements of ss. 1855 and 1856 of the
82 Balanced Budget Act of 1997 and 42 C.F.R. s. 422.350, subpart H,
83 ~~rules adopted by the Secretary of the United States Department~~
84 ~~of Health and Human Services~~ apply to a health maintenance
85 organization that is a provider-sponsored organization rather
86 than the solvency requirements of this part. However, if the
87 provider-sponsored organization does not meet the solvency
88 requirements of this part, the organization is limited to the
89 issuance of Medicare+Choice plans to eligible individuals. For
90 the purposes of this section, the terms "Medicare+Choice plans,"
91 "provider-sponsored organizations," and "solvency requirements"
92 have the same meaning as defined in the federal act and federal
93 rules and regulations.
94 (2) The solvency requirements of 42 C.F.R. s. 422.350,
95 subpart H, and the solvency requirements established in the
96 approved federal waiver pursuant to chapter 409 apply to a
97 Medicaid provider service network rather than the solvency
98 requirements of this part.
99 Section 2. Subsection (9) of section 409.911, Florida
100 Statutes, is amended to read:
101 409.911 Disproportionate share program.--Subject to
102 specific allocations established within the General
103 Appropriations Act and any limitations established pursuant to
104 chapter 216, the agency shall distribute, pursuant to this
105 section, moneys to hospitals providing a disproportionate share

106 of Medicaid or charity care services by making quarterly
107 Medicaid payments as required. Notwithstanding the provisions of
108 s. 409.915, counties are exempt from contributing toward the
109 cost of this special reimbursement for hospitals serving a
110 disproportionate share of low-income patients.
111 (9) The Agency for Health Care Administration shall create
112 a Medicaid Low Income Pool ~~Disproportionate Share~~ Council. The
113 Low Income Pool Council shall consist of 17 members, including
114 three representatives of statutory teaching hospitals, three
115 representatives of public hospitals, three representatives of
116 nonprofit hospitals, three representatives of for-profit
117 hospitals, two representatives of rural hospitals, two
118 representatives of units of local government which contribute
119 funding, and one representative from the Department of Health.
120 The council shall have the following responsibilities:
121 (a) Make recommendations on the financing of the upper
122 payment limit program, the hospital disproportionate share
123 program, or the low income pool as implemented by the agency
124 pursuant to federal waiver and on the distribution of funds.
125 (b) Advise the agency on the development of the low income
126 pool plan required by the Centers for Medicare and Medicaid
127 Services pursuant to the Medicaid reform waiver.
128 (c) Advise the agency on the distribution of hospital
129 funds used to adjust inpatient hospital rates and rebase rates
130 or otherwise exempt hospitals from reimbursement limits as
131 financed by intergovernmental transfers.
132 ~~(a) The purpose of the council is to study and make~~
133 ~~recommendations regarding:~~

134 ~~1. The formula for the regular disproportionate share~~
135 ~~program and alternative financing options.~~
136 ~~2. Enhanced Medicaid funding through the Special Medicaid~~
137 ~~Payment program.~~
138 ~~3. The federal status of the upper-payment-limit funding~~
139 ~~option and how this option may be used to promote health care~~
140 ~~initiatives determined by the council to be state health care~~
141 ~~priorities.~~
142 ~~(b) The council shall include representatives of the~~
143 ~~Executive Office of the Governor and of the agency;~~
144 ~~representatives from teaching, public, private nonprofit,~~
145 ~~private for-profit, and family practice teaching hospitals; and~~
146 ~~representatives from other groups as needed.~~
147 (d) ~~(c) The council shall~~ submit its findings and
148 recommendations to the Governor and the Legislature no later
149 than February 1 of each year.
150 Section 3. Paragraphs (b) and (d) of subsection (4) of
151 section 409.912, Florida Statutes, are amended to read:
152 409.912 Cost-effective purchasing of health care.--The
153 agency shall purchase goods and services for Medicaid recipients
154 in the most cost-effective manner consistent with the delivery
155 of quality medical care. To ensure that medical services are
156 effectively utilized, the agency may, in any case, require a
157 confirmation or second physician's opinion of the correct
158 diagnosis for purposes of authorizing future services under the
159 Medicaid program. This section does not restrict access to
160 emergency services or poststabilization care services as defined
161 in 42 C.F.R. part 438.114. Such confirmation or second opinion

162 shall be rendered in a manner approved by the agency. The agency
163 shall maximize the use of prepaid per capita and prepaid
164 aggregate fixed-sum basis services when appropriate and other
165 alternative service delivery and reimbursement methodologies,
166 including competitive bidding pursuant to s. 287.057, designed
167 to facilitate the cost-effective purchase of a case-managed
168 continuum of care. The agency shall also require providers to
169 minimize the exposure of recipients to the need for acute
170 inpatient, custodial, and other institutional care and the
171 inappropriate or unnecessary use of high-cost services. The
172 agency shall contract with a vendor to monitor and evaluate the
173 clinical practice patterns of providers in order to identify
174 trends that are outside the normal practice patterns of a
175 provider's professional peers or the national guidelines of a
176 provider's professional association. The vendor must be able to
177 provide information and counseling to a provider whose practice
178 patterns are outside the norms, in consultation with the agency,
179 to improve patient care and reduce inappropriate utilization.
180 The agency may mandate prior authorization, drug therapy
181 management, or disease management participation for certain
182 populations of Medicaid beneficiaries, certain drug classes, or
183 particular drugs to prevent fraud, abuse, overuse, and possible
184 dangerous drug interactions. The Pharmaceutical and Therapeutics
185 Committee shall make recommendations to the agency on drugs for
186 which prior authorization is required. The agency shall inform
187 the Pharmaceutical and Therapeutics Committee of its decisions
188 regarding drugs subject to prior authorization. The agency is
189 authorized to limit the entities it contracts with or enrolls as

190 Medicaid providers by developing a provider network through
191 provider credentialing. The agency may competitively bid single-
192 source-provider contracts if procurement of goods or services
193 results in demonstrated cost savings to the state without
194 limiting access to care. The agency may limit its network based
195 on the assessment of beneficiary access to care, provider
196 availability, provider quality standards, time and distance
197 standards for access to care, the cultural competence of the
198 provider network, demographic characteristics of Medicaid
199 beneficiaries, practice and provider-to-beneficiary standards,
200 appointment wait times, beneficiary use of services, provider
201 turnover, provider profiling, provider licensure history,
202 previous program integrity investigations and findings, peer
203 review, provider Medicaid policy and billing compliance records,
204 clinical and medical record audits, and other factors. Providers
205 shall not be entitled to enrollment in the Medicaid provider
206 network. The agency shall determine instances in which allowing
207 Medicaid beneficiaries to purchase durable medical equipment and
208 other goods is less expensive to the Medicaid program than long-
209 term rental of the equipment or goods. The agency may establish
210 rules to facilitate purchases in lieu of long-term rentals in
211 order to protect against fraud and abuse in the Medicaid program
212 as defined in s. 409.913. The agency may seek federal waivers
213 necessary to administer these policies.
214 (4) The agency may contract with:
215 (b) An entity that is providing comprehensive behavioral
216 health care services to certain Medicaid recipients through a
217 capitated, prepaid arrangement pursuant to the federal waiver

218 provided for by s. 409.905(5). Such an entity must be licensed
219 under chapter 624, chapter 636, or chapter 641 and must possess
220 the clinical systems and operational competence to manage risk
221 and provide comprehensive behavioral health care to Medicaid
222 recipients. As used in this paragraph, the term "comprehensive
223 behavioral health care services" means covered mental health and
224 substance abuse treatment services that are available to
225 Medicaid recipients. The secretary of the Department of Children
226 and Family Services shall approve provisions of procurements
227 related to children in the department's care or custody prior to
228 enrolling such children in a prepaid behavioral health plan. Any
229 contract awarded under this paragraph must be competitively
230 procured. In developing the behavioral health care prepaid plan
231 procurement document, the agency shall ensure that the
232 procurement document requires the contractor to develop and
233 implement a plan to ensure compliance with s. 394.4574 related
234 to services provided to residents of licensed assisted living
235 facilities that hold a limited mental health license. Except as
236 provided in subparagraph 8. <u>and except in counties where the</u>
237 <u>Medicaid managed care pilot program is authorized under s.</u>
238 <u>409.91211</u>, the agency shall seek federal approval to contract
239 with a single entity meeting these requirements to provide
240 comprehensive behavioral health care services to all Medicaid
241 recipients not enrolled in a <u>Medicaid capitated</u> managed care
242 plan <u>authorized under s. 409.91211 or a Medicaid health</u>
243 <u>maintenance organization</u> in an AHCA area. <u>In an AHCA area where</u>
244 <u>the Medicaid managed care pilot program is authorized under s.</u>
245 <u>409.91211 in one or more counties, the agency may procure a</u>

246 contract with a single entity to serve the remaining counties as
247 an AHCA area or the remaining counties may be included with an
248 adjacent AHCA area and shall be subject to this paragraph. Each
249 entity must offer sufficient choice of providers in its network
250 to ensure recipient access to care and the opportunity to select
251 a provider with whom they are satisfied. The network shall
252 include all public mental health hospitals. To ensure unimpaired
253 access to behavioral health care services by Medicaid
254 recipients, all contracts issued pursuant to this paragraph
255 shall require 80 percent of the capitation paid to the managed
256 care plan, including health maintenance organizations, to be
257 expended for the provision of behavioral health care services.
258 In the event the managed care plan expends less than 80 percent
259 of the capitation paid pursuant to this paragraph for the
260 provision of behavioral health care services, the difference
261 shall be returned to the agency. The agency shall provide the
262 managed care plan with a certification letter indicating the
263 amount of capitation paid during each calendar year for the
264 provision of behavioral health care services pursuant to this
265 section. The agency may reimburse for substance abuse treatment
266 services on a fee-for-service basis until the agency finds that
267 adequate funds are available for capitated, prepaid
268 arrangements.
269 1. By January 1, 2001, the agency shall modify the
270 contracts with the entities providing comprehensive inpatient
271 and outpatient mental health care services to Medicaid
272 recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk
273 Counties, to include substance abuse treatment services.

274 2. By July 1, 2003, the agency and the Department of
275 Children and Family Services shall execute a written agreement
276 that requires collaboration and joint development of all policy,
277 budgets, procurement documents, contracts, and monitoring plans
278 that have an impact on the state and Medicaid community mental
279 health and targeted case management programs.
280 3. Except as provided in subparagraph 8., by July 1, 2006,
281 the agency and the Department of Children and Family Services
282 shall contract with managed care entities in each AHCA area
283 except area 6 or arrange to provide comprehensive inpatient and
284 outpatient mental health and substance abuse services through
285 capitated prepaid arrangements to all Medicaid recipients who
286 are eligible to participate in such plans under federal law and
287 regulation. In AHCA areas where eligible individuals number less
288 than 150,000, the agency shall contract with a single managed
289 care plan to provide comprehensive behavioral health services to
290 all recipients who are not enrolled in a Medicaid health
291 maintenance organization <u>or a Medicaid capitated managed care</u>
292 <u>plan authorized under s. 409.91211</u>. The agency may contract with
293 more than one comprehensive behavioral health provider to
294 provide care to recipients who are not enrolled in a Medicaid
295 health maintenance organization <u>or a Medicaid capitated managed</u>
296 <u>care plan authorized under s. 409.91211</u> in AHCA areas where the
297 eligible population exceeds 150,000. <u>In an AHCA area where the</u>
298 <u>Medicaid managed care pilot program is authorized under s.</u>
299 <u>409.91211 in one or more counties, the agency may procure a</u>
300 <u>contract with a single entity to serve the remaining counties as</u>
301 <u>an AHCA area or the remaining counties may be included with an</u>

302 adjacent AHCA area and shall be subject to this paragraph.
303 Contracts for comprehensive behavioral health providers awarded
304 pursuant to this section shall be competitively procured. Both
305 for-profit and not-for-profit corporations shall be eligible to
306 compete. Managed care plans contracting with the agency under
307 subsection (3) shall provide and receive payment for the same
308 comprehensive behavioral health benefits as provided in AHCA
309 rules, including handbooks incorporated by reference. In AHCA
310 area 11, the agency shall contract with at least two
311 comprehensive behavioral health care providers to provide
312 behavioral health care to recipients in that area who are
313 enrolled in, or assigned to, the MediPass program. One of the
314 behavioral health care contracts shall be with the existing
315 provider service network pilot project, as described in
316 paragraph (d), for the purpose of demonstrating the cost-
317 effectiveness of the provision of quality mental health services
318 through a public hospital-operated managed care model. Payment
319 shall be at an agreed-upon capitated rate to ensure cost
320 savings. ~~Of the recipients in area 11 who are assigned to~~
321 ~~MediPass under the provisions of s. 409.9122(2)(k),~~ A minimum of
322 50,000 ~~of those~~ MediPass-enrolled recipients shall be assigned
323 to the existing provider service network in area 11 for their
324 behavioral care.
325 4. By October 1, 2003, the agency and the department shall
326 submit a plan to the Governor, the President of the Senate, and
327 the Speaker of the House of Representatives which provides for
328 the full implementation of capitated prepaid behavioral health
329 care in all areas of the state.

330 a. Implementation shall begin in 2003 in those AHCA areas
331 of the state where the agency is able to establish sufficient
332 capitation rates.
333 b. If the agency determines that the proposed capitation
334 rate in any area is insufficient to provide appropriate
335 services, the agency may adjust the capitation rate to ensure
336 that care will be available. The agency and the department may
337 use existing general revenue to address any additional required
338 match but may not over-obligate existing funds on an annualized
339 basis.
340 c. Subject to any limitations provided for in the General
341 Appropriations Act, the agency, in compliance with appropriate
342 federal authorization, shall develop policies and procedures
343 that allow for certification of local and state funds.
344 5. Children residing in a statewide inpatient psychiatric
345 program, or in a Department of Juvenile Justice or a Department
346 of Children and Family Services residential program approved as
347 a Medicaid behavioral health overlay services provider shall not
348 be included in a behavioral health care prepaid health plan or
349 any other Medicaid managed care plan pursuant to this paragraph.
350 6. In converting to a prepaid system of delivery, the
351 agency shall in its procurement document require an entity
352 providing only comprehensive behavioral health care services to
353 prevent the displacement of indigent care patients by enrollees
354 in the Medicaid prepaid health plan providing behavioral health
355 care services from facilities receiving state funding to provide
356 indigent behavioral health care, to facilities licensed under
357 chapter 395 which do not receive state funding for indigent

358 behavioral health care, or reimburse the unsubsidized facility
359 for the cost of behavioral health care provided to the displaced
360 indigent care patient.
361 7. Traditional community mental health providers under
362 contract with the Department of Children and Family Services
363 pursuant to part IV of chapter 394, child welfare providers
364 under contract with the Department of Children and Family
365 Services in areas 1 and 6, and inpatient mental health providers
366 licensed pursuant to chapter 395 must be offered an opportunity
367 to accept or decline a contract to participate in any provider
368 network for prepaid behavioral health services.
369 8. For fiscal year 2004-2005, all Medicaid eligible
370 children, except children in areas 1 and 6, whose cases are open
371 for child welfare services in the HomeSafeNet system, shall be
372 enrolled in MediPass or in Medicaid fee-for-service and all
373 their behavioral health care services including inpatient,
374 outpatient psychiatric, community mental health, and case
375 management shall be reimbursed on a fee-for-service basis.
376 Beginning July 1, 2005, such children, who are open for child
377 welfare services in the HomeSafeNet system, shall receive their
378 behavioral health care services through a specialty prepaid plan
379 operated by community-based lead agencies either through a
380 single agency or formal agreements among several agencies. The
381 specialty prepaid plan must result in savings to the state
382 comparable to savings achieved in other Medicaid managed care
383 and prepaid programs. Such plan must provide mechanisms to
384 maximize state and local revenues. The specialty prepaid plan
385 shall be developed by the agency and the Department of Children

386 and Family Services. The agency is authorized to seek any
387 federal waivers to implement this initiative.
388 (d) A provider service network which may be reimbursed on
389 a fee-for-service or prepaid basis. A provider service network
390 which is reimbursed by the agency on a prepaid basis shall be
391 exempt from parts I and III of chapter 641, but must comply with
392 the solvency requirements in s. 641.2261(2) and meet appropriate
393 financial reserve, quality assurance, and patient rights
394 requirements as established by the agency. ~~The agency shall~~
395 ~~award contracts on a competitive bid basis and shall select~~
396 ~~bidders based upon price and quality of care.~~ Medicaid
397 recipients assigned to a provider service network ~~demonstration~~
398 ~~project~~ shall be chosen equally from those who would otherwise
399 have been assigned to prepaid plans and MediPass. The agency is
400 authorized to seek federal Medicaid waivers as necessary to
401 implement the provisions of this section. Any contract
402 previously awarded to a provider service network operated by a
403 hospital pursuant to this subsection shall remain in effect for
404 a period of 3 years following the current contract expiration
405 date, regardless of any contractual provisions to the contrary.
406 A provider service network is a network established or organized
407 and operated by a health care provider, or group of affiliated
408 health care providers, which provides a substantial proportion
409 of the health care items and services under a contract directly
410 through the provider or affiliated group of providers and may
411 make arrangements with physicians or other health care
412 professionals, health care institutions, or any combination of
413 such individuals or institutions to assume all or part of the

414 financial risk on a prospective basis for the provision of basic
415 health services by the physicians, by other health
416 professionals, or through the institutions. The health care
417 providers must have a controlling interest in the governing body
418 of the provider service network organization.
419 Section 4. Section 409.91211, Florida Statutes, is amended
420 to read:
421 409.91211 Medicaid managed care pilot program.--
422 (1)(a) The agency is authorized to seek experimental,
423 pilot, or demonstration project waivers, pursuant to s. 1115 of
424 the Social Security Act, to create a statewide initiative to
425 provide for a more efficient and effective service delivery
426 system that enhances quality of care and client outcomes in the
427 Florida Medicaid program pursuant to this section. Phase one of
428 the demonstration shall be implemented in two geographic areas.
429 One demonstration site shall include only Broward County. A
430 second demonstration site shall initially include Duval County
431 and shall be expanded to include Baker, Clay, and Nassau
432 Counties within 1 year after the Duval County program becomes
433 operational. This waiver authority is contingent upon federal
434 approval to preserve the upper-payment-limit funding mechanism
435 for hospitals, including a guarantee of a reasonable growth
436 factor, a methodology to allow the use of a portion of these
437 funds to serve as a risk pool for demonstration sites,
438 provisions to preserve the state's ability to use
439 intergovernmental transfers, and provisions to protect the
440 disproportionate share program authorized pursuant to this
441 chapter. Under the upper payment limit program, the hospital

442 disproportionate share program, or the low income pool as
443 implemented by the agency pursuant to federal waiver, the state
444 matching funds required for the program shall be provided by the
445 state and by local governmental entities through
446 intergovernmental transfers. The agency shall distribute funds
447 from the upper payment limit program, the hospital
448 disproportionate share program, and the low income pool
449 according to federal regulations and waivers and the low income
450 pool methodology approved by the Centers for Medicare and
451 Medicaid Services. ~~Upon completion of the evaluation conducted~~
452 ~~under s. 3, ch. 2005-133, Laws of Florida, the agency may~~
453 ~~request statewide expansion of the demonstration projects.~~
454 ~~Statewide phase-in to additional counties shall be contingent~~
455 ~~upon review and approval by the Legislature.~~
456 (b) It is the intent of the Legislature that the low
457 income pool plan required by the terms and conditions of the
458 Medicaid reform waiver and submitted to the Centers for Medicare
459 and Medicaid Services propose the distribution of the program
460 funds in paragraph (a) based on the following objectives:
461 1. Ensure a broad and fair distribution of available funds
462 based on the access provided by Medicaid participating
463 hospitals, regardless of their ownership status, through their
464 delivery of inpatient or outpatient care for Medicaid
465 beneficiaries and uninsured and underinsured individuals.
466 2. Ensure accessible emergency inpatient and outpatient
467 care for Medicaid beneficiaries and uninsured and underinsured
468 individuals.

469 3. Enhance primary, preventive, and other ambulatory care
470 coverages for uninsured individuals.
471 4. Promote teaching and specialty hospital programs.
472 5. Promote the stability and viability of statutorily
473 defined rural hospitals and hospitals that serve as sole
474 community hospitals.
475 6. Recognize the extent of hospital uncompensated care
476 costs.
477 7. Maintain and enhance essential community hospital care.
478 8. Maintain incentives for local governmental entities to
479 contribute to the cost of uncompensated care.
480 9. Promote measures to avoid preventable hospitalizations.
481 10. Account for hospital efficiency.
482 11. Contribute to a community's overall health system.
483 (2) The Legislature intends for the capitated managed care
484 pilot program to:
485 (a) Provide recipients in Medicaid fee-for-service or the
486 MediPass program a comprehensive and coordinated capitated
487 managed care system for all health care services specified in
488 ss. 409.905 and 409.906.
489 (b) Stabilize Medicaid expenditures under the pilot
490 program compared to Medicaid expenditures in the pilot area for
491 the 3 years before implementation of the pilot program, while
492 ensuring:
493 1. Consumer education and choice.
494 2. Access to medically necessary services.
495 3. Coordination of preventative, acute, and long-term
496 care.

497 4. Reductions in unnecessary service utilization.
498 (c) Provide an opportunity to evaluate the feasibility of
499 statewide implementation of capitated managed care networks as a
500 replacement for the current Medicaid fee-for-service and
501 MediPass systems.
502 (3) The agency shall have the following powers, duties,
503 and responsibilities with respect to the ~~development of a~~ pilot
504 program:
505 (a) To implement ~~develop and recommend~~ a system to deliver
506 all mandatory services specified in s. 409.905 and optional
507 services specified in s. 409.906, as approved by the Centers for
508 Medicare and Medicaid Services and the Legislature in the waiver
509 pursuant to this section. Services to recipients under plan
510 benefits shall include emergency services provided under s.
511 409.9128.
512 (b) To implement a pilot program that includes ~~recommend~~
513 Medicaid eligibility categories~~, from those~~ specified in ss.
514 409.903 and 409.904 as authorized in an approved federal waiver~~,~~
515 ~~which shall be included in the pilot program~~.
516 (c) To implement ~~determine and recommend how to design~~ the
517 managed care pilot program that maximizes ~~in order to take~~
518 ~~maximum advantage of~~ all available state and federal funds,
519 including those obtained through intergovernmental transfers,
520 the low income pool, supplemental Medicaid payments ~~upper-~~
521 ~~payment-level funding systems~~, and the disproportionate share
522 program. Within the parameters allowed by federal statute and
523 rule, the agency is authorized to seek options for making direct
524 payments to hospitals and physicians employed by or under

525 contract with the state's medical schools for the costs
526 associated with graduate medical education under Medicaid
527 reform.
528 (d) To implement ~~determine and recommend~~ actuarially
529 sound, risk-adjusted capitation rates for Medicaid recipients in
530 the pilot program which ~~can be separated to~~ cover comprehensive
531 care, enhanced services, and catastrophic care.
532 (e) To implement ~~determine and recommend~~ policies and
533 guidelines for phasing in financial risk for approved provider
534 service networks over a 3-year period. These policies and
535 guidelines shall include an option for a provider service
536 network to be paid ~~to pay~~ fee-for-service rates. For any
537 provider service network established in a managed care pilot
538 area, the option to be paid fee-for-service rates shall include
539 a savings-settlement mechanism that is consistent with s.
540 409.912(44) ~~that may include a savings-settlement option for at~~
541 ~~least 2 years~~. This model shall ~~may~~ be converted to a risk-
542 adjusted capitated rate no later than the beginning of the
543 fourth ~~in the third~~ year of operation and may be converted
544 earlier at the option of the provider service network. Federally
545 qualified health centers may be offered an opportunity to accept
546 or decline a contract to participate in any provider network for
547 prepaid primary care services.
548 (f) To implement ~~determine and recommend provisions~~
549 ~~related to~~ stop-loss requirements and the transfer of excess
550 cost to catastrophic coverage that accommodates the risks
551 associated with the development of the pilot program.

552 (g) To ~~determine and~~ recommend a process to be used by the
553 Social Services Estimating Conference to determine and validate
554 the rate of growth of the per-member costs of providing Medicaid
555 services under the managed care pilot program.
556 (h) To implement ~~determine and recommend~~ program standards
557 and credentialing requirements for capitated managed care
558 networks to participate in the pilot program, including those
559 related to fiscal solvency, quality of care, and adequacy of
560 access to health care providers. It is the intent of the
561 Legislature that, to the extent possible, any pilot program
562 authorized by the state under this section include any federally
563 qualified health center, any federally qualified rural health
564 clinic, county health department, the Division of Children's
565 Medical Services Network within the Department of Health, or any
566 other federally, state, or locally funded entity that serves the
567 geographic areas within the boundaries of the pilot program that
568 requests to participate. This paragraph does not relieve an
569 entity that qualifies as a capitated managed care network under
570 this section from any other licensure or regulatory requirements
571 contained in state or federal law which would otherwise apply to
572 the entity. The standards and credentialing requirements shall
573 be based upon, but are not limited to:
574 1. Compliance with the accreditation requirements as
575 provided in s. 641.512.
576 2. Compliance with early and periodic screening,
577 diagnosis, and treatment screening requirements under federal
578 law.
579 3. The percentage of voluntary disenrollments.

580 4. Immunization rates.
581 5. Standards of the National Committee for Quality
582 Assurance and other approved accrediting bodies.
583 6. Recommendations of other authoritative bodies.
584 7. Specific requirements of the Medicaid program, or
585 standards designed to specifically meet the unique needs of
586 Medicaid recipients.
587 8. Compliance with the health quality improvement system
588 as established by the agency, which incorporates standards and
589 guidelines developed by the Centers for Medicare and Medicaid
590 Services as part of the quality assurance reform initiative.
591 9. The network's infrastructure capacity to manage
592 financial transactions, recordkeeping, data collection, and
593 other administrative functions.
594 10. The network's ability to submit any financial,
595 programmatic, or patient-encounter data or other information
596 required by the agency to determine the actual services provided
597 and the cost of administering the plan.
598 (i) To implement ~~develop and recommend~~ a mechanism for
599 providing information to Medicaid recipients for the purpose of
600 selecting a capitated managed care plan. For each plan available
601 to a recipient, the agency, at a minimum, shall ensure that the
602 recipient is provided with:
603 1. A list and description of the benefits provided.
604 2. Information about cost sharing.
605 3. Plan performance data, if available.
606 4. An explanation of benefit limitations.

607 5. Contact information, including identification of
608 providers participating in the network, geographic locations,
609 and transportation limitations.
610 6. Any other information the agency determines would
611 facilitate a recipient's understanding of the plan or insurance
612 that would best meet his or her needs.
613 (j) To implement ~~develop and recommend~~ a system to ensure
614 that there is a record of recipient acknowledgment that choice
615 counseling has been provided.
616 (k) To implement ~~develop and recommend~~ a choice counseling
617 system to ensure that the choice counseling process and related
618 material are designed to provide counseling through face-to-face
619 interaction, by telephone, and in writing and through other
620 forms of relevant media. Materials shall be written at the
621 fourth-grade reading level and available in a language other
622 than English when 5 percent of the county speaks a language
623 other than English. Choice counseling shall also use language
624 lines and other services for impaired recipients, such as
625 TTD/TTY.
626 (l) To implement ~~develop and recommend~~ a system that
627 prohibits capitated managed care plans, their representatives,
628 and providers employed by or contracted with the capitated
629 managed care plans from recruiting persons eligible for or
630 enrolled in Medicaid, from providing inducements to Medicaid
631 recipients to select a particular capitated managed care plan,
632 and from prejudicing Medicaid recipients against other capitated
633 managed care plans. The system shall require the entity
634 performing choice counseling to determine if the recipient has

635 made a choice of a plan or has opted out because of duress,
636 threats, payment to the recipient, or incentives promised to the
637 recipient by a third party. If the choice counseling entity
638 determines that the decision to choose a plan was unlawfully
639 influenced or a plan violated any of the provisions of s.
640 409.912(21), the choice counseling entity shall immediately
641 report the violation to the agency's program integrity section
642 for investigation. Verification of choice counseling by the
643 recipient shall include a stipulation that the recipient
644 acknowledges the provisions of this subsection.
645 (m) To implement ~~develop and recommend~~ a choice counseling
646 system that promotes health literacy and provides information
647 aimed to reduce minority health disparities through outreach
648 activities for Medicaid recipients.
649 (n) To ~~develop and recommend a system for the agency to~~
650 contract with entities to perform choice counseling. The agency
651 may establish standards and performance contracts, including
652 standards requiring the contractor to hire choice counselors who
653 are representative of the state's diverse population and to
654 train choice counselors in working with culturally diverse
655 populations.
656 (o) To implement ~~determine and recommend descriptions of~~
657 ~~the~~ eligibility assignment processes ~~which will be used~~ to
658 facilitate client choice while ensuring pilot programs of
659 adequate enrollment levels. These processes shall ensure that
660 pilot sites have sufficient levels of enrollment to conduct a
661 valid test of the managed care pilot program within a 2-year
662 timeframe.

663 (p) To implement standards for plan compliance, including,
664 but not limited to, quality assurance and performance
665 improvement standards, peer or professional review standards,
666 grievance policies, and program integrity policies.
667 (q) To develop a data reporting system, seek input from
668 managed care plans to establish patient-encounter reporting
669 requirements, and ensure that the data reported is accurate and
670 complete.
671 (r) To work with managed care plans to establish a uniform
672 system to measure and monitor outcomes of a recipient of
673 Medicaid services which shall use financial, clinical, and other
674 criteria based on pharmacy services, medical services, and other
675 data related to the provision of Medicaid services, including,
676 but not limited to:
677 1. Health Plan Employer Data and Information Set (HEDIS)
678 or HEDIS measures specific to Medicaid.
679 2. Member satisfaction.
680 3. Provider satisfaction.
681 4. Report cards on plan performance and best practices.
682 5. Compliance with the prompt payment of claims
683 requirements provided in ss. 627.613, 641.3155, and 641.513.
684 (s) To require managed care plans that have contracted
685 with the agency to establish a quality assurance system that
686 incorporates the provisions of s. 409.912(27) and any standards,
687 rules, and guidelines developed by the agency.
688 (t) To establish a patient-encounter database to compile
689 data on health care services rendered by health care
690 practitioners that provide services to patients enrolled in

691 managed care plans in the demonstration sites. Health care
692 practitioners and facilities in the demonstration sites shall
693 submit, and managed care plans participating in the
694 demonstration sites shall receive, claims payment and any other
695 information reasonably related to the patient-encounter database
696 electronically in a standard format as required by the agency.
697 The agency shall establish reasonable deadlines for phasing in
698 the electronic transmittal of full-encounter data. The patient-
699 encounter database shall:
700 1. Collect the following information, if applicable, for
701 each type of patient encounter with a health care practitioner
702 or facility, including:
703 a. The demographic characteristics of the patient.
704 b. The principal, secondary, and tertiary diagnosis.
705 c. The procedure performed.
706 d. The date when and the location where the procedure was
707 performed.
708 e. The amount of the payment for the procedure.
709 f. The health care practitioner's universal identification
710 number.
711 g. If the health care practitioner rendering the service
712 is a dependent practitioner, the modifiers appropriate to
713 indicate that the service was delivered by the dependent
714 practitioner.
715 2. Collect appropriate information relating to
716 prescription drugs for each type of patient encounter.
717 3. Collect appropriate information related to health care
718 costs and utilization from managed care plans participating in

719 the demonstration sites. To the extent practicable, the agency
720 shall utilize a standardized claim form or electronic transfer
721 system that is used by health care practitioners, facilities,
722 and payors. ~~To develop and recommend a system to monitor the~~
723 ~~provision of health care services in the pilot program,~~
724 ~~including utilization and quality of health care services for~~
725 ~~the purpose of ensuring access to medically necessary services.~~
726 ~~This system shall include an encounter data information system~~
727 ~~that collects and reports utilization information. The system~~
728 ~~shall include a method for verifying data integrity within the~~
729 ~~database and within the provider's medical records.~~
730 (u) ~~(q)~~ To implement ~~recommend~~ a grievance resolution
731 process for Medicaid recipients enrolled in a capitated managed
732 care network under the pilot program modeled after the
733 subscriber assistance panel, as created in s. 408.7056. This
734 process shall include a mechanism for an expedited review of no
735 greater than 24 hours after notification of a grievance if the
736 life of a Medicaid recipient is in imminent and emergent
737 jeopardy.
738 (v) ~~(r)~~ To implement ~~recommend~~ a grievance resolution
739 process for health care providers employed by or contracted with
740 a capitated managed care network under the pilot program in
741 order to settle disputes among the provider and the managed care
742 network or the provider and the agency.
743 (w) ~~(s)~~ To implement ~~develop and recommend~~ criteria in an
744 approved federal waiver to designate health care providers as
745 eligible to participate in the pilot program. ~~The agency and~~
746 ~~capitated managed care networks must follow national guidelines~~

747 ~~for selecting health care providers, whenever available.~~ These
748 criteria must include at a minimum those criteria specified in
749 s. 409.907.
750 (x) ~~(t)~~ To use ~~develop and recommend~~ health care provider
751 agreements for participation in the pilot program.
752 (y) ~~(u)~~ To require that all health care providers under
753 contract with the pilot program be duly licensed in the state,
754 if such licensure is available, and meet other criteria as may
755 be established by the agency. These criteria shall include at a
756 minimum those criteria specified in s. 409.907.
757 (z) ~~(v)~~ To ensure that managed care organizations work
758 collaboratively ~~develop and recommend agreements~~ with other
759 state or local governmental programs or institutions for the
760 coordination of health care to eligible individuals receiving
761 services from such programs or institutions.
762 (aa) ~~(w)~~ To implement procedures to minimize the risk of
763 Medicaid fraud and abuse in all plans operating in the Medicaid
764 managed care pilot program authorized in this section:
765 1. The agency shall ensure that applicable provisions of
766 chapters 409, 414, 626, 641, and 932, relating to Medicaid fraud
767 and abuse, are applied and enforced at the demonstration sites.
768 2. Providers shall have the necessary certification,
769 license, and credentials required by law and federal waiver.
770 3. The agency shall ensure that the plan is in compliance
771 with the provisions of s. 409.912(21) and (22).
772 4. The agency shall require each plan to establish program
773 integrity functions and activities to reduce the incidence of

774 fraud and abuse. Plans must report instances of fraud and abuse
775 pursuant to chapter 641.
776 5. The plan shall have written administrative and
777 management procedures, including a mandatory compliance plan,
778 that are designed to guard against fraud and abuse. The plan
779 shall designate a compliance officer with sufficient experience
780 in health care.
781 6.a. The agency shall require all managed care plan
782 contractors in the pilot program to report all instances of
783 suspected fraud and abuse. A failure to report instances of
784 suspected fraud and abuse is a violation of law and subject to
785 the penalties provided by law.
786 b. An instance of fraud and abuse in the managed care
787 plan, including, but not limited to, defrauding the state health
788 care benefit program by misrepresentation of fact in reports,
789 claims, certifications, enrollment claims, demographic
790 statistics, and patient-encounter data; misrepresentation of the
791 qualifications of persons rendering health care and ancillary
792 services; bribery and false statements relating to the delivery
793 of health care; unfair and deceptive marketing practices; and
794 managed care false claims actions, is a violation of law and
795 subject to the penalties provided by law.
796 c. The agency shall require all contractors to make all
797 files and relevant billing and claims data accessible to state
798 regulators and investigators and all such data shall be linked
799 into a unified system for seamless reviews and investigations.
800 ~~To develop and recommend a system to oversee the activities of~~
801 ~~pilot program participants, health care providers, capitated~~

802 managed care networks, and their representatives in order to
803 prevent fraud or abuse, overutilization or duplicative
804 utilization, underutilization or inappropriate denial of
805 services, and neglect of participants and to recover
806 overpayments as appropriate. For the purposes of this paragraph,
807 the terms "abuse" and "fraud" have the meanings as provided in
808 s. 409.913. The agency must refer incidents of suspected fraud,
809 abuse, overutilization and duplicative utilization, and
810 underutilization or inappropriate denial of services to the
811 appropriate regulatory agency.
812 (bb) (x) To develop and provide actuarial and benefit
813 design analyses that indicate the effect on capitation rates and
814 benefits offered in the pilot program over a prospective 5-year
815 period based on the following assumptions:
816 1. Growth in capitation rates which is limited to the
817 estimated growth rate in general revenue.
818 2. Growth in capitation rates which is limited to the
819 average growth rate over the last 3 years in per-recipient
820 Medicaid expenditures.
821 3. Growth in capitation rates which is limited to the
822 growth rate of aggregate Medicaid expenditures between the 2003-
823 2004 fiscal year and the 2004-2005 fiscal year.
824 (cc) (y) To develop a mechanism to require capitated
825 managed care plans to reimburse qualified emergency service
826 providers, including, but not limited to, ambulance services, in
827 accordance with ss. 409.908 and 409.9128. The pilot program must
828 include a provision for continuing fee-for-service payments for
829 emergency services, including, but not limited to, individuals

830 who access ambulance services or emergency departments and who
831 are subsequently determined to be eligible for Medicaid
832 services.
833 (dd) ~~(z)~~ To ensure ~~develop a system whereby~~ school
834 districts participating in the certified school match program
835 pursuant to ss. 409.908(21) and 1011.70 shall be reimbursed by
836 Medicaid, subject to the limitations of s. 1011.70(1), for a
837 Medicaid-eligible child participating in the services as
838 authorized in s. 1011.70, as provided for in s. 409.9071,
839 regardless of whether the child is enrolled in a capitated
840 managed care network. Capitated managed care networks must make
841 a good faith effort to execute agreements with school districts
842 regarding the coordinated provision of services authorized under
843 s. 1011.70. County health departments delivering school-based
844 services pursuant to ss. 381.0056 and 381.0057 must be
845 reimbursed by Medicaid for the federal share for a Medicaid-
846 eligible child who receives Medicaid-covered services in a
847 school setting, regardless of whether the child is enrolled in a
848 capitated managed care network. Capitated managed care networks
849 must make a good faith effort to execute agreements with county
850 health departments regarding the coordinated provision of
851 services to a Medicaid-eligible child. To ensure continuity of
852 care for Medicaid patients, the agency, the Department of
853 Health, and the Department of Education shall develop procedures
854 for ensuring that a student's capitated managed care network
855 provider receives information relating to services provided in
856 accordance with ss. 381.0056, 381.0057, 409.9071, and 1011.70.

857 (ee) ~~(aa)~~ To implement ~~develop and recommend~~ a mechanism
858 whereby Medicaid recipients who are already enrolled in a
859 managed care plan or the MediPass program in the pilot areas
860 shall be offered the opportunity to change to capitated managed
861 care plans on a staggered basis, as defined by the agency. All
862 Medicaid recipients shall have 30 days in which to make a choice
863 of capitated managed care plans. Those Medicaid recipients who
864 do not make a choice shall be assigned to a capitated managed
865 care plan in accordance with paragraph (4)(a) and shall be
866 exempt from s. 409.9122. To facilitate continuity of care for a
867 Medicaid recipient who is also a recipient of Supplemental
868 Security Income (SSI), prior to assigning the SSI recipient to a
869 capitated managed care plan, the agency shall determine whether
870 the SSI recipient has an ongoing relationship with a provider or
871 capitated managed care plan, and, if so, the agency shall assign
872 the SSI recipient to that provider or capitated managed care
873 plan where feasible. Those SSI recipients who do not have such a
874 provider relationship shall be assigned to a capitated managed
875 care plan provider in accordance with paragraph (4)(a) and shall
876 be exempt from s. 409.9122.
877 (ff) ~~(bb)~~ To develop and recommend a service delivery
878 alternative for children having chronic medical conditions which
879 establishes a medical home project to provide primary care
880 services to this population. The project shall provide
881 community-based primary care services that are integrated with
882 other subspecialties to meet the medical, developmental, and
883 emotional needs for children and their families. This project
884 shall include an evaluation component to determine impacts on

885 hospitalizations, length of stays, emergency room visits, costs,
886 and access to care, including specialty care and patient and
887 family satisfaction.
888 (gg) ~~(cc)~~ To develop and recommend service delivery
889 mechanisms within capitated managed care plans to provide
890 Medicaid services as specified in ss. 409.905 and 409.906 to
891 persons with developmental disabilities sufficient to meet the
892 medical, developmental, and emotional needs of these persons.
893 (hh) ~~(dd)~~ To develop and recommend service delivery
894 mechanisms within capitated managed care plans to provide
895 Medicaid services as specified in ss. 409.905 and 409.906 to
896 Medicaid-eligible children in foster care. These services must
897 be coordinated with community-based care providers as specified
898 in s. 409.1675, where available, and be sufficient to meet the
899 medical, developmental, and emotional needs of these children.
900 (4)(a) A Medicaid recipient in the pilot area who is not
901 currently enrolled in a capitated managed care plan upon
902 implementation is not eligible for services as specified in ss.
903 409.905 and 409.906, for the amount of time that the recipient
904 does not enroll in a capitated managed care network. If a
905 Medicaid recipient has not enrolled in a capitated managed care
906 plan within 30 days after eligibility, the agency shall assign
907 the Medicaid recipient to a capitated managed care plan based on
908 the assessed needs of the recipient as determined by the agency
909 and shall be exempt from s. 409.9122. When making assignments,
910 the agency shall take into account the following criteria:
911 1. A capitated managed care network has sufficient network
912 capacity to meet the needs of members.

913 2. The capitated managed care network has previously
914 enrolled the recipient as a member, or one of the capitated
915 managed care network's primary care providers has previously
916 provided health care to the recipient.
917 3. The agency has knowledge that the member has previously
918 expressed a preference for a particular capitated managed care
919 network as indicated by Medicaid fee-for-service claims data,
920 but has failed to make a choice.
921 4. The capitated managed care network's primary care
922 providers are geographically accessible to the recipient's
923 residence.
924 (b) When more than one capitated managed care network
925 provider meets the criteria specified in paragraph (3)(h), the
926 agency shall make recipient assignments consecutively by family
927 unit.
928 (c) If a recipient is currently enrolled with a Medicaid
929 managed care organization that also operates an approved reform
930 plan within a pilot area and the recipient fails to choose a
931 plan during the reform enrollment process or during
932 redetermination of eligibility, the recipient shall be
933 automatically assigned by the agency into the most appropriate
934 reform plan operated by the recipient's current Medicaid managed
935 care organization. If the recipient's current managed care
936 organization does not operate a reform plan in the pilot area
937 that adequately meets the needs of the Medicaid recipient, the
938 agency shall use the auto assignment process as prescribed in
939 the Centers for Medicare and Medicaid Services Special Terms and
940 Conditions number 11-W-00206/4. All agency enrollment and choice

941 counseling materials shall communicate the provisions of this
942 paragraph to current managed care recipients.
943 (d) ~~(c)~~ The agency may not engage in practices that are
944 designed to favor one capitated managed care plan over another
945 or that are designed to influence Medicaid recipients to enroll
946 in a particular capitated managed care network in order to
947 strengthen its particular fiscal viability.
948 (e) ~~(d)~~ After a recipient has made a selection or has been
949 enrolled in a capitated managed care network, the recipient
950 shall have 90 days in which to voluntarily disenroll and select
951 another capitated managed care network. After 90 days, no
952 further changes may be made except for cause. Cause shall
953 include, but not be limited to, poor quality of care, lack of
954 access to necessary specialty services, an unreasonable delay or
955 denial of service, inordinate or inappropriate changes of
956 primary care providers, service access impairments due to
957 significant changes in the geographic location of services, or
958 fraudulent enrollment. The agency may require a recipient to use
959 the capitated managed care network's grievance process as
960 specified in paragraph (3)(g) prior to the agency's
961 determination of cause, except in cases in which immediate risk
962 of permanent damage to the recipient's health is alleged. The
963 grievance process, when used, must be completed in time to
964 permit the recipient to disenroll no later than the first day of
965 the second month after the month the disenrollment request was
966 made. If the capitated managed care network, as a result of the
967 grievance process, approves an enrollee's request to disenroll,
968 the agency is not required to make a determination in the case.

969 The agency must make a determination and take final action on a
970 recipient's request so that disenrollment occurs no later than
971 the first day of the second month after the month the request
972 was made. If the agency fails to act within the specified
973 timeframe, the recipient's request to disenroll is deemed to be
974 approved as of the date agency action was required. Recipients
975 who disagree with the agency's finding that cause does not exist
976 for disenrollment shall be advised of their right to pursue a
977 Medicaid fair hearing to dispute the agency's finding.
978 (f) ~~(e)~~ The agency shall apply for federal waivers from the
979 Centers for Medicare and Medicaid Services to lock eligible
980 Medicaid recipients into a capitated managed care network for 12
981 months after an open enrollment period. After 12 months of
982 enrollment, a recipient may select another capitated managed
983 care network. However, nothing shall prevent a Medicaid
984 recipient from changing primary care providers within the
985 capitated managed care network during the 12-month period.
986 (g) ~~(f)~~ The agency shall apply for federal waivers from the
987 Centers for Medicare and Medicaid Services to allow recipients
988 to purchase health care coverage through an employer-sponsored
989 health insurance plan instead of through a Medicaid-certified
990 plan. This provision shall be known as the opt-out option.
991 1. A recipient who chooses the Medicaid opt-out option
992 shall have an opportunity for a specified period of time, as
993 authorized under a waiver granted by the Centers for Medicare
994 and Medicaid Services, to select and enroll in a Medicaid-
995 certified plan. If the recipient remains in the employer-
996 sponsored plan after the specified period, the recipient shall

997 remain in the opt-out program for at least 1 year or until the
998 recipient no longer has access to employer-sponsored coverage,
999 until the employer's open enrollment period for a person who
1000 opts out in order to participate in employer-sponsored coverage,
1001 or until the person is no longer eligible for Medicaid,
1002 whichever time period is shorter.
1003 2. Notwithstanding any other provision of this section,
1004 coverage, cost sharing, and any other component of employer-
1005 sponsored health insurance shall be governed by applicable state
1006 and federal laws.
1007 ~~(5) This section does not authorize the agency to~~
1008 ~~implement any provision of s. 1115 of the Social Security Act~~
1009 ~~experimental, pilot, or demonstration project waiver to reform~~
1010 ~~the state Medicaid program in any part of the state other than~~
1011 ~~the two geographic areas specified in this section unless~~
1012 ~~approved by the Legislature.~~
1013 (5) ~~(6)~~ The agency shall develop and submit for approval
1014 applications for waivers of applicable federal laws and
1015 regulations as necessary to implement the managed care pilot
1016 project as defined in this section. The agency shall post all
1017 waiver applications under this section on its Internet website
1018 30 days before submitting the applications to the United States
1019 Centers for Medicare and Medicaid Services. All waiver
1020 applications shall be provided for review and comment to the
1021 appropriate committees of the Senate and House of
1022 Representatives for at least 10 working days prior to
1023 submission. All waivers submitted to and approved by the United
1024 States Centers for Medicare and Medicaid Services under this

1025 section must be approved by the Legislature. Federally approved
1026 waivers must be submitted to the President of the Senate and the
1027 Speaker of the House of Representatives for referral to the
1028 appropriate legislative committees. The appropriate committees
1029 shall recommend whether to approve the implementation of any
1030 waivers to the Legislature as a whole. The agency shall submit a
1031 plan containing a recommended timeline for implementation of any
1032 waivers and budgetary projections of the effect of the pilot
1033 program under this section on the total Medicaid budget for the
1034 2006-2007 through 2009-2010 state fiscal years. This
1035 implementation plan shall be submitted to the President of the
1036 Senate and the Speaker of the House of Representatives at the
1037 same time any waivers are submitted for consideration by the
1038 Legislature. The agency is authorized to implement the waiver
1039 and Centers for Medicare and Medicaid Services Special Terms and
1040 Conditions number 11-W-00206/4. If the agency seeks approval by
1041 the Federal Government of any modifications to these special
1042 terms and conditions, the agency shall provide written
1043 notification of its intent to modify these terms and conditions
1044 to the President of the Senate and Speaker of the House of
1045 Representatives at least 15 days prior to submitting the
1046 modifications to the Federal Government for consideration. The
1047 notification shall identify all modifications being pursued and
1048 the reason they are needed. Upon receiving federal approval of
1049 any modifications to the special terms and conditions, the
1050 agency shall report to the Legislature describing the federally
1051 approved modifications to the special terms and conditions
1052 within 7 days after their approval by the Federal Government.

1053 (6) ~~(7)~~ Upon review and approval of the applications for
1054 waivers of applicable federal laws and regulations to implement
1055 the managed care pilot program by the Legislature, the agency
1056 may initiate adoption of rules pursuant to ss. 120.536(1) and
1057 120.54 to implement and administer the managed care pilot
1058 program as provided in this section and the agency shall
1059 initiate adoption of rules pursuant to ss. 120.536(1) and 120.54
1060 to develop, implement, and administer the following provisions
1061 of the managed care pilot program:
1062 (a) Risk-adjusted capitation rates pursuant to paragraph
1063 (3)(d).
1064 (b) A mechanism for providing information to Medicaid
1065 recipients pursuant to paragraph (3)(i).
1066 (c) A choice counseling system pursuant to paragraphs
1067 (3)(k), (l), and (m).
1068 (7)(a) The Office of Insurance Regulation shall provide
1069 ongoing guidance to the agency in the implementation of risk-
1070 adjusted rates. Beginning on the effective date of this act, the
1071 Office of Insurance Regulation shall make advisory
1072 recommendations to the agency regarding the following items:
1073 1. The methodology adopted by the agency for risk-adjusted
1074 rates, including any suggestions to improve the predictive value
1075 of the system.
1076 2. Alternative options based on the agency's methodology.
1077 3. The risk-adjusted rate for each Medicaid eligibility
1078 category in the demonstration program.

1079 4. Administrative and implementation issues regarding the
1080 use of risk-adjusted rates, including, but not limited to, cost,
1081 simplicity, client privacy, data accuracy, and data exchange.
1082 5. The appropriateness of phasing in risk-adjusted rates.
1083 (b) As a part of this process, the Office of Insurance
1084 Regulation shall contract with an independent actuary firm to
1085 assist in the annual review and to provide technical expertise.
1086 (c) As a part of this process, the agency shall solicit
1087 input concerning the agency's rate setting methodology from the
1088 Florida Association of Health Plans, the Florida Hospital
1089 Association, the Florida Medical Association, Medicaid recipient
1090 advocacy groups, and other stakeholder representatives as
1091 necessary to obtain a broad representation of perspectives on
1092 the effects of the agency's adopted rate setting methodology and
1093 recommendations on possible modifications to the methodology.
1094 (d) The Office of Insurance Regulation shall submit a
1095 report of its findings and advisory recommendations to the
1096 Governor, the President of the Senate, and the Speaker of the
1097 House of Representatives prior to the implementation of risk-
1098 adjusted rates on July 1, 2006, and annually thereafter no later
1099 than February 1 of each year for consideration by the
1100 Legislature for inclusion in the General Appropriations Act.
1101 (8) Any provision of law to the contrary notwithstanding,
1102 adjustments to risk-adjusted capitation rates shall be
1103 implemented through rules of the agency, as required by s.
1104 409.9124, based upon the recommendation of the committee.
1105 (9) The capitation rates for plans participating under
1106 this section shall be phased in as follows:

1107 (a) In the first fiscal year, the capitation rates shall
1108 be weighted so that 75 percent of each capitation rate is based
1109 upon the current methodology and 25 percent is based upon a new
1110 risk-adjusted capitation rate methodology.
1111 (b) In the second fiscal year, the capitation rates shall
1112 be weighted so that 50 percent of each capitation rate is based
1113 upon the current methodology and 50 percent is based upon a new
1114 risk-adjusted rate methodology.
1115 (c) In the third fiscal year, the capitation rates shall
1116 be weighted so that 25 percent of each capitation rate is based
1117 upon the current methodology and 75 percent is based upon a new
1118 risk-adjusted capitation rate methodology.
1119 (d) In the following fiscal year, the risk-adjusted
1120 capitation rate methodology may be fully implemented.
1121 (10) The agency must ensure the following when using a
1122 risk-adjustment rate methodology in whole or part:
1123 (a) The agency's total annual payment shall be based on
1124 each managed care plan's own aggregate risk score, except that
1125 in no case shall the aggregate risk score of any managed care
1126 plan in an area vary by more than 10 percent from the aggregate
1127 weighted mean of all managed care plans providing comprehensive
1128 benefits to TANF and SSI recipients in that area. The agency's
1129 total annual payment to a managed care plan shall be based on
1130 such revised aggregate risk score.
1131 (b) After any adjustments required pursuant to paragraph
1132 (a), the aggregate payments calculated to be made to managed
1133 care plans on behalf of enrollees in any pilot area must be no
1134 less than what the aggregate payments would have been using the

1135 current rate methodology under s. 409.9124. If the agency
1136 determines that such aggregate payments under the risk-adjusted
1137 methodology will be lower than the aggregate payments that the
1138 plans would have been paid using the current rate methodology
1139 under s. 409.9124, supplemental payments shall be made to
1140 managed care plans so that the proportion of overall revenue
1141 remains the same on an aggregate basis per plan. Such
1142 supplemental payments shall be made to bring total payments up
1143 to the amount that would have been paid under s. 409.9124.
1144 (11) Prior to the implementation of risk-adjusted
1145 capitation rates, the rates shall be certified by an actuary and
1146 approved by the Centers for Medicare and Medicaid Services.
1147 (12) For purposes of this section, the term "capitated
1148 managed care plan" includes health insurers authorized under
1149 chapter 624, exclusive provider organizations authorized under
1150 chapter 627, health maintenance organizations authorized under
1151 chapter 641, and provider service networks that elect to be paid
1152 fee-for-service for up to 3 years as authorized under this
1153 section.
1154 Section 5. Section 409.91212, Florida Statutes, is created
1155 to read:
1156 409.91212 Medicaid reform demonstration program
1157 expansion.--
1158 (1) The agency may expand the Medicaid reform
1159 demonstration program pursuant to s. 409.91211 into any county
1160 of the state beginning in year two of the demonstration program
1161 if readiness criteria are met, the Joint Legislative Committee
1162 on Medicaid Reform Implementation has submitted a recommendation

1163 pursuant to s. 11.72 regarding the extent to which the criteria
1164 have been met, and the agency has secured budget approval from
1165 the Legislative Budget Commission pursuant to s. 11.90. For the
1166 purpose of this section, the term "readiness" means there is
1167 evidence that at least two programs in a county meet the
1168 following criteria:
1169 (a) Demonstrate knowledge and understanding of managed
1170 care under the framework of Medicaid reform.
1171 (b) Demonstrate financial capability to meet solvency
1172 standards.
1173 (c) Demonstrate adequate controls and process for
1174 financial management.
1175 (d) Demonstrate the capability for clinical management of
1176 Medicaid recipients.
1177 (e) Demonstrate the adequacy, capacity, and accessibility
1178 of the services network.
1179 (f) Demonstrate the capability to operate a management
1180 information system and an encounter data system.
1181 (g) Demonstrate capability to implement quality assurance
1182 and utilization management activities.
1183 (h) Demonstrate capability to implement fraud control
1184 activities.
1185 (2) The agency shall conduct meetings and public hearings
1186 in the targeted expansion county with the public and provider
1187 community. The agency shall provide notice regarding public
1188 hearings. The agency shall maintain records of the proceedings.
1189 (3) The agency shall provide a 30-day notice of intent to
1190 expand the demonstration program with supporting documentation

1191 that the readiness criteria has been met to the President of the
1192 Senate, the Speaker of the House of Representatives, the
1193 Minority Leader of the Senate, the Minority Leader of the House
1194 of Representatives, and the Office of Program Policy Analysis
1195 and Government Accountability.
1196 (4) The agency shall request a hearing and consideration
1197 by the Joint Legislative Committee on Medicaid Reform
1198 Implementation after the 30-day notice required in subsection
1199 (3) has expired in the form of a letter to the chair of the
1200 committee.
1201 (5) Upon receiving a memorandum from the Joint Legislative
1202 Committee on Medicaid Reform Implementation regarding the extent
1203 to which the expansion criteria pursuant to subsection (1) have
1204 been met, the agency may submit a budget amendment, pursuant to
1205 chapter 216, to request the necessary budget transfers
1206 associated with the expansion of the demonstration program.
1207 Section 6. Subsections (8) through (14) of section
1208 409.9122, Florida Statutes, are renumbered as subsections (7)
1209 through (13), respectively, and paragraphs (e), (f), (g), (h),
1210 (k), and (l) of subsection (2) and present subsection (7) of
1211 that section are amended to read:
1212 409.9122 Mandatory Medicaid managed care enrollment;
1213 programs and procedures.--
1214 (2)
1215 (e) ~~Medicaid recipients who are already enrolled in a~~
1216 ~~managed care plan or MediPass shall be offered the opportunity~~
1217 ~~to change managed care plans or MediPass providers on a~~
1218 ~~staggered basis, as defined by the agency.~~ All Medicaid

1219 recipients shall have 30 days in which to make a choice of
1220 managed care plans or MediPass providers. ~~Those Medicaid~~
1221 ~~recipients who do not make a choice shall be assigned to a~~
1222 ~~managed care plan or MediPass in accordance with paragraph (f).~~
1223 ~~To facilitate continuity of care, for a Medicaid recipient who~~
1224 ~~is also a recipient of Supplemental Security Income (SSI), prior~~
1225 ~~to assigning the SSI recipient to a managed care plan or~~
1226 ~~MediPass, the agency shall determine whether the SSI recipient~~
1227 ~~has an ongoing relationship with a MediPass provider or managed~~
1228 ~~care plan, and if so, the agency shall assign the SSI recipient~~
1229 ~~to that MediPass provider or managed care plan. Those SSI~~
1230 ~~recipients who do not have such a provider relationship shall be~~
1231 ~~assigned to a managed care plan or MediPass provider in~~
1232 ~~accordance with paragraph (f).~~
1233 (f) When a Medicaid recipient does not choose a managed
1234 care plan or MediPass provider, the agency shall assign the
1235 Medicaid recipient to a managed care plan ~~or MediPass provider~~.
1236 Medicaid recipients who are subject to mandatory assignment but
1237 who fail to make a choice shall be assigned to managed care
1238 plans ~~until an enrollment of 40 percent in MediPass and 60~~
1239 ~~percent in managed care plans is achieved~~. ~~Once this enrollment~~
1240 ~~is achieved, the assignments shall be divided in order to~~
1241 ~~maintain an enrollment in MediPass and managed care plans which~~
1242 ~~is in a 40 percent and 60 percent proportion, respectively.~~
1243 ~~Thereafter, assignment of Medicaid recipients who fail to make a~~
1244 ~~choice shall be based proportionally on the preferences of~~
1245 ~~recipients who have made a choice in the previous period. Such~~
1246 ~~proportions shall be revised at least quarterly to reflect an~~

1247 ~~update of the preferences of Medicaid recipients. The agency~~
1248 ~~shall disproportionately assign Medicaid-eligible recipients who~~
1249 ~~are required to but have failed to make a choice of managed care~~
1250 ~~plan or MediPass, including children, and who are to be assigned~~
1251 ~~to the MediPass program to children's networks as described in~~
1252 ~~s. 409.912(4)(g), Children's Medical Services Network as defined~~
1253 ~~in s. 391.021, exclusive provider organizations, provider~~
1254 ~~service networks, minority physician networks, and pediatric~~
1255 ~~emergency department diversion programs authorized by this~~
1256 ~~chapter or the General Appropriations Act, in such manner as the~~
1257 ~~agency deems appropriate, until the agency has determined that~~
1258 ~~the networks and programs have sufficient numbers to be~~
1259 ~~economically operated.~~ For purposes of this paragraph, when
1260 referring to assignment, the term "managed care plans" includes
1261 health maintenance organizations, exclusive provider
1262 organizations, provider service networks, minority physician
1263 networks, Children's Medical Services Network, and pediatric
1264 emergency department diversion programs authorized by this
1265 chapter or the General Appropriations Act. When making
1266 assignments, the agency shall take into account the following
1267 criteria:
1268 1. A managed care plan has sufficient network capacity to
1269 meet the need of members.
1270 2. The managed care plan ~~or MediPass~~ has previously
1271 enrolled the recipient as a member, or one of the managed care
1272 plan's primary care providers ~~or MediPass providers~~ has
1273 previously provided health care to the recipient.

1274 3. The agency has knowledge that the member has previously
1275 expressed a preference for a particular managed care plan or
1276 MediPass provider as indicated by Medicaid fee-for-service
1277 claims data, but has failed to make a choice.
1278 4. The managed care plan is ~~plan's or MediPass primary~~
1279 ~~care providers are~~ geographically accessible to the recipient's
1280 residence.
1281 5. The agency has authority to make mandatory assignments
1282 based on quality of service and performance of managed care
1283 plans.
1284 (g) When more than one managed care plan ~~or MediPass~~
1285 ~~provider~~ meets the criteria specified in paragraph (f), the
1286 agency shall make recipient assignments consecutively by family
1287 unit.
1288 (h) The agency may not engage in practices that are
1289 designed to favor one managed care plan over another ~~or that are~~
1290 ~~designed to influence Medicaid recipients to enroll in MediPass~~
1291 ~~rather than in a managed care plan or to enroll in a managed~~
1292 ~~care plan rather than in MediPass~~. This subsection does not
1293 prohibit the agency from reporting on the performance of
1294 MediPass or any managed care plan, as measured by performance
1295 criteria developed by the agency.
1296 ~~(k) When a Medicaid recipient does not choose a managed~~
1297 ~~care plan or MediPass provider, the agency shall assign the~~
1298 ~~Medicaid recipient to a managed care plan, except in those~~
1299 ~~counties in which there are fewer than two managed care plans~~
1300 ~~accepting Medicaid enrollees, in which case assignment shall be~~
1301 ~~to a managed care plan or a MediPass provider. Medicaid~~

1302 ~~recipients in counties with fewer than two managed care plans~~
1303 ~~accepting Medicaid enrollees who are subject to mandatory~~
1304 ~~assignment but who fail to make a choice shall be assigned to~~
1305 ~~managed care plans until an enrollment of 40 percent in MediPass~~
1306 ~~and 60 percent in managed care plans is achieved. Once that~~
1307 ~~enrollment is achieved, the assignments shall be divided in~~
1308 ~~order to maintain an enrollment in MediPass and managed care~~
1309 ~~plans which is in a 40 percent and 60 percent proportion,~~
1310 ~~respectively. In service areas 1 and 6 of the Agency for Health~~
1311 ~~Care Administration where the agency is contracting for the~~
1312 ~~provision of comprehensive behavioral health services through a~~
1313 ~~capitated prepaid arrangement, recipients who fail to make a~~
1314 ~~choice shall be assigned equally to MediPass or a managed care~~
1315 ~~plan. For purposes of this paragraph, when referring to~~
1316 ~~assignment, the term "managed care plans" includes exclusive~~
1317 ~~provider organizations, provider service networks, Children's~~
1318 ~~Medical Services Network, minority physician networks, and~~
1319 ~~pediatric emergency department diversion programs authorized by~~
1320 ~~this chapter or the General Appropriations Act. When making~~
1321 ~~assignments, the agency shall take into account the following~~
1322 ~~criteria:~~
1323 ~~1. A managed care plan has sufficient network capacity to~~
1324 ~~meet the need of members.~~
1325 ~~2. The managed care plan or MediPass has previously~~
1326 ~~enrolled the recipient as a member, or one of the managed care~~
1327 ~~plan's primary care providers or MediPass providers has~~
1328 ~~previously provided health care to the recipient.~~

1329 ~~3. The agency has knowledge that the member has previously~~
1330 ~~expressed a preference for a particular managed care plan or~~
1331 ~~MediPass provider as indicated by Medicaid fee-for-service~~
1332 ~~claims data, but has failed to make a choice.~~
1333 ~~4. The managed care plan's or MediPass primary care~~
1334 ~~providers are geographically accessible to the recipient's~~
1335 ~~residence.~~
1336 ~~5. The agency has authority to make mandatory assignments~~
1337 ~~based on quality of service and performance of managed care~~
1338 ~~plans.~~
1339 (k) ~~(l)~~ Notwithstanding the provisions of chapter 287, the
1340 agency may, at its discretion, renew cost-effective contracts
1341 for choice counseling services once or more for such periods as
1342 the agency may decide. However, all such renewals may not
1343 combine to exceed a total period longer than the term of the
1344 original contract.
1345 ~~(7) The agency shall investigate the feasibility of~~
1346 ~~developing managed care plan and MediPass options for the~~
1347 ~~following groups of Medicaid recipients:~~
1348 ~~(a) Pregnant women and infants.~~
1349 ~~(b) Elderly and disabled recipients, especially those who~~
1350 ~~are at risk of nursing home placement.~~
1351 ~~(c) Persons with developmental disabilities.~~
1352 ~~(d) Qualified Medicare beneficiaries.~~
1353 ~~(e) Adults who have chronic, high-cost medical conditions.~~
1354 ~~(f) Adults and children who have mental health problems.~~

1355 ~~(g) Other recipients for whom managed care plans and~~
1356 ~~MediPass offer the opportunity of more cost-effective care and~~
1357 ~~greater access to qualified providers.~~
1358 Section 7. The Agency for Health Care Administration shall
1359 report to the Legislature by April 1, 2006, the specific
1360 preimplementation milestones required by the Centers for
1361 Medicare and Medicaid Services Special Terms and Conditions
1362 related to the low income pool that have been approved by the
1363 Federal Government and the status of any remaining
1364 preimplementation milestones that have not been approved by the
1365 Federal Government.
1366 Section 8. Quarterly progress and annual reports.--The
1367 Agency for Health Care Administration shall submit to the
1368 Governor, the President of the Senate, the Speaker of the House
1369 of Representatives, the Minority Leader of the Senate, the
1370 Minority Leader of the House of Representatives, and the Office
1371 of Program Policy Analysis and Government Accountability the
1372 following reports:
1373 (1) Quarterly progress reports submitted to Centers for
1374 Medicare and Medicaid Services no later than 60 days following
1375 the end of each quarter. These reports shall present the
1376 agency's analysis and the status of various operational areas.
1377 The quarterly progress reports shall include, but are not
1378 limited to, the following:
1379 (a) Documentation of events that occurred during the
1380 quarter or that are anticipated to occur in the near future that
1381 affect health care delivery, including, but not limited to, the
1382 approval of contracts with new managed care plans, the

1383 procedures for designating coverage areas, the process of
1384 phasing in managed care, a description of the populations served
1385 and the benefits provided, the number of recipients enrolled, a
1386 list of grievances submitted by enrollees, and other operational
1387 issues.
1388 (b) Action plans for addressing policy and administrative
1389 issues.
1390 (c) Documentation of agency efforts related to the
1391 collection and verification of encounter and utilization data.
1392 (d) Enrollment data for each managed care plan according
1393 to the following specifications: total number of enrollees,
1394 eligibility category, number of enrollees receiving Temporary
1395 Assistance for Needy Families or Supplemental Security Income,
1396 market share, and percentage change in enrollment. In addition,
1397 the agency shall provide a summary of voluntary and mandatory
1398 selection rates and disenrollment data. Enrollment data, number
1399 of members by month, and expenditures shall be submitted in the
1400 format for monitoring budget neutrality provided by the Centers
1401 for Medicare and Medicaid Services.
1402 (e) Documentation of low income pool activities and
1403 associated expenditures.
1404 (f) Documentation of activities related to the
1405 implementation of choice counseling including efforts to improve
1406 health literacy and the methods used to obtain public input
1407 including recipient focus groups.
1408 (g) Participation rates in the Enhanced Benefit Accounts
1409 Program, as established in the Centers for Medicare and Medicaid
1410 Services Special Terms and Conditions number 11-W-00206/4, which

1411 shall include: participation levels, summary of activities and
1412 associated expenditures, number of accounts established
1413 including active participants and individuals who continue to
1414 retain access to funds in an account but no longer actively
1415 participate, estimated quarterly deposits in accounts, and
1416 expenditures from the accounts.
1417 (h) Enrollment data on employer-sponsored insurance that
1418 documents the number of individuals selecting to opt out when
1419 employer-sponsored insurance is available. The agency shall
1420 include data that identifies enrollee characteristics to include
1421 eligibility category, type of employer-sponsored insurance, and
1422 type of coverage based on whether the coverage is for the
1423 individual or the family. The agency shall develop and maintain
1424 disenrollment reports specifying the reason for disenrolling in
1425 an employer-sponsored insurance program. The agency shall also
1426 track and report on those enrollees who elect to reenroll in the
1427 Medicaid reform waiver demonstration program.
1428 (i) Documentation of progress toward the demonstration
1429 program goals.
1430 (j) Documentation of evaluation activities.
1431 (2) The annual report shall document accomplishments,
1432 program status, quantitative and case study findings,
1433 utilization data, and policy and administrative difficulties in
1434 the operation of the Medicaid reform waiver demonstration
1435 program. The agency shall submit the draft annual report no
1436 later than October 1 after the end of each fiscal year.
1437 (a) Beginning with the annual report for demonstration
1438 program year two, the agency shall include a section on the

1439 administration of enhanced benefit accounts, participation
1440 rates, an assessment of expenditures, and potential cost
1441 savings.
1442 (b) Beginning with the annual report for demonstration
1443 program year four, the agency shall include a section that
1444 provides qualitative and quantitative data that describes the
1445 impact of the low income pool on the number of uninsured persons
1446 in the state from the start of the implementation of the
1447 demonstration program.
1448 Section 9. Section 11.72, Florida Statutes, is created to
1449 read:
1450 11.72 Joint Legislative Committee on Medicaid Reform
1451 Implementation; creation; membership; powers; duties.--
1452 (1) There is created a standing joint committee of the
1453 Legislature designated the Joint Legislative Committee on
1454 Medicaid Reform Implementation for the purpose of reviewing
1455 policy issues related to expansion of the Medicaid managed care
1456 pilot program pursuant to s. 409.91211.
1457 (2) The Joint Legislative Committee on Medicaid Reform
1458 Implementation shall be composed of eight members appointed as
1459 follows: four members of the House of Representatives appointed
1460 by the Speaker of the House of Representatives, one of whom
1461 shall be a member of the minority party; and four members of the
1462 Senate appointed by the President of the Senate, one of whom
1463 shall be a member of the minority party. The President of the
1464 Senate shall appoint the chair in even-numbered years and the
1465 vice chair in odd-numbered years, and the Speaker of the House
1466 of Representatives shall appoint the chair in odd-numbered years

1467 and the vice chair in even-numbered years from among the
1468 committee membership. Vacancies shall be filled in the same
1469 manner as the original appointment. Members shall serve without
1470 compensation, except that members are entitled to reimbursement
1471 for per diem and travel expenses in accordance with s. 112.061.
1472 (3) The committee shall be governed by joint rules of the
1473 Senate and the House of Representatives which shall remain in
1474 effect until repealed or amended by concurrent resolution.
1475 (4) The committee shall meet at the call of the chair. The
1476 committee may hold hearings on matters within its purview which
1477 are in the public interest. A quorum shall consist of a majority
1478 of members from each house, plus one additional member from
1479 either house. Action by the committee requires a majority vote
1480 of the members present of each house.
1481 (5) The committee shall be jointly staffed by the
1482 appropriations and substantive committees of the House of
1483 Representatives and the Senate. During even-numbered years the
1484 Senate shall serve as lead staff and during odd-numbered years
1485 the House of Representatives shall serve as lead staff.
1486 (6) The committee shall:
1487 (a) Review reports, public hearing proceedings, documents,
1488 and materials provided by the Agency for Health Care
1489 Administration relating to the expansion of the Medicaid managed
1490 care pilot program to other counties of the state pursuant to s.
1491 409.91212.
1492 (b) Consult with the substantive and fiscal committees of
1493 the House of Representatives and the Senate which have

1494 jurisdiction over the Medicaid matters relating to agency action
1495 to expand the Medicaid managed care pilot program.
1496 (c) Meet to consider and make a recommendation regarding
1497 the extent to which the expansion criteria pursuant to s.
1498 409.91212 have been met.
1499 (7) Within 2 days after meeting, during which the
1500 committee reviewed documents, material, and testimony related to
1501 the expansion criteria, the committee shall submit a memorandum
1502 to the Speaker of the House of Representatives, the President of
1503 the Senate, the Legislative Budget Commission, and the agency
1504 delineating the extent to which the agency met the expansion
1505 criteria.
1506 Section 10. It is the intent of the Legislature that if
1507 any conflict exists between the provisions contained in s.
1508 409.91211, Florida Statutes, and other provisions of chapter
1509 409, Florida Statutes, as they relate to implementation of the
1510 Medicaid managed care pilot program, the provisions contained in
1511 s. 409.91211, Florida Statutes, shall control. The Agency for
1512 Health Care Administration shall provide a written report to the
1513 President of the Senate and the Speaker of the House of
1514 Representatives by April 1, 2006, identifying any provisions of
1515 chapter 409, Florida Statutes, that conflict with the
1516 implementation of the Medicaid managed care pilot program as
1517 created in s. 409.91211, Florida Statutes. After April 1, 2006,
1518 the agency shall provide a written report to the President of
1519 the Senate and the Speaker of the House of Representatives
1520 immediately upon identifying any provisions of chapter 409,
1521 Florida Statutes, that conflict with the implementation of the

1522 Medicaid managed care pilot program as created in s. 409.91211,
1523 Florida Statutes.
1524 Section 11. Section 216.346, Florida Statutes, is amended
1525 to read:
1526 216.346 Contracts between state agencies; restriction on
1527 overhead or other indirect costs.--In any contract between state
1528 agencies, including any contract involving the State University
1529 System or the Florida Community College System, the agency
1530 receiving the contract or grant moneys shall charge no more than
1531 a reasonable percentage ~~5 percent~~ of the total cost of the
1532 contract or grant for overhead or indirect costs or any other
1533 costs not required for the payment of direct costs. This
1534 provision is not intended to limit an agency's ability to
1535 certify matching funds or designate in-kind contributions which
1536 will allow the drawdown of federal Medicaid dollars that do not
1537 affect state budgeting.
1538 Section 12. One full-time equivalent position is
1539 authorized and the sum of $250,000 is appropriated for fiscal
1540 year 2006-2007 from the General Revenue Fund to the Office of
1541 Insurance Regulation of the Financial Services Commission to
1542 fund the annual review of the Medicaid managed care pilot
1543 program's risk-adjusted rate setting methodology.
1544 Section 13. This act shall take effect upon becoming a
1545 law.

HB 47B

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 47B Appropriation to Compensate Wilton Dedge
SPONSOR(S): Goodlette and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 12B

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Fiscal Council		Overton	Kelly
2)			
3)			
4)			
5)			

SUMMARY ANALYSIS

Wilton Dedge was convicted of burglary with assault, sexual battery with a weapon, and aggravated battery and imprisoned for 22 years. During that time he was convicted twice: his first conviction was reversed and remanded. His second trial resulted in a conviction that was upheld on appeal. Wilton Dedge was released from imprisonment in 2004 based on DNA evidence that excluded him as the perpetrator of the crimes. In the 2005 session of the Legislature, attempts to compensate Wilton Dedge did not pass.

Wilton Dedge has filed suit against the State of Florida and James Crosby, the Secretary of the Florida Department of Corrections, alleging both tort and constitutional violations (see section entitled 'Pending Lawsuit' in the Effect of Proposed Changes section herein). The Second Circuit Court dismissed the claim, acknowledging that "while everyone is in agreement that what happened to Wilton Dedge is tragic, only the Legislature can address the issue of compensation under existing law." The ruling of the Second Circuit Court was appealed by Mr. Dedge in the First District Court of Appeal, and was dismissed on jurisdictional grounds on November 29, 2005.

This bill appropriates $ 2 million from the General Revenue Fund to compensate Wilton Dedge under the following conditions:

- Delivery of an executed release and waiver of all present and future claims against the state of Florida, and any agency, instrumentality, officer, employee, or political subdivision thereof; and
- An order dismissing Mr. Dedge's current legal case with prejudice.

The authority of the Chief Financial Officer to draw a warrant to compensate Wilton Dedge expires on March 6, 2006. The bill requires that the $2 million be paid to the State Board of Administration, which will distribute the funds as provided in a letter of agreement between Wilton Dedge and his parents and the State Board of Administration. The bill also requires that health care insurance be provided at Mr. Dedge's expense, and that he be provided access to state education programs on a scholarship basis.

The award is intended to provide compensation for any and all present and future claims arising out of the factual situation in connection with Wilton Dedge's conviction and imprisonment. The bill provides that no further award will be made by the state. The bill also provides that the defense of sovereign immunity is not waived by the act.

The act also expresses legislative intent that compensation is based on a moral desire to acknowledge Wilton Dedge's actual innocence, and not on a recognition of a constitutional right or violation, and makes an apology on behalf of the state.

The bill provides for a conditional appropriation of $2 million to be paid out of the General Revenue Fund.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:
Provide limited government – this bill affirms that it is the constitutional role of the Legislature to appropriate state funds.

B. EFFECT OF PROPOSED CHANGES:

Wilton Dedge - In January, 1982, Wilton Dedge was arrested and ultimately adjudicated guilty of burglary with assault, two counts of sexual battery, and aggravated battery. Those judgments were reversed and remanded based on trial court errors regarding the disqualification of an expert witness and improper admission of hearsay evidence.[1] Upon remand, Wilton Dedge was again convicted. That conviction was affirmed on appeal.[2] He was sentenced to two concurrent life sentences, plus consecutive 15-year sentences.

Ten years after his convictions, Wilton Dedge filed a motion pursuant to Florida Rule of Criminal Procedure 3.850[3] seeking DNA testing. The trial court denied that motion as time-barred, which was affirmed on appeal.[4] Mr. Dedge then filed a motion for release of DNA evidence, which motion was granted. Mr. Dedge then filed another 3.850 motion arguing that the DNA test results constituted newly discovered evidence which established that he was not guilty. The trial court denied the motion as time-barred, which was also affirmed on appeal.[5]

Ultimately the State moved for Y-Chromosome testing which was granted by order of the court. That test excluded Wilton Dedge as the perpetrator of the crimes. The Eighteenth Circuit Court in Brevard County granted the State's 3.850 motion to dismiss the charges and to discharge Mr. Dedge from custody on August 11, 2004.[6] He was released the following day, after spending 22 years in prison.

Pending Lawsuit – Following his release, Wilton Dedge sought compensation from the Legislature in the 2005 session. Both chambers filed bills which attempted to create a policy under which the wrongfully incarcerated would be compensated. Both bills ultimately failed.[7]

Wilton Dedge and his parents then petitioned the circuit court for declaratory relief, equitable relief, damages, and expungement of his record. The request for damages included damages for taking of Mr. Dedge's liberty and for wrongful imprisonment, damages for the taking of Mr. Dedge's property interests, damages for the state's unjust enrichment resulting from his provision of services to the state without compensation, and damages for his parents who paid for his legal defense.[8] The Second Circuit court dismissed the petition, making the following findings:

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[1] Dedge v. State, 442 So.2d 429 (Fla. 5th DCA 1983).
[2] Dedge v. State, 479 So.2d 882 (Fla. 5th DCA 1985). The judgments were affirmed on all points, but the minimum mandatory portions of Dedge's sexual battery sentences were reversed and remanded for the trial court to delete the minimum mandatory provisions.
[3] Rule 3.850 of the Florida Rules of Criminal Procedure allows a person to claim that judgment was entered or that the sentence was imposed in violation of the Constitution or laws of the United States or of Florida, that the court was without jurisdiction to enter the judgment or to impose the sentence, that the sentence was in excess of the maximum authorized by law, that the plea was given involuntarily, or that the judgment or sentence is otherwise subject to collateral attack. Such prisoner may move that the sentence be vacated, set aside, or corrected. The motion must be filed within two years after the judgment and sentence became final in non-capital cases. There are enumerated exceptions to the time limitation, none of which were found to apply in Mr. Dedge's case.
[4] Dedge v. State, 723 So.2d 322 (Fla. 5th DCA 1998).
[5] Facts recited in Dedge v. State, 832 So.2d 835, 836 (Fla. 5th DCA 2002).
[6] Order, Case No. 05-1982-00135, Eighteenth Judicial Circuit, August 11, 2004. Based on the earlier denials of Mr. Dedge's 3.850 motions as time-barred, it would appear that Mr. Dedge's release on the instant 3.850 motion was granted based on the joint nature of the motion, rather than a strict application of the rule.
[7] HCR 1879 and CS/CS/SB 1964 (second engrossed).
[8] Wilton Dedge, Walter Gary Dedge, Sr., and Mary Dedge v. James Crosby, Secretary of the Department of Corrections, and the State of Florida, Petition for the Expungement of Record, Factual Findings and other Relief Including Actions for Declaratory Relief and

- Wilton Dedge's parents have no standing to recover damages suffered by their adult child under existing Florida law;
- Wilton Dedge failed to comply with Florida statutes relating to the expunction of Mr. Dedge's criminal records;[9]
- Wilton Dedge's claims for damages are banned by sovereign immunity;
- Wilton Dedge seeks to have the court rule on matters which are clearly the province of the legislative branch of government, not the judicial branch; and
- Only the Legislature can address the issue of compensation under existing law.[10]

The order dismissing the petition was appealed to the First District Court of Appeal,[11] and was dismissed for lack of jurisdiction on November 29, 2005.[12] Mr. Dedge made two arguments on appeal: 1) the trial court erred in holding that there is no judicial remedy for the wrongful taking of liberty; and 2) the trial court erred in dismissing the claim of Walter and Mary Dedge (Wilton Dedge's parents).

Compensation – This bill acknowledges that Mr. Dedge incurred significant losses as a result of his conviction and physical confinement, that he provided valuable services for the state while imprisoned, and that his parents incurred significant expenses related to his legal defense. The bill expresses legislative intent that compensation provided is based on a moral desire to acknowledge his actual innocence, and not on a recognition of a constitutional right or violation. The bill also issues an apology to Wilton Dedge on behalf of the state.

The bill appropriates $2 million from the General Revenue Fund to be paid to the State Board of Administration and authorizes the Chief Financial Officer (CFO) to draw a warrant upon funds in the State Treasury. After March 6, 2006, the CFO is no longer authorized to draw the warrant.

The warrant is payable to the State Board of Administration upon delivery by Wilton Dedge to the CFO, the State Board of Administration, the President of the Senate, and the Speaker of the House of Representatives of all of the following:

- An executed release and waiver on behalf of Wilton Dedge, and his parents, heirs, successors, and assigns, forever releasing the State of Florida and any agency, instrumentality, officer, employee, or political subdivision thereof, or any other entity subject to the provisions of s. 768.28, Florida Statutes, from any and all present or future claims arising out of the factual situation in connection with the conviction for which compensation is awarded; and
- An order from the court having jurisdiction over the legal claim dismissing the claim with prejudice.[13]

The State Board of Administration is directed to distribute funds to Mr. Dedge in accordance with the letter of agreement between the Wilton Dedge, his parents, and the State Board of Administration. The bill requires the State Board of Administration, the State Division of Retirement, and the State Department of Management Services to provide such support and assistance as directed by the terms of the letter of agreement, and are authorized and directed to provide for health care insurance, including mental health and dental coverage for Wilton Dedge, at his expense. The bill also requires that Mr. Dedge be provided access to state education programs on a scholarship basis without tuition

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Damages and Equitable Relief under Extraordinary Writ Authority; filed in the Eighteenth Circuit Court and transferred to the Second Circuit Court, case no. 37 2005 CA 001807, filed in June 2005.

[9] Section 943.0585, F.S.

[10] Dedge et al v. Crosby and State, Order Granting Amended Motion to Dismiss, Second Circuit Court, case no. 2005-CA-001807, filed August 29, 2005.

[11] Dedge et al v. Crosby and State, First District Court of Appeal, case no. 1D05-4288.

[12] Dismissal for lack of jurisdiction based on the non-final nature of the underlying trial court order.

[13] The term "dismissal with prejudice" generally means that the dismissal is conclusive of the rights of the parties as if the action had been prosecuted to final adjudication adverse to the plaintiff. Black's Law Dictionary, 5th Edition, p. 1438.

or fees, provided that he is required to meet and maintain the regular admission requirements of, and be registered at, such state educational program.

The bill provides that passage of this act shall not be deemed to waive the defense of sovereign immunity, nor to increase the statutory limits of liability. Further, the bill is intended to provide sole compensation for any and all present and future claims arising out of the factual situation in connection with Wilton Dedge's conviction and imprisonment.

The act takes effect upon becoming a law.

C. SECTION DIRECTORY:

Section 1 provides that the facts stated in the preamble are found and declared to be true.

Section 2 appropriates $2 million from the General Revenue Fund.

Section 3 directs the Chief Financial Officer to draw the warrant to the State Board of Administration, which is directed to disburse the funds in accordance with the specified letter of agreement. Section 3 also directs that health care insurance be provided as specified, and that access to state educational programs be provided.

Section 4 requires the State Board of Administration to disburse the funds upon delivery of an executed release and waiver of governmental liability, and an order of dismissal with prejudice.

Section 5 provides that the Legislature is not deemed to have waived any defense of sovereign immunity or to have increased the limits of liability.

Section 6 provides that the award is intended to provide sole compensation for any and all present and future claims.

Section 7 provides that the act shall become effective upon becoming a law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   This bill authorizes the payment of $2 million out of the General Revenue Fund, if specific conditions are met.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable because this bill does not appear to require the counties or cities to spend funds or take an action requiring the expenditure of funds; reduce the authority that cities or counties have to raise revenues in the aggregate; or reduce the percentage of a state tax shared with cities or counties.

2. Other:

Suits Against the State – Article X, section 13 of the Florida Constitution provides that, "Provision may be made by general law for bringing suit against the state as to all liabilities now existing or hereafter originating." If passed, this bill would be a general law.

Separation of Powers – Article II, section 3 of the Florida Constitution provides that, "No person belonging to one branch shall exercise any powers appertaining to either of the other branches unless expressly provided herein." By acting upon its unique constitutional authority to make appropriations,[14] the Legislature expresses its intent that compensation of Wilton Dedge belongs squarely within the Legislature's constitutional authority. The bill further adheres to the Separation of Powers doctrine by requiring the dismissal of any pending court case prior to making the appropriation, thus avoiding a legislative encroachment in an ongoing judicial matter.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The date on line 97 should be "March 6, 2006" rather than "2005."

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

[14] The power to appropriate state funds is legislative and to be exercised only through duly enacted statutes. Chiles v. Children A, B, C, D, E, and F, 589 So.2d 260 (Fla. 1991) and Article VII, section 1(c) of the Florida Constitution which provides that "no money shall be drawn from the treasury except in pursuance of appropriation made by law."

1 A bill to be entitled
2 An act providing an appropriation to compensate Wilton
3 Dedge; providing authority to draw warrant; providing a
4 limitation on the authority to draw the warrant; requiring
5 a specified distribution of funds; providing a condition
6 for payment; providing legislative intent; providing an
7 effective date.
8
9 WHEREAS, Wilton Dedge was convicted of rape and imprisoned
10 for 22 years, and
11 WHEREAS, the initial conviction was appealed and reversed,
12 and
13 WHEREAS, on retrial Wilton Dedge was again convicted, which
14 conviction was affirmed on appeal, and
15 WHEREAS, the Circuit Court in the Eighteenth Judicial
16 Circuit granted the state's motion to dismiss pending charges
17 and discharge Wilton Dedge from custody based on DNA evidence
18 that excluded Wilton Dedge as the perpetrator of the crime, and
19 WHEREAS, Wilton Dedge was in fact released on August 12,
20 2004, and
21 WHEREAS, Wilton Dedge and his parents filed suit in the
22 Second Judicial Circuit requesting, among other things, a
23 declaratory judgment that Mr. Dedge's liberty was taken by the
24 government without compensation and requesting damages for the
25 taking of Mr. Dedge's liberty and property, and
26 WHEREAS, the suit was dismissed by order of the Second
27 Judicial Circuit court, which found that Mr. Dedge's parents
28 have no standing to recover damages suffered by an adult child,

29 that claims for damages from the state are banned by the
30 doctrine of sovereign immunity, and that only the Legislature
31 can address the issue of compensation under existing law, and
32 WHEREAS, Wilton Dedge has appealed the order to the First
33 District Court of Appeal, Case No. 1D05-4288, which appeal is
34 pending, and
35 WHEREAS, the Legislature recognizes that no system of
36 justice is impervious to human error. "Given the myriad
37 safeguards provided to assure a fair trial, and taking into
38 account the reality of the human fallibility of the
39 participants, there can be no such thing as an error-free,
40 perfect trial, and ... the Constitution does not guarantee such
41 a trial." United States v. Hasting, 461 U.S. 499(1983), and
42 WHEREAS, the Legislature acknowledges that the state's
43 system of justice yielded an imperfect result with tragic
44 consequences in this case, and
45 WHEREAS, the Legislature acknowledges that Wilton Dedge
46 incurred significant losses unique to Wilton Dedge as a result
47 of his conviction and physical confinement and that all the
48 losses flowed from the fact that he was physically restrained
49 and prevented from exercising the freedom to which all innocent
50 citizens are entitled, and
51 WHEREAS, the Legislature acknowledges that Wilton Dedge
52 performed valuable services for the state while imprisoned,
53 including serving as a licensed waste-water plant operator, and
54 WHEREAS, the Legislature acknowledges that Wilton Dedge's
55 parents incurred significant expenses related to his defense and

56 related to the prolonged efforts to establish his innocence and
57 secure his release from prison, and
58 WHEREAS, the Legislature is providing compensation to
59 Wilton Dedge to acknowledge the fact that he suffered
60 significant damages unique to Wilton Dedge which resulted from
61 his physical restraint and the deprivation of freedom, and
62 WHEREAS, the Legislature is providing compensation to
63 Wilton Dedge based on a moral desire to acknowledge his
64 undisputed and actual innocence and not on a recognition of a
65 constitutional right or violation, and
66 WHEREAS, the Legislature intends that compensation made
67 pursuant to this act shall be the sole compensation to be
68 provided by the state for any and all present and future claims
69 arising out of the factual situation in connection with Wilton
70 Dedge's conviction and imprisonment, and
71 WHEREAS, the Legislature apologizes to Wilton Dedge on
72 behalf of the state, NOW, THEREFORE,
73
74 Be It Enacted by the Legislature of the State of Florida:
75
76 Section 1. The facts stated in the preamble to this act
77 are found and declared to be true.
78 Section 2. There is appropriated from the General Revenue
79 Fund the sum of $2,000,000 to be paid to Wilton Dedge under the
80 conditions provided in this act.
81 Section 3. The Chief Financial Officer is directed to draw
82 a warrant to the State Board of Administration in the sum of
83 $2,000,000 for the purposes provided in this act, the funds to

84 be distributed in accordance with the letter of agreement
85 between Wilton Dedge, Mr. and Mrs. Walter Gary Dedge, Sr., and
86 the State Board of Administration. The State Board of
87 Administration, the State Division of Retirement, and the State
88 Department of Management Services are required to provide such
89 support and assistance as directed by the terms of the letter of
90 agreement and are authorized and directed to provide for health
91 care insurance, including mental health and dental coverage for
92 Wilton Dedge, the expense of which shall be borne by Wilton
93 Dedge. Access to state education programs shall be provided on a
94 scholarship basis without tuition or fees, provided that Wilton
95 Dedge shall be required to meet and maintain the regular
96 admission requirements of, and be registered at, such state
97 educational program. After March 6, 2005, the Chief Financial
98 Officer is no longer authorized to draw a warrant under this
99 section.
100 Section 4. The State Board of Administration shall
101 disburse funds under the letter of agreement upon delivery by
102 Wilton Dedge to the Chief Financial Officer, the State Board of
103 Administration, the President of the Senate, and the Speaker of
104 the House of Representatives of all of the following:
105 (1) An executed release and waiver on behalf of Wilton
106 Dedge and his parents, heirs, successors, and assigns forever
107 releasing the State of Florida and any agency, instrumentality,
108 officer, employee, or political subdivision thereof or any other
109 entity subject to the provisions of s. 768.28, Florida Statutes,
110 from any and all present or future claims the claimant or any of
111 his parents, heirs, successors, or assigns may have against such

112 enumerated entities and arising out of the factual situation in
113 connection with the conviction for which compensation is
114 awarded.
115 (2) An order from the court having jurisdiction of the
116 legal claim filed by Wilton Dedge and his parents dismissing the
117 claim with prejudice, provided that it is the intent of this
118 legislation to allow Wilton Dedge to obtain full expungement of
119 the judicial and executive branch records of his conviction as
120 otherwise provided by law.
121 Section 5. The Legislature shall not be deemed by this act
122 to have waived any defense of sovereign immunity or to have
123 increased the limits of liability on behalf of the state or any
124 person or entity subject to the provisions of s. 768.28, Florida
125 Statutes, or any other law.
126 Section 6. This award is intended to provide sole
127 compensation for any and all present and future claims arising
128 out of the factual situation in connection with Wilton Dedge's
129 conviction and imprisonment. No further award for attorney's
130 fees, lobbying fees, costs, or other similar expenses will be
131 made by the state.
132 Section 7. This act shall take effect upon becoming a law.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 41B Judges
SPONSOR(S): Goodlette
TIED BILLS: **IDEN./SIM. BILLS:** SB 14B

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Fiscal Council		DeBeaugrine	Kelly
2)			
3)			
4)			
5)			

SUMMARY ANALYSIS

The Supreme Court issued Order No. SC04-2154, dated November 30, 2004, certifying the need for 110 additional judges. During the 2005 Legislative Session, 35 circuit court and 20 county court judgeships were established (chapter 2005-150, Laws of Florida).

This bill revises sections 26.031 and 34.022, Florida Statutes, as amended by chapter 2005-150, Laws of Florida, creating 3 new circuit court judgeships in the Twentieth Judicial Circuit and 2 new county court judgeships in Collier County effective January 2, 2006. Judges for these new positions will be appointed by the Governor.

The bill authorizes General Revenue funds for the State Court System of $643,372 to fund 11 positions for Fiscal Year 2005-2006. This includes the 5 new judges plus associated support staff. Estimated annual recurring costs are projected to be $1.2 million.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:
This bill does not appear to implicate any of the House principles.

B. EFFECT OF PROPOSED CHANGES:

Certification of Need for Additional Judges
Section 9, Article V of the State Constitution requires the Florida Supreme Court to recommend to the Legislature the need for additional judges. The Florida Supreme Court was directed in budget proviso to the 1998 General Appropriations Act to develop "a Delphi-based case load weighting system to determine the optimum caseloads for circuit and county judges and to determine the need for additional circuit and county court judges." The system was used to develop the Court's latest certification of need for new trial court judgeships.

As a result of the last caseload analysis, the Supreme Court issued Order No. SC04-2154, dated November 30, 2004, certifying the need for 67 circuit, 41 county and 2 appellate judges for a total of 110 new judges.

The Supreme Court's Certification Order recommended 3 judges for the Twentieth Circuit and 2 judges for Collier County.

2005 Legislation
Senate Bill 2048 passed during the 2005 Legislative Session (chapter 2005-150, Laws of Florida), creating 35 new circuit court and 20 new county court judgeships. The bill staggered the effective dates: 18 circuit and 10 county judge positions were effective on November 1, 2005 and 17 circuit and 10 county judge positions are effective on January 2, 2006.

Circuit court positions were established as follows:
- Four judges each for the Tenth and Thirteenth Circuits;
- Three judges each for the Fifth, Sixth, Eleventh, Seventeenth and Nineteenth Circuits;
- Two judges each for the Seventh and Ninth Circuits;
- One judge each for the First, Second, Third, Fourth, Eighth, Fourteenth, Fifteenth and Eighteenth Circuits.

County court positions were established as follows:
- Two judges each for Broward and Hillsborough County.
- One judge each for Bay, Brevard, Duval, Hernando, Lake, Lee, Manatee, Martin, Miami-Dade, Orange, Palm Beach, Pasco, Pinellas, Seminole, St. Lucie, and Volusia Counties.

No new judges were authorized for the Twentieth Circuit or any of the counties that make up the Twentieth Circuit.

Effect of This Bill
HB 41B increases the number of circuit judges for the Twentieth Circuit from 23 to 26 and increases the number of county court judges for Collier County from 3 to 5. The bill also authorizes 11 positions and provides $643,372 from the General Revenue Fund to the State Courts System to cover the cost of the judges and associated supported staff. Support staff consists of a law clerk and 3 judicial assistants for the circuit and 2 judicial assistants for the county. Judges will be appointed by the Governor and take office on January 2, 2006.

C. SECTION DIRECTORY:

Section 1. Amends section 26.031, Florida Statutes, as amended by section 2 of chapter 2005-150, Laws of Florida, providing for 3 new circuit judges for the Twentieth Circuit effective January 2, 2006.
Section 2. Amends section 34.022, Florida Statutes, as amended by section 4 of chapter 2005-150, Laws of Florida, providing for 2 new county judges for Collier County effective January 2, 2006.
Section 3. Provides that the judges filling the new offices shall be appointed by the Governor.
Section 4. Provides the State Court System with an appropriation from the General Revenue Fund, 11 new positions and associated salary rate.
Section 5. Provides that the act shall take effect upon becoming law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

The bill provides for an appropriation of $643,372 from the General Revenue Fund to cover the cost of the 11 positions for approximately one-half of Fiscal Year 2005-2006. Subsequent annual recurring appropriations will be approximately $1.2 million. Salary rate of 877,168 is provided to enable the courts to pay currently authorized salary amounts for judges and to authorize salaries at 10 percent above the minimum for the respective pay range for support staff.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

The cost of county judges and judicial assistants are paid for by the state. Under section 29.008, Florida Statutes, counties are responsible for facilities, security, communications and information technology costs for county and circuit courts. This bill could result in additional costs in these areas. In addition, the bill could result in an increase in the workload of the clerk of the courts in the Twentieth Circuit and in Collier County.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not appear to affect municipal or county government.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

N/A

1 A bill to be entitled
2 An act relating to judges; amending s. 26.031, F.S.;
3 revising the number of circuit court judges in the 20th
4 judicial circuit; amending s. 34.022, F.S.; revising the
5 number of county court judges in Collier County; providing
6 for the additional judges provided under the act to be
7 appointed by the Governor; providing an appropriation and
8 authorizing positions and approved salary rate; providing
9 effective dates.
10
11 Be It Enacted by the Legislature of the State of Florida:
12
13 Section 1. Effective January 2, 2006, section 26.031,
14 Florida Statutes, as amended by section 2 of chapter 2005-150,
15 Laws of Florida, is amended to read:
16 26.031 Judicial circuits; number of judges.--The number of
17 circuit judges in each circuit shall be as follows:
18
19 JUDICIAL CIRCUIT TOTAL
20 (1) First 22
21 (2) Second 16
22 (3) Third 7
23 (4) Fourth 32
24 (5) Fifth 28
25 (6) Sixth. 44
26 (7) Seventh 26
27 (8) Eighth 13
28 (9) Ninth 40

29 (10) Tenth 26
30 (11) Eleventh 77
31 (12) Twelfth 19
32 (13) Thirteenth 41
33 (14) Fourteenth 10
34 (15) Fifteenth 35
35 (16) Sixteenth 4
36 (17) Seventeenth 56
37 (18) Eighteenth 25
38 (19) Nineteenth 18
39 (20) Twentieth .....26 ~~23~~
40
41 Section 2. Effective January 2, 2006, section 34.022,
42 Florida Statutes, as amended by section 4 of chapter 2005-150,
43 Laws of Florida, is amended to read:
44 34.022 Number of county court judges for each county.--The
45 number of county court judges in each county shall be as
46 follows:
47
48 COUNTY TOTAL
49 (1) Alachua 5
50 (2) Baker 1
51 (3) Bay 4
52 (4) Bradford 1
53 (5) Brevard 9
54 (6) Broward 28
55 (7) Calhoun 1
56 (8) Charlotte 2

57 (9) Citrus 1
58 (10) Clay 2
59 (11) Collier .....5 ~~3~~
60 (12) Columbia 1
61 (13) DeSoto 1
62 (14) Dixie 1
63 (15) Duval 16
64 (16) Escambia 5
65 (17) Flagler 1
66 (18) Franklin 1
67 (19) Gadsden 1
68 (20) Gilchrist 1
69 (21) Glades 1
70 (22) Gulf 1
71 (23) Hamilton 1
72 (24) Hardee 1
73 (25) Hendry 1
74 (26) Hernando 2
75 (27) Highlands 1
76 (28) Hillsborough 17
77 (29) Holmes 1
78 (30) Indian River 2
79 (31) Jackson 1
80 (32) Jefferson 1
81 (33) Lafayette 1
82 (34) Lake 3
83 (35) Lee 7
84 (36) Leon 5

85 (37) Levy 1
86 (38) Liberty 1
87 (39) Madison 1
88 (40) Manatee 4
89 (41) Marion 4
90 (42) Martin 3
91 (43) Miami-Dade 42
92 (44) Monroe 4
93 (45) Nassau 1
94 (46) Okaloosa 3
95 (47) Okeechobee 1
96 (48) Orange 16
97 (49) Osceola 3
98 (50) Palm Beach 18
99 (51) Pasco 5
100 (52) Pinellas 15
101 (53) Polk 9
102 (54) Putnam 2
103 (55) St. Johns 2
104 (56) St. Lucie 4
105 (57) Santa Rosa 2
106 (58) Sarasota 5
107 (59) Seminole 6
108 (60) Sumter 1
109 (61) Suwannee 1
110 (62) Taylor 1
111 (63) Union 1
112 (64) Volusia 10

113 (65) Wakulla 1
114 (66) Walton 1
115 (67) Washington 1
116
117 Section 3. The judges filling new offices created by this
118 act shall be appointed by the Governor.
119 Section 4. The sums of $616,776 in recurring funds and
120 $26,596 in nonrecurring funds are appropriated from the General
121 Revenue Fund to the circuit and county courts for the 2005-2006
122 fiscal year, and 11 full-time positions and 877,168 in approved
123 salary rate are authorized.
124 Section 5. Except as otherwise expressly provided in this
125 act, this act shall take effect upon becoming a law.

COUNCIL/COMMITTEE ACTION

ADOPTED	__	(Y/N)
ADOPTED AS AMENDED	__	(Y/N)
ADOPTED W/O OBJECTION	__	(Y/N)
FAILED TO ADOPT	__	(Y/N)
WITHDRAWN	__	(Y/N)
OTHER	____	

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1 Council/Committee hearing bill: Fiscal Council
2 Representative(s) Goodlette offered the following:
3
4 **Amendment (with title amendment)**
5 Remove everything after the enacting clause and insert:
6 Section 1. Effective January 2, 2006, section 26.031,
7 Florida Statutes, as amended by section 2 of chapter 2005-150,
8 Laws of Florida, is amended to read:
9 26.031 Judicial circuits; number of judges.--The number of
10 circuit judges in each circuit shall be as follows:
11
12 JUDICIAL CIRCUIT TOTAL
13 (1) First 22
14 (2) Second 16
15 (3) Third 7
16 (4) Fourth 32
17 (5) Fifth 28
18 (6) Sixth. 44
19 (7) Seventh 26
20 (8) Eighth 13
21 (9) Ninth 40

22 (10) Tenth 26
23 (11) Eleventh 77
24 (12) Twelfth 19
25 (13) Thirteenth 41
26 (14) Fourteenth 10
27 (15) Fifteenth 35
28 (16) Sixteenth 4
29 (17) Seventeenth 56
30 (18) Eighteenth 25
31 (19) Nineteenth 18
32 (20) Twentieth ..... 25 ~~23~~
33
34 Section 2. Effective January 2, 2006, section 34.022,
35 Florida Statutes, as amended by section 4 of chapter 2005-150,
36 Laws of Florida, is amended to read:
37 34.022 Number of county court judges for each county.--The
38 number of county court judges in each county shall be as
39 follows:
40
41 COUNTY TOTAL
42 (1) Alachua 5
43 (2) Baker 1
44 (3) Bay 4
45 (4) Bradford 1
46 (5) Brevard 9
47 (6) Broward 28
48 (7) Calhoun 1
49 (8) Charlotte 2
50 (9) Citrus 1
51 (10) Clay 2

52 (11) Collier ..... 5 ~~3~~
53 (12) Columbia 1
54 (13) DeSoto 1
55 (14) Dixie 1
56 (15) Duval 16
57 (16) Escambia 5
58 (17) Flagler 1
59 (18) Franklin 1
60 (19) Gadsden 1
61 (20) Gilchrist 1
62 (21) Glades 1
63 (22) Gulf 1
64 (23) Hamilton 1
65 (24) Hardee 1
66 (25) Hendry 1
67 (26) Hernando 2
68 (27) Highlands 1
69 (28) Hillsborough 17
70 (29) Holmes 1
71 (30) Indian River 2
72 (31) Jackson 1
73 (32) Jefferson 1
74 (33) Lafayette 1
75 (34) Lake 3
76 (35) Lee 7
77 (36) Leon 5
78 (37) Levy 1
79 (38) Liberty 1
80 (39) Madison 1
81 (40) Manatee 4

82 (41) Marion 4
83 (42) Martin 3
84 (43) Miami-Dade 42
85 (44) Monroe 4
86 (45) Nassau 1
87 (46) Okaloosa 3
88 (47) Okeechobee 1
89 (48) Orange 16
90 (49) Osceola 3
91 (50) Palm Beach 18
92 (51) Pasco 5
93 (52) Pinellas 15
94 (53) Polk 9
95 (54) Putnam 2
96 (55) St. Johns 2
97 (56) St. Lucie 4
98 (57) Santa Rosa 2
99 (58) Sarasota 5
100 (59) Seminole 6
101 (60) Sumter 1
102 (61) Suwannee 1
103 (62) Taylor 1
104 (63) Union 1
105 (64) Volusia 10
106 (65) Wakulla 1
107 (66) Walton 1
108 (67) Washington 1
109
110 Section 3. The judges filling new offices created by this
111 act shall be appointed by the Governor.

112 Section 4. The sums of $517,568 in recurring funds and
113 $20,214 in nonrecurring funds are appropriated from the General
114 Revenue Fund to the circuit and county courts for the 2005-2006
115 fiscal year, and 9 full-time equivalent positions and 705,157 in
116 approved salary rate are authorized. The sum of $41,846 in
117 recurring funds is appropriated from the General Revenue Fund to
118 the Office of the State Attorney 20th Circuit for the 2005-2006
119 fiscal year, and 2 full-time equivalent positions and 58,791 in
120 approved salary rate are authorized.
121 Section 5. Except as otherwise expressly provided in this
122 act, this act shall take effect upon becoming a law.
123
124 ========== T I T L E A M E N D M E N T ==========
125 Remove Title and insert:
126 An act relating to judges; amending s. 26.031, F.S.; revising
127 the number of circuit court judges in the 20th judicial circuit;
128 amending s. 34.022, F.S.; revising the number of county court
129 judges in Collier County; providing for the additional judges
130 provided under the act to be appointed by the Governor;
131 providing appropriations and authorizing positions and approved
132 salary rate; providing effective dates.
133
134
135
136
137

Fiscal Council

ADDENDUM 1

Joe Negron, Chair
Fred Brummer, Vice Chair

December 06, 2005
9:30 a.m. – 12:00 p.m.
Morris Hall

Allan G. Bense
Speaker

Joe Negron
Chair

HOUSE BILL
HB 31B

Relating to
NASCAR

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 31B Specialty License Plates
SPONSOR(S): Patterson and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 16B

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Finance & Tax Committee	8 Y, 1 N	Levin	Diez-Arguelles
2) Fiscal Council			
3)			
4)			
5)			

SUMMARY ANALYSIS

HB 31B creates the "NASCAR" specialty license plate, and it establishes an annual use fee of $25, to be paid by purchasers of the plate in addition to license taxes and fees. Annual use fees are distributed to the NASCAR Hall of Fame to be used exclusively for the construction and operation of the NASCAR Hall of Fame. The authorization of the NASCAR license plate is contingent upon the City of Daytona Beach being designated by the National Association for Stock Care Auto Racing, Inc., as the site for the official NASCAR Hall of Fame.

The bill provides for the distribution of annual use fees to the NASCAR Hall of Fame to be used exclusively for the construction and operation of the NASCAR Hall of Fame.

The creation of the NASCAR license plate is contingent upon an organization meeting the requirements of s. 320.08053, F.S., prior to approval of a license plate by the Department of Highway Safety and Motor Vehicles ("DHSMV").

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide Limited Government

If the NASCAR license plate satisfies all the conditions for issuance, the bill appears to increase the responsibilities of the Department of Highway Safety and Motor Vehicles (DHSMV) to develop and provide for the manufacture of a new license plate, and it also requires county Tax Collectors to maintain an appropriate inventory and administer the new plate.

B. EFFECT OF PROPOSED CHANGES:

Present Situation

The Florida Legislature created the first specialty license plates in 1986, one commemorating the seven astronauts who died when the space shuttle Challenger exploded after lift-off, and one for each of the nine universities then in the State University System. The Legislature has subsequently authorized ninety-six more specialty license plates.

Specialty license plates are available to any owner or lessee of a motor vehicle who is willing to pay an annual use fee for the privilege. Annual use fees ranging from $15 to $25, paid in addition to required license taxes and service fees, are distributed to an organization or organizations in support of a particular cause or charity and designated in statute. Under s. 320.08053, F.S., an organization may seek legislative authorization for a new specialty license plate by meeting a number of requirements.

An organization is first required to submit to the DHSMV:

- A request for the plate describing it in general terms;
- The results of a professional, independent, and scientific sample survey of Florida residents indicating that 15,000 vehicle owners intend to purchase the plate at the increased cost;
- An application fee of up to $60,000 defraying DHSMV's cost for reviewing the application, developing the new plate, and providing for the manufacture and distribution of the first run of plates; and
- A marketing strategy for the plate and a financial analysis of anticipated revenues and planned expenditures.

These requirements should be satisfied at least 90 days prior to the convening of the regular session of the Legislature. Once the requirements are met, DHSMV notifies the committees of the House of Representatives and Senate with jurisdiction over the issue, and the organization is free to find sponsors and pursue Legislative action. Alternatively, the Legislature may authorize creation of the license plate following an organization's compliance with s. 320.08053, F.S.

If a proposed specialty plate fails to be enacted by the Legislature, DHSMV returns the application fee and other required documents to the organization. If the legislation passes and becomes law, DHSMV notifies the organization, modifies its computer programming to accommodate the new plate, and requests the laminate manufacturer, 3M Company, to produce a prototype. PRIDE at Union Correctional Facility, the contracted manufacturer of license plates, laminates, embosses and roll-coats sample plates that must be submitted to FHP, the Governor, and the Cabinet for approval. Once approval is given, PRIDE begins full production of the plates and distributes them to the Tax Collectors' offices for sale to the public.

A particular specialty license plate must be discontinued if the number of valid specialty plate registrations falls below 1,000 for at least 12 consecutive months. To date, three plates have been discontinued for lack of sales and three plates have been discontinued because of their temporary nature.

The Legislature has authorized 106 specialty license plates to date. Sales of specialty license plates generated more than $26 million in annual revenue use fees in FY 2003-2004, and more than $29 million in FY 2004-2005. Since the program's inception in 1986, the DHSMV has collected annual use fees totaling more than $280 million.

Effect of Proposed Changes

HB 31B creates the "NASCAR" specialty license plate, and establishes an annual use fee of $25, to be paid by purchasers of the plate in addition to license taxes and fees. Annual use fees are to be distributed to the NASCAR Hall of Fame to be used exclusively for the construction and operation of the NASCAR Hall of Fame.

The bill is contingent upon the City of Daytona Beach being designated by the National Association for Stock Car Auto Racing, Inc. as the site for the official NASCAR Hall of Fame facility.

The creation of the NASCAR license plate is contingent upon an organization meeting the requirements of s. 320.08053, F.S., prior to approval of a license plate by the "DHSMV".

C. SECTION DIRECTORY:

Section 1. Amends s. 320.08056, F.S., providing an annual use fee of $25.

Section 2. Amends s. 320.08058, F.S., creating the NASCAR specialty license plate and providing for the distribution of annual use fees collected from its sale.

Section 3. Provides an effective date 30 days after the city of Daytona Beach is designated as the official site of the NASCAR Hall of Fame facility.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

	FY 2005-06	FY 2006-07	FY 2007-08
1. Revenues:			
HS Op. TF (App. Fee):	$ 60,000	$ -0-	$ -0-
2. Expenditures:			
(Data Processing):	$ 7,560	$ -0-	$ -0-

HS Op. TF

(Salaries/Bene.):	$ 15,000	$ -0-	$ -0-
(Purchase of License Plates):	$ 36,900	$ -0-	$ -0-
TOTAL:	**$ 59,460**	**$ -0-**	**$ -0-**

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None

2. Expenditures:

   None

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Those persons electing to purchase a NASCAR plate would be required to pay a $25 annual use fee in addition to the license taxes and fees that are due annually.

D. FISCAL COMMENTS:

None

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable because this bill does not appear to: require cities or counties to spend funds or take actions requiring the expenditure of funds; reduce the authority that cities or counties have to raise revenues in the aggregate; or reduce the percentage of a state tax shared with cities or counties.

2. Other:

   None

B. RULE-MAKING AUTHORITY:

No exercise of rulemaking authority is required to implement the provisions of this bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The bill provides that the annual use fees must be distributed to the NASCAR Hall of Fame. However, the NASCAR Hall of Fame is not a legal entity and will not be able to receive distributions.

The sentence beginning on line 23 is redundant of Section 3.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

1 A bill to be entitled
2 An act relating to specialty license plates; amending ss.
3 320.08056 and 320.08058, F.S.; creating the NASCAR license
4 plate under certain circumstances; providing an annual use
5 fee; providing for the distribution of annual use fees
6 received from the sale of such plates; providing a
7 conditional effective date.
8
9 Be It Enacted by the Legislature of the State of Florida:
10
11 Section 1. Paragraph (eee) is added to subsection (4) of
12 section 320.08056, Florida Statutes, to read:
13 320.08056 Specialty license plates.--
14 (4) The following license plate annual use fees shall be
15 collected for the appropriate specialty license plates:
16 (eee) NASCAR license plate, $25.
17 Section 2. Subsection (57) is added to section 320.08058,
18 Florida Statutes, to read:
19 320.08058 Specialty license plates.--
20 (57) NASCAR LICENSE PLATES.--
21 (a) Upon an organization meeting the requirements of s.
22 320.08053, the department shall develop a NASCAR license plate
23 as provided in this subsection. The authorization of the NASCAR
24 license plate as provided in this subsection is contingent upon
25 the City of Daytona Beach being designated by the National
26 Association for Stock Car Auto Racing, Inc., as the site for the
27 official NASCAR Hall of Fame. NASCAR license plates must bear
28 the colors and design approved by the department. The word

29 "Florida" must appear at the top of the plate, and the term
30 "NASCAR" must appear at the bottom of the plate. The NASCAR Hall
31 of Fame, after consultation with the National Association for
32 Stock Car Auto Racing, Inc., and the International Speedway
33 Corporation, may submit a sample plate for consideration by the
34 department.
35 (b) The annual use fees shall be distributed to the NASCAR
36 Hall of Fame to be used exclusively for the construction and
37 operation of the NASCAR Hall of Fame.
38 Section 3. This act shall take effect 30 days after the
39 City of Daytona Beach is designated by the National Association
40 for Stock Car Auto Racing, Inc., as the site for the official
41 NASCAR Hall of Fame facility.

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. (1)

Bill No. **31B**

COUNCIL/COMMITTEE ACTION

ADOPTED	__	(Y/N)
ADOPTED AS AMENDED	__	(Y/N)
ADOPTED W/O OBJECTION	__	(Y/N)
FAILED TO ADOPT	__	(Y/N)
WITHDRAWN	__	(Y/N)
OTHER	____	

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1 Council/Committee hearing bill: Fiscal Council
2 Representative(s) Patterson offered the following:
3
4 **Amendment**
5 Remove line(s) 21 and insert:
6 (a) Upon the NASCAR Hall of Fame, Inc., meeting the requirements
7 of s.
8
9

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HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. (3)

Bill No. **31B**

COUNCIL/COMMITTEE ACTION

ADOPTED	__	(Y/N)
ADOPTED AS AMENDED	__	(Y/N)
ADOPTED W/O OBJECTION	__	(Y/N)
FAILED TO ADOPT	__	(Y/N)
WITHDRAWN	__	(Y/N)
OTHER	____	

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1 Council/Committee hearing bill: Fiscal Council
2 Representative(s) Patterson offered the following:
3
4 **Amendment**
5 Remove line(s) 36 and insert:
6 Hall of Fame, Inc., to be used exclusively for the construction
7 and
8
9

000000

HOUSE BILL
HB 15B

Relating to
AD VALOREM
DISCOUNT

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 15B Ad Valorem Property Tax Payment Discounts
SPONSOR(S): Hasner and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 10B

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Finance & Tax Committee	9 Y, 0 N	Monroe	Diez-Arguelles
2) Fiscal Council			
3)			
4)			
5)			

SUMMARY ANALYSIS

Under current law, property taxes are due and payable in November and are delinquent on April 1st of the following year. Taxpayers are given an early payment discount on their property tax bills depending upon when the payment is made. Under this bill, a county which was declared a major disaster area by the President of the United States because of a 2005 named storm may, by an affirmative vote of the local governing body, authorize any of the following discount periods:

- Four percent for taxes paid by January 31, 2006,
- Three percent for taxes paid by February 28, 2006, and
- Two percent for taxes paid by March 31, 2006.

These discount periods will not apply to payments made on behalf of taxpayers by financial institutions.

This bill takes effect upon becoming law.

The fiscal impact of this bill is limited to local governments and is indeterminate.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:
Lower Taxes – by allowing counties to extend the discount periods this bill could result in some taxpayers paying less in property taxes.

B. EFFECT OF PROPOSED CHANGES:

Under current law, property taxes are due and payable in November and are delinquent on April 1st of the following year. Taxpayers are given an early payment discount on their property tax bills depending upon when the payment is made. Section 197.162, F.S., specifies that the discount is four percent for payments made in November or within 30 days of the mailing of the tax bills, three percent for payments made in December, two percent for payments made in January and one percent for payments made in February. Payments made in March or within 30 days of the date of delinquency receive no discount.

Under this bill, a county which was declared a major disaster area by the President of the United States because of a 2005 named storm may, by affirmative vote of the local governing body, authorize any of the following extended discount periods:

- Four percent for taxes paid by January 31, 2006,
- Three percent for taxes paid by February 28, 2006, and
- Two percent for taxes paid by March 31, 2006.

These discount periods will not apply to payments made on behalf of taxpayers by financial institutions.

C. SECTION DIRECTORY:

Section 1 provides for additional or extended discount periods to be authorized by certain counties.

Section 2 specifies that the bill shall take effect upon becoming law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

Indeterminate. Because the discount periods provided for in this bill are only available if a county chooses to enact them, the fiscal impact of this legislation is impossible to predict. However, if all counties which have already been declared disaster areas and approved for individual assistance were to implement the discount periods to their fullest extent, the revenue estimating conference has estimated the fiscal impact would be $46.9 million.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

To the extent the some taxpayers may receive a greater discount than they would otherwise have been eligible for, this bill will reduce taxes.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable because this bill does not appear to: require cities or counties to spend funds or take actions requiring the expenditure of funds; reduce the authority that cities or counties have to raise revenues in the aggregate; or reduce the percentage of a state tax shared with cities or counties.

2. Other:

Because the 2005 hurricane season has now ended, the counties which are eligible for this program can be determined and this bill could be seen as a general bill of local application. Under Article III, Section 11(a)(2), Florida Constitution, there can be no general law of local application concerning the "assessment or collection of taxes for state or county purposes, including extension of time therefore".

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

By changing the description of the class of counties eligible for this program to a class which any county could become a member of, this bill becomes a general bill rather than a general bill of local application, and any potential constitutional problems are avoided.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

1 A bill to be entitled
2 An act relating to ad valorem property tax payment
3 discounts; authorizing certain counties to extend the time
4 during which ad valorem property tax payments made by
5 property owners may be eligible for discounts for early
6 payment under certain circumstances; providing an
7 exception; providing an effective date.
8
9 Be It Enacted by the Legislature of the State of Florida:
10
11 Section 1. Notwithstanding s. 197.162, Florida Statutes,
12 in any county that has been declared a major disaster area by
13 the President of the United States because of a 2005 named
14 storm, and upon an affirmative vote of the governing body of
15 that county, property tax payments made by the owners of the
16 property shall be eligible for any of the following early
17 payment discounts authorized by the county: 4 percent if made by
18 January 31, 2006, 3 percent if made by February 28, 2006, and 2
19 percent if made by March 31, 2006. This provision shall not
20 apply to payments made on behalf of property owners by financial
21 institutions.
22 Section 2. This act shall take effect upon becoming a law.

COUNCIL/COMMITTEE ACTION

ADOPTED	__	(Y/N)
ADOPTED AS AMENDED	__	(Y/N)
ADOPTED W/O OBJECTION	__	(Y/N)
FAILED TO ADOPT	__	(Y/N)
WITHDRAWN	__	(Y/N)
OTHER	____	

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1 Council/Committee hearing bill: Fiscal Council
2 Representative(s) Brummer offered the following:
3
4 **Amendment (with title amendment)**
5 Remove everything after the enacting clause and insert:
6
7 Section 1. (1) Notwithstanding s. 197.162, Florida
8 Statutes, upon an affirmative vote of the governing body of any
9 county that has been declared a major disaster area approved for
10 individual assistance by the President of the United States, the
11 property tax payment made by an owner of property in that county
12 is eligible for an early-payment discount. The county governing
13 body may adopt by emergency ordinance any or all of the
14 following options for such discounts:
15 (a) Four percent for a payment made by January 31, 2006.
16 (b) Three percent for a payment made by February 28, 2006.
17 (c) Two percent for a payment made by March 31, 2006.
18 (2) The Tax Collector shall implement any discount period
19 adopted under subsection (1). Subsection (1) does not apply to
20 payments made on behalf of property owners by the holder or
21 mortgagee of an unsatisfied mortgage, lienholder, or vendee
22 under a contract for deed.

23 (3) If the governing body of any county adopts a discount
24 period as authorized in subsection (1) after tax notices have
25 already been mailed for that tax year, no additional direct mail
26 notice shall be necessary to notify taxpayers of the change.
27 Notice by advertisement in a newspaper of general circulation
28 and posting at all offices of the tax collector shall be
29 sufficient notice.
30 (4) This act expires April 1, 2006.
31 Section 2. This act shall take effect upon becoming a law.
32
33
34 ========== T I T L E A M E N D M E N T ==========
35 Remove the entire title and insert:
36 A bill to be entitled
37 An act relating to the payment of ad valorem taxes;
38 allowing the governing body of a county that has been
39 declared a major disaster area to adopt an ordinance
40 extending the time in which property tax payments made by
41 property owners qualify for early-payment discounts;
42 providing options that counties may choose; providing that
43 additional tax notices are not required; providing for
44 expiration of the act; providing an effective date.
45