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1 A bill to be entitled
2 An act relating to Medicaid services; amending s.
3 409.902, F.S.; creating, subject to appropriation, an
4 Internet-based system for eligibility determination
5 for Medicaid and the Children's Health Insurance
6 Program; requiring the system to accomplish specified
7 business objectives; requiring the Department of
8 Children and Family Services to develop the system
9 contingent upon an appropriation; requiring the system
10 to be completed and implemented by specified dates;
11 requiring the department to implement a governance
12 structure pending implementation of the program;
13 providing for the membership and duties of an
14 executive steering committee and a project management
15 team; amending s. 409.905, F.S.; limiting payment for
16 emergency room services for a nonpregnant Medicaid
17 recipient 21 years of age or older under certain
18 circumstances; amending s. 409.906, F.S.; eliminating
19 Medicaid optional coverage for chiropractic services
20 for a Medicaid recipient 21 years of age or older by a
21 specified date; eliminating Medicaid optional coverage
22 for podiatric services for a Medicaid recipient 21
23 years of age or older by a specified date; amending s.
24 409.911, F.S.; continuing the audited data specified
25 for use in calculating amounts due to hospitals under
26 the disproportionate share program; amending s.
27 409.9112, F.S.; continuing the prohibition against
28 distributing moneys under the disproportionate share

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CODING: Words ~~stricken~~ are deletions; words underlined are additions.

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29 program for regional perinatal intensive care centers;
30 amending s. 409.9113, F.S.; continuing the
31 authorization for the distribution of moneys to
32 certain teaching hospitals under the disproportionate
33 share program; amending s. 409.9117, F.S.; continuing
34 the prohibition against distributing moneys under the
35 primary care disproportionate share program; amending
36 ss. 409.979 and 430.04, F.S.; deleting references to
37 the Adult Day Health Care Waiver in provisions
38 relating to Medicaid eligibility and duties and
39 responsibilities of the Department of Elderly Affairs;
40 amending s. 31, ch. 2009-223, Laws of Florida, as
41 amended, and redesignating the section as s. 409.9132,
42 F.S.; expanding the scope of the home health agency
43 monitoring pilot project; amending s. 32, ch. 2009-
44 223, Laws of Florida, and redesignating the section as
45 s. 409.9133, F.S.; expanding the scope of the
46 comprehensive care management pilot project for home
47 health services; authorizing the Agency for Health
48 Care Administration to contract with certain
49 organizations to provide services under the federal
50 Program of All-inclusive Care for the Elderly in
51 specified counties; exempting such organizations from
52 ch. 641, F.S., relating to health care services
53 programs; authorizing, subject to appropriation,
54 enrollment slots for the program in such counties;
55 providing an effective date.
56

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

58

59 Section 1. Subsections (3) through (8) are added to
60 section 409.902, Florida Statutes, to read:

61 409.902 Designated single state agency; payment
62 requirements; program title; release of medical records.-

63 (3) To the extent that funds are appropriated, the
64 department shall collaborate with the Agency for Health Care
65 Administration to develop an Internet-based system for
66 eligibility determination for Medicaid and the Children's Health
67 Insurance Program (CHIP) that complies with all applicable
68 federal and state laws and requirements.

69 (4) The system shall accomplish the following primary
70 business objectives:

71 (a) Provide individuals and families with a single point
72 of access to information that explains benefits, premiums, and
73 cost-sharing available through Medicaid, the Children's Health
74 Insurance Program, or any other state or federal health
75 insurance exchange.

76 (b) Enable timely, accurate, and efficient enrollment of
77 eligible persons into available assistance programs.

78 (c) Prevent eligibility fraud.

79 (d) Allow for detailed financial analysis of eligibility-
80 based cost drivers.

81 (5) The system shall include, but is not limited to, the
82 following business and functional requirements:

83 (a) Allow for the completion and submission of an online
84 application for eligibility determination that accepts the use

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85 of electronic signatures.

86 (b) Include a process that enables automatic enrollment of
87 qualified individuals in Medicaid, the Children's Health
88 Insurance Program, or any other state or federal exchange that
89 offers cost-sharing benefits for the purchase of health
90 insurance.

91 (c) Allow for the determination of Medicaid eligibility
92 based on modified adjusted gross income by using information
93 submitted in the application and information accessed and
94 verified through automated and secure interfaces with authorized
95 databases.

96 (d) Include the ability to determine specific categories
97 of Medicaid eligibility and interfaces with the Florida Medicaid
98 Management Information System to support a determination, using
99 federally approved assessment methodologies, of state and
100 federal financial participation rates for persons in each
101 eligibility category.

102 (e) Allow for the accurate and timely processing of
103 eligibility claims and adjudications.

104 (f) Align with and incorporate all applicable state and
105 federal laws, requirements, and standards to include the
106 information technology security requirements established
107 pursuant to s. 282.318 and the accessibility standards
108 established under part II of chapter 282.

109 (g) Produce transaction data, reports, and performance
110 information that contribute to an evaluation of the program,
111 continuous improvement in business operations, and increased
112 transparency and accountability.

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113 (6) The department shall develop the system subject to the
114 approval by the Legislative Budget Commission and as required by
115 the General Appropriations Act for the 2012-2013 fiscal year.

116 (7) The system must be completed by October 1, 2013, and
117 ready for implementation by January 1, 2014.

118 (8) The department shall implement the following project-
119 governance structure until the system is implemented:

120 (a) The director of the Economic Self-Sufficiency Services
121 program office of the department shall have overall
122 responsibility for the project.

123 (b) The project shall be governed by an executive steering
124 committee that is composed of three staff members of the
125 department appointed by the Secretary of Children and Family
126 Services and three staff members of the Agency for Health Care
127 Administration, including at least two Florida Medicaid program
128 staff members, appointed by the Secretary of Health Care
129 Administration.

130 (c) The executive steering committee shall have the
131 overall responsibility for ensuring that the project meets its
132 primary business objectives and shall:

133 1. Provide management direction and support to the project
134 management team.

135 2. Review and approve any changes to the project's scope,
136 schedule, and budget.

137 3. Review, approve, and determine whether to proceed with
138 any major deliverable project.

139 4. Recommend suspension or termination of the project to
140 the Governor, the President of the Senate, and the Speaker of

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141 the House of Representatives if the committee determines that
142 the primary business objectives cannot be achieved.

143 (d) A project management team shall be appointed by and
144 work under the direction of the executive steering committee.
145 The project management team shall:

146 1. Provide planning, management, and oversight of the
147 project.

148 2. Submit an operational work plan and provide quarterly
149 updates to the plan to the executive steering committee. The
150 plan must specify project milestones, deliverables, and
151 expenditures.

152 3. Submit written monthly project status reports to the
153 executive steering committee.

154 Section 2. Subsection (5) of section 409.905, Florida
155 Statutes, is amended to read:

156 409.905 Mandatory Medicaid services.—The agency may make
157 payments for the following services, which are required of the
158 state by Title XIX of the Social Security Act, furnished by
159 Medicaid providers to recipients who are determined to be
160 eligible on the dates on which the services were provided. Any
161 service under this section shall be provided only when medically
162 necessary and in accordance with state and federal law.
163 Mandatory services rendered by providers in mobile units to
164 Medicaid recipients may be restricted by the agency. Nothing in
165 this section shall be construed to prevent or limit the agency
166 from adjusting fees, reimbursement rates, lengths of stay,
167 number of visits, number of services, or any other adjustments
168 necessary to comply with the availability of moneys and any

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169 limitations or directions provided for in the General
 170 Appropriations Act or chapter 216.

171 (5) HOSPITAL INPATIENT SERVICES.—The agency shall pay for
 172 all covered services provided for the medical care and treatment
 173 of a recipient who is admitted as an inpatient by a licensed
 174 physician or dentist to a hospital licensed under part I of
 175 chapter 395. However, the agency shall limit the payment for
 176 inpatient hospital services for a Medicaid recipient 21 years of
 177 age or older to 45 days or the number of days necessary to
 178 comply with the General Appropriations Act. The agency shall
 179 also limit the payment for emergency room services for a
 180 nonpregnant Medicaid recipient 21 years of age or older to 12
 181 visits per fiscal year or the number of visits necessary to
 182 comply with the General Appropriations Act.

183 (a) The agency may ~~is authorized to~~ implement
 184 reimbursement and utilization management reforms in order to
 185 comply with any limitations or directions in the General
 186 Appropriations Act, which may include, but are not limited to:
 187 prior authorization for inpatient psychiatric days; prior
 188 authorization for nonemergency hospital inpatient admissions for
 189 individuals 21 years of age and older; authorization of
 190 emergency and urgent-care admissions within 24 hours after
 191 admission; enhanced utilization and concurrent review programs
 192 for highly utilized services; reduction or elimination of
 193 covered days of service; adjusting reimbursement ceilings for
 194 variable costs; adjusting reimbursement ceilings for fixed and
 195 property costs; and implementing target rates of increase. The
 196 agency may limit prior authorization for hospital inpatient

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197 services to selected diagnosis-related groups, based on an
198 analysis of the cost and potential for unnecessary
199 hospitalizations represented by certain diagnoses. Admissions
200 for normal delivery and newborns are exempt from requirements
201 for prior authorization. In implementing the provisions of this
202 section related to prior authorization, the agency shall ensure
203 that the process for authorization is accessible 24 hours per
204 day, 7 days per week and authorization is automatically granted
205 when not denied within 4 hours after the request. Authorization
206 procedures must include steps for review of denials. Upon
207 implementing the prior authorization program for hospital
208 inpatient services, the agency shall discontinue its hospital
209 retrospective review program.

210 (b) A licensed hospital maintained primarily for the care
211 and treatment of patients having mental disorders or mental
212 diseases is not eligible to participate in the hospital
213 inpatient portion of the Medicaid program except as provided in
214 federal law. However, the department shall apply for a waiver,
215 within 9 months after June 5, 1991, designed to provide
216 hospitalization services for mental health reasons to children
217 and adults in the most cost-effective and lowest cost setting
218 possible. Such waiver shall include a request for the
219 opportunity to pay for care in hospitals known under federal law
220 as "institutions for mental disease" or "IMD's." The waiver
221 proposal shall propose no additional aggregate cost to the state
222 or Federal Government, and shall be conducted in Hillsborough
223 County, Highlands County, Hardee County, Manatee County, and
224 Polk County. The waiver proposal may incorporate competitive

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225 bidding for hospital services, comprehensive brokering, prepaid
226 capitated arrangements, or other mechanisms deemed by the
227 department to show promise in reducing the cost of acute care
228 and increasing the effectiveness of preventive care. When
229 developing the waiver proposal, the department shall take into
230 account price, quality, accessibility, linkages of the hospital
231 to community services and family support programs, plans of the
232 hospital to ensure the earliest discharge possible, and the
233 comprehensiveness of the mental health and other health care
234 services offered by participating providers.

235 (c) The agency shall implement a methodology for
236 establishing base reimbursement rates for each hospital based on
237 allowable costs, as defined by the agency. Rates shall be
238 calculated annually and take effect July 1 of each year based on
239 the most recent complete and accurate cost report submitted by
240 each hospital. Adjustments may not be made to the rates after
241 September 30 of the state fiscal year in which the rate takes
242 effect. Errors in cost reporting or calculation of rates
243 discovered after September 30 must be reconciled in a subsequent
244 rate period. The agency may not make any adjustment to a
245 hospital's reimbursement rate more than 5 years after a hospital
246 is notified of an audited rate established by the agency. The
247 requirement that the agency may not make any adjustment to a
248 hospital's reimbursement rate more than 5 years after a hospital
249 is notified of an audited rate established by the agency is
250 remedial and shall apply to actions by providers involving
251 Medicaid claims for hospital services. Hospital rates shall be
252 subject to such limits or ceilings as may be established in law

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253 or described in the agency's hospital reimbursement plan.
254 Specific exemptions to the limits or ceilings may be provided in
255 the General Appropriations Act.

256 (d) The agency shall implement a comprehensive utilization
257 management program for hospital neonatal intensive care stays in
258 certain high-volume participating hospitals, select counties, or
259 statewide, and replace existing hospital inpatient utilization
260 management programs for neonatal intensive care admissions. The
261 program shall be designed to manage the lengths of stay for
262 children being treated in neonatal intensive care units and must
263 seek the earliest medically appropriate discharge to the child's
264 home or other less costly treatment setting. The agency may
265 competitively bid a contract for the selection of a qualified
266 organization to provide neonatal intensive care utilization
267 management services. The agency may seek federal waivers to
268 implement this initiative.

269 (e) The agency may develop and implement a program to
270 reduce the number of hospital readmissions among the non-
271 Medicare population eligible in areas 9, 10, and 11.

272 (f) The agency shall develop a plan to convert inpatient
273 hospital rates to a prospective payment system that categorizes
274 each case into diagnosis-related groups (DRG) and assigns a
275 payment weight based on the average resources used to treat
276 Medicaid patients in that DRG. To the extent possible, the
277 agency shall propose an adaptation of an existing prospective
278 payment system, such as the one used by Medicare, and shall
279 propose such adjustments as are necessary for the Medicaid
280 population and to maintain budget neutrality for inpatient

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281 hospital expenditures. The agency shall submit the Medicaid DRG
282 plan, identifying all steps necessary for the transition and any
283 costs associated with plan implementation, to the Governor, the
284 President of the Senate, and the Speaker of the House of
285 Representatives no later than January 1, 2013.

286 Section 3. Subsections (7) and (19) of section 409.906,
287 Florida Statutes, are amended to read:

288 409.906 Optional Medicaid services.—Subject to specific
289 appropriations, the agency may make payments for services which
290 are optional to the state under Title XIX of the Social Security
291 Act and are furnished by Medicaid providers to recipients who
292 are determined to be eligible on the dates on which the services
293 were provided. Any optional service that is provided shall be
294 provided only when medically necessary and in accordance with
295 state and federal law. Optional services rendered by providers
296 in mobile units to Medicaid recipients may be restricted or
297 prohibited by the agency. Nothing in this section shall be
298 construed to prevent or limit the agency from adjusting fees,
299 reimbursement rates, lengths of stay, number of visits, or
300 number of services, or making any other adjustments necessary to
301 comply with the availability of moneys and any limitations or
302 directions provided for in the General Appropriations Act or
303 chapter 216. If necessary to safeguard the state's systems of
304 providing services to elderly and disabled persons and subject
305 to the notice and review provisions of s. 216.177, the Governor
306 may direct the Agency for Health Care Administration to amend
307 the Medicaid state plan to delete the optional Medicaid service
308 known as "Intermediate Care Facilities for the Developmentally

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309 Disabled." Optional services may include:

310 (7) CHIROPRACTIC SERVICES.—Effective August 1, 2012, the
 311 agency may pay for manual manipulation of the spine and initial
 312 services, screening, and X rays provided to a Medicaid recipient
 313 under the age of 21 by a licensed chiropractic physician.

314 (19) PODIATRIC SERVICES.—Effective August 1, 2012, the
 315 agency may pay for services, including diagnosis and medical,
 316 surgical, palliative, and mechanical treatment, related to
 317 ailments of the human foot and lower leg, if provided to a
 318 Medicaid recipient under the age of 21 by a podiatric physician
 319 licensed under state law.

320 Section 4. Paragraph (a) of subsection (2) and paragraph
 321 (d) of subsection (4) of section 409.911, Florida Statutes, are
 322 amended to read:

323 409.911 Disproportionate share program.—Subject to
 324 specific allocations established within the General
 325 Appropriations Act and any limitations established pursuant to
 326 chapter 216, the agency shall distribute, pursuant to this
 327 section, moneys to hospitals providing a disproportionate share
 328 of Medicaid or charity care services by making quarterly
 329 Medicaid payments as required. Notwithstanding the provisions of
 330 s. 409.915, counties are exempt from contributing toward the
 331 cost of this special reimbursement for hospitals serving a
 332 disproportionate share of low-income patients.

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

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337 (a) The average of the 2004, 2005, and 2006 audited
 338 disproportionate share data to determine each hospital's
 339 Medicaid days and charity care for the 2012-2013 ~~2011-2012~~ state
 340 fiscal year.

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

343 (d) Any nonstate government owned or operated hospital
 344 eligible for payments under this section on July 1, 2011,
 345 remains eligible for payments during the 2012-2013 ~~2011-2012~~
 346 state fiscal year.

347 Section 5. Section 409.9112, Florida Statutes, is amended
 348 to read:

349 409.9112 Disproportionate share program for regional
 350 perinatal intensive care centers.—In addition to the payments
 351 made under s. 409.911, the agency shall design and implement a
 352 system for making disproportionate share payments to those
 353 hospitals that participate in the regional perinatal intensive
 354 care center program established pursuant to chapter 383. The
 355 system of payments must conform to federal requirements and
 356 distribute funds in each fiscal year for which an appropriation
 357 is made by making quarterly Medicaid payments. Notwithstanding
 358 s. 409.915, counties are exempt from contributing toward the
 359 cost of this special reimbursement for hospitals serving a
 360 disproportionate share of low-income patients. For the 2012-2013
 361 ~~2011-2012~~ state fiscal year, the agency may not distribute
 362 moneys under the regional perinatal intensive care centers
 363 disproportionate share program.

364 (1) The following formula shall be used by the agency to

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365 calculate the total amount earned for hospitals that participate
 366 in the regional perinatal intensive care center program:

$$367 \quad \text{TAE} = \text{HDSP} / \text{THDSP}$$

368 Where:

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

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

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

377 (2) The total additional payment for hospitals that
 378 participate in the regional perinatal intensive care center
 379 program shall be calculated by the agency as follows:

$$380 \quad \text{TAP} = \text{TAE} \times \text{TA}$$

381 Where:

382 TAP = total additional payment for a regional perinatal
 383 intensive care center.

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

386 TA = total appropriation for the regional perinatal
 387 intensive care center disproportionate share program.

388 (3) In order to receive payments under this section, a
 389 hospital must be participating in the regional perinatal
 390 intensive care center program pursuant to chapter 383 and must
 391 meet the following additional requirements:

392 (a) Agree to conform to all departmental and agency

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393 requirements to ensure high quality in the provision of
394 services, including criteria adopted by departmental and agency
395 rule concerning staffing ratios, medical records, standards of
396 care, equipment, space, and such other standards and criteria as
397 the department and agency deem appropriate as specified by rule.

398 (b) Agree to provide information to the Department of
399 Health and the agency, in a form and manner prescribed by rule
400 of the department and agency, concerning the care provided to
401 all patients in neonatal intensive care centers and high-risk
402 maternity care.

403 (c) Agree to accept all patients for neonatal intensive
404 care and high-risk maternity care, regardless of ability to pay,
405 on a functional space-available basis.

406 (d) Agree to develop arrangements with other maternity and
407 neonatal care providers in the hospital's region for the
408 appropriate receipt and transfer of patients in need of
409 specialized maternity and neonatal intensive care services.

410 (e) Agree to establish and provide a developmental
411 evaluation and services program for certain high-risk neonates,
412 as prescribed and defined by rule of the department.

413 (f) Agree to sponsor a program of continuing education in
414 perinatal care for health care professionals within the region
415 of the hospital, as specified by rule.

416 (g) Agree to provide backup and referral services to the
417 county health departments and other low-income perinatal
418 providers within the hospital's region, including the
419 development of written agreements between these organizations
420 and the hospital.

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421 (h) Agree to arrange for transportation for high-risk
 422 obstetrical patients and neonates in need of transfer from the
 423 community to the hospital or from the hospital to another more
 424 appropriate facility.

425 (4) Hospitals that fail to comply with any of the
 426 conditions in subsection (3) or the applicable rules of the
 427 Department of Health and the agency may not receive any payments
 428 under this section until full compliance is achieved. A hospital
 429 that is not in compliance in two or more consecutive quarters
 430 may not receive its share of the funds. Any forfeited funds
 431 shall be distributed by the remaining participating regional
 432 perinatal intensive care center program hospitals.

433 Section 6. Section 409.9113, Florida Statutes, is amended
 434 to read:

435 409.9113 Disproportionate share program for teaching
 436 hospitals.—In addition to the payments made under ss. 409.911
 437 and 409.9112, the agency shall make disproportionate share
 438 payments to teaching hospitals, as defined in s. 408.07, for
 439 their increased costs associated with medical education programs
 440 and for tertiary health care services provided to the indigent.
 441 This system of payments must conform to federal requirements and
 442 distribute funds in each fiscal year for which an appropriation
 443 is made by making quarterly Medicaid payments. Notwithstanding
 444 s. 409.915, counties are exempt from contributing toward the
 445 cost of this special reimbursement for hospitals serving a
 446 disproportionate share of low-income patients. For the 2012-2013
 447 ~~2011-2012~~ state fiscal year, the agency shall distribute the
 448 moneys provided in the General Appropriations Act to statutorily

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449 defined teaching hospitals and family practice teaching
450 hospitals, as defined in s. 395.805, pursuant to this section.
451 The funds provided for statutorily defined teaching hospitals
452 shall be distributed as provided in the General Appropriations
453 Act. The funds provided for family practice teaching hospitals
454 shall be distributed equally among family practice teaching
455 hospitals.

456 (1) On or before September 15 of each year, the agency
457 shall calculate an allocation fraction to be used for
458 distributing funds to statutory teaching hospitals. Subsequent
459 to the end of each quarter of the state fiscal year, the agency
460 shall distribute to each statutory teaching hospital an amount
461 determined by multiplying one-fourth of the funds appropriated
462 for this purpose by the Legislature times such hospital's
463 allocation fraction. The allocation fraction for each such
464 hospital shall be determined by the sum of the following three
465 primary factors, divided by three:

466 (a) The number of nationally accredited graduate medical
467 education programs offered by the hospital, including programs
468 accredited by the Accreditation Council for Graduate Medical
469 Education and the combined Internal Medicine and Pediatrics
470 programs acceptable to both the American Board of Internal
471 Medicine and the American Board of Pediatrics at the beginning
472 of the state fiscal year preceding the date on which the
473 allocation fraction is calculated. The numerical value of this
474 factor is the fraction that the hospital represents of the total
475 number of programs, where the total is computed for all
476 statutory teaching hospitals.

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477 (b) The number of full-time equivalent trainees in the
478 hospital, which comprises two components:

479 1. The number of trainees enrolled in nationally
480 accredited graduate medical education programs, as defined in
481 paragraph (a). Full-time equivalents are computed using the
482 fraction of the year during which each trainee is primarily
483 assigned to the given institution, over the state fiscal year
484 preceding the date on which the allocation fraction is
485 calculated. The numerical value of this factor is the fraction
486 that the hospital represents of the total number of full-time
487 equivalent trainees enrolled in accredited graduate programs,
488 where the total is computed for all statutory teaching
489 hospitals.

490 2. The number of medical students enrolled in accredited
491 colleges of medicine and engaged in clinical activities,
492 including required clinical clerkships and clinical electives.
493 Full-time equivalents are computed using the fraction of the
494 year during which each trainee is primarily assigned to the
495 given institution, over the course of the state fiscal year
496 preceding the date on which the allocation fraction is
497 calculated. The numerical value of this factor is the fraction
498 that the given hospital represents of the total number of full-
499 time equivalent students enrolled in accredited colleges of
500 medicine, where the total is computed for all statutory teaching
501 hospitals.

502

503 The primary factor for full-time equivalent trainees is computed
504 as the sum of these two components, divided by two.

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505 (c) A service index that comprises three components:
506 1. The Agency for Health Care Administration Service
507 Index, computed by applying the standard Service Inventory
508 Scores established by the agency to services offered by the
509 given hospital, as reported on Worksheet A-2 for the last fiscal
510 year reported to the agency before the date on which the
511 allocation fraction is calculated. The numerical value of this
512 factor is the fraction that the given hospital represents of the
513 total index values, where the total is computed for all
514 statutory teaching hospitals.

515 2. A volume-weighted service index, computed by applying
516 the standard Service Inventory Scores established by the agency
517 to the volume of each service, expressed in terms of the
518 standard units of measure reported on Worksheet A-2 for the last
519 fiscal year reported to the agency before the date on which the
520 allocation factor is calculated. The numerical value of this
521 factor is the fraction that the given hospital represents of the
522 total volume-weighted service index values, where the total is
523 computed for all statutory teaching hospitals.

524 3. Total Medicaid payments to each hospital for direct
525 inpatient and outpatient services during the fiscal year
526 preceding the date on which the allocation factor is calculated.
527 This includes payments made to each hospital for such services
528 by Medicaid prepaid health plans, whether the plan was
529 administered by the hospital or not. The numerical value of this
530 factor is the fraction that each hospital represents of the
531 total of such Medicaid payments, where the total is computed for
532 all statutory teaching hospitals.

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533
 534 The primary factor for the service index is computed as the sum
 535 of these three components, divided by three.

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

$$TAP = THAF \times A$$

540 Where:

541 TAP = total additional payment.

542 THAF = teaching hospital allocation factor.

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

545 Section 7. Section 409.9117, Florida Statutes, is amended
 546 to read:

547 409.9117 Primary care disproportionate share program.—For
 548 the 2012-2013 ~~2011-2012~~ state fiscal year, the agency shall not
 549 distribute moneys under the primary care disproportionate share
 550 program.

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

555 (2) The following formula shall be used by the agency to
 556 calculate the total amount earned for hospitals that participate
 557 in the primary care disproportionate share program:

$$TAE = HDSP/THDSP$$

559 Where:

560 TAE = total amount earned by a hospital participating in

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561 the primary care disproportionate share program.

562 HDSP = the prior state fiscal year primary care
563 disproportionate share payment to the individual hospital.

564 THDSP = the prior state fiscal year total primary care
565 disproportionate share payments to all hospitals.

566 (3) The total additional payment for hospitals that
567 participate in the primary care disproportionate share program
568 shall be calculated by the agency as follows:

$$TAP = TAE \times TA$$

570 Where:

571 TAP = total additional payment for a primary care hospital.

572 TAE = total amount earned by a primary care hospital.

573 TA = total appropriation for the primary care
574 disproportionate share program.

575 (4) In establishing and funding this program, the agency
576 shall use the following criteria in addition to those specified
577 in s. 409.911, and payments may not be made to a hospital unless
578 the hospital agrees to:

579 (a) Cooperate with a Medicaid prepaid health plan, if one
580 exists in the community.

581 (b) Ensure the availability of primary and specialty care
582 physicians to Medicaid recipients who are not enrolled in a
583 prepaid capitated arrangement and who are in need of access to
584 such physicians.

585 (c) Coordinate and provide primary care services free of
586 charge, except copayments, to all persons with incomes up to 100
587 percent of the federal poverty level who are not otherwise
588 covered by Medicaid or another program administered by a

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589 governmental entity, and to provide such services based on a
590 sliding fee scale to all persons with incomes up to 200 percent
591 of the federal poverty level who are not otherwise covered by
592 Medicaid or another program administered by a governmental
593 entity, except that eligibility may be limited to persons who
594 reside within a more limited area, as agreed to by the agency
595 and the hospital.

596 (d) Contract with any federally qualified health center,
597 if one exists within the agreed geopolitical boundaries,
598 concerning the provision of primary care services, in order to
599 guarantee delivery of services in a nonduplicative fashion, and
600 to provide for referral arrangements, privileges, and
601 admissions, as appropriate. The hospital shall agree to provide
602 primary care services within 24 hours at an onsite or offsite
603 facility to which all Medicaid recipients and persons eligible
604 under this paragraph who do not require emergency room services
605 are referred during normal daylight hours.

606 (e) Cooperate with the agency, the county, and other
607 entities to ensure the provision of certain public health
608 services, case management, referral and acceptance of patients,
609 and sharing of epidemiological data, as the agency and the
610 hospital find mutually necessary and desirable to promote and
611 protect the public health within the agreed geopolitical
612 boundaries.

613 (f) In cooperation with the county in which the hospital
614 resides, develop a low-cost, outpatient, prepaid health care
615 program to persons who are not eligible for the Medicaid
616 program, and who reside within the area.

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617 (g) Provide inpatient services to residents within the
618 area who are not eligible for Medicaid or Medicare, and who do
619 not have private health insurance, regardless of ability to pay,
620 on the basis of available space, except that hospitals may not
621 be prevented from establishing bill collection programs based on
622 ability to pay.

623 (h) Work with the Florida Healthy Kids Corporation, the
624 Florida Health Care Purchasing Cooperative, and business health
625 coalitions, as appropriate, to develop a feasibility study and
626 plan to provide a low-cost comprehensive health insurance plan
627 to persons who reside within the area and who do not have access
628 to such a plan.

629 (i) Work with public health officials and other experts to
630 provide community health education and prevention activities
631 designed to promote healthy lifestyles and appropriate use of
632 health services.

633 (j) Work with the local health council to develop a plan
634 for promoting access to affordable health care services for all
635 persons who reside within the area, including, but not limited
636 to, public health services, primary care services, inpatient
637 services, and affordable health insurance generally.

638
639 Any hospital that fails to comply with any of the provisions of
640 this subsection, or any other contractual condition, may not
641 receive payments under this section until full compliance is
642 achieved.

643 Section 8. Subsection (2) of section 409.979, Florida
644 Statutes, is amended to read:

645 409.979 Eligibility.—

646 (2) Medicaid recipients who, on the date long-term care
 647 managed care plans become available in their region, reside in a
 648 nursing home facility or are enrolled in one of the following
 649 long-term care Medicaid waiver programs are eligible to
 650 participate in the long-term care managed care program for up to
 651 12 months without being reevaluated for their need for nursing
 652 facility care as defined in s. 409.985(3):

653 (a) The Assisted Living for the Frail Elderly Waiver.

654 (b) The Aged and Disabled Adult Waiver.

655 ~~(c) The Adult Day Health Care Waiver.~~

656 (c)~~(d)~~ The Consumer-Directed Care Plus Program as
 657 described in s. 409.221.

658 (d)~~(e)~~ The Program of All-inclusive Care for the Elderly.

659 (e)~~(f)~~ The long-term care community-based diversion pilot
 660 project as described in s. 430.705.

661 (f)~~(g)~~ The Channeling Services Waiver for Frail Elders.

662 Section 9. Subsection (15) of section 430.04, Florida
 663 Statutes, is amended to read:

664 430.04 Duties and responsibilities of the Department of
 665 Elderly Affairs.—The Department of Elderly Affairs shall:

666 (15) Administer all Medicaid waivers and programs relating
 667 to elders and their appropriations. The waivers include, but are
 668 not limited to:

669 (a) The Assisted Living for the Frail Elderly Waiver.

670 (b) The Aged and Disabled Adult Waiver.

671 ~~(c) The Adult Day Health Care Waiver.~~

672 (c)~~(d)~~ The Consumer-Directed Care Plus Program as defined

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673 | in s. 409.221.

674 | ~~(d)(e)~~ The Program of All-inclusive Care for the Elderly.

675 | ~~(e)(f)~~ The Long-Term Care Community-Based Diversion Pilot
676 | Project as described in s. 430.705.

677 | ~~(f)(g)~~ The Channeling Services Waiver for Frail Elders.

678 |

679 | The department shall develop a transition plan for recipients
680 | receiving services in long-term care Medicaid waivers for elders
681 | or disabled adults on the date eligible plans become available
682 | in each recipient's region defined in s. 409.981(2) to enroll
683 | those recipients in eligible plans. This subsection expires
684 | October 1, 2014.

685 | Section 10. Section 31 of chapter 2009-223, Laws of
686 | Florida, as amended by section 44 of chapter 2010-151, Laws of
687 | Florida, is redesignated as section 409.9132, Florida Statutes,
688 | and amended to read:

689 | 409.9132 ~~Section 31.~~ Pilot project to monitor home health
690 | services.—The Agency for Health Care Administration may expand
691 | the shall develop and implement a home health agency monitoring
692 | pilot project in Miami-Dade County to include Broward, Escambia,
693 | Martin, and Palm Beach Counties, effective July 1, 2012 by
694 | January 1, 2010. The agency shall contract with a vendor to
695 | verify the utilization and delivery of home health services and
696 | provide an electronic billing interface for home health
697 | services. The contract must require the creation of a program to
698 | submit claims electronically for the delivery of home health
699 | services. The program must verify telephonically visits for the
700 | delivery of home health services using voice biometrics. The

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701 agency may seek amendments to the Medicaid state plan and
 702 waivers of federal laws, as necessary, to implement or expand
 703 the pilot project. Notwithstanding s. 287.057(3)(f), ~~Florida~~
 704 ~~Statutes~~, the agency must award the contract through the
 705 competitive solicitation process and may use the current
 706 contract to expand the home health agency monitoring pilot
 707 project to include additional counties as authorized under this
 708 section. ~~The agency shall submit a report to the Governor, the~~
 709 ~~President of the Senate, and the Speaker of the House of~~
 710 ~~Representatives evaluating the pilot project by February 1,~~
 711 ~~2011.~~

712 Section 11. Section 32 of chapter 2009-223, Laws of
 713 Florida, is redesignated as section 409.9133, Florida Statutes,
 714 and amended to read:

715 409.9133 ~~Section 32.~~ Pilot project for home health care
 716 management.—The Agency for Health Care Administration may expand
 717 the ~~shall implement~~ a comprehensive care management pilot
 718 project for home health services to include private duty nursing
 719 and personal care services effective July 1, 2012 ~~by January 1,~~
 720 ~~2010~~, which includes face-to-face assessments by a nurse
 721 licensed pursuant to chapter 464, Florida Statutes, consultation
 722 with physicians ordering services to substantiate the medical
 723 necessity for services, and on-site or desk reviews of
 724 recipients' medical records, in Miami-Dade, Broward, Orange, and
 725 Palm Beach Counties ~~County~~. The agency may enter into a contract
 726 with a qualified organization to implement or expand the pilot
 727 project. The agency may use the current contract to expand the
 728 comprehensive care management pilot project to include the

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729 additional services and counties as authorized under this
730 section. The agency may seek amendments to the Medicaid state
731 plan and waivers of federal laws, as necessary, to implement or
732 expand the pilot project.

733 Section 12. Notwithstanding s. 430.707, Florida Statutes,
734 and subject to federal approval of the application to be a site
735 for the Program of All-inclusive Care for the Elderly (PACE),
736 the Agency for Health Care Administration shall contract with
737 one not-for-profit organization with more than 30 years'
738 experience as a licensed hospice provider and currently licensed
739 as a hospice provider to serve individuals and families in
740 Duval, Clay, and Alachua Counties. This not-for-profit
741 organization shall provide PACE services to frail elders who
742 reside in Duval, Clay, and Alachua Counties. The organization
743 shall be exempt from the requirements of chapter 641, Florida
744 Statutes. The agency, in consultation with the Department of
745 Elderly Affairs and subject to an appropriation, shall approve
746 up to 150 initial enrollees in the Program of All-inclusive Care
747 for the Elderly established by this organization to serve frail
748 elders who reside in Duval, Clay, and Alachua Counties.

749 Section 13. Notwithstanding s. 430.707, Florida Statutes,
750 and subject to federal approval of the application to be a site
751 for the Program of All-inclusive Care for the Elderly (PACE),
752 the Agency for Health Care Administration shall contract with
753 one private health care organization, the sole member of which
754 is a private, not-for-profit corporation that owns and manages
755 health care organizations licensed in Manatee, Sarasota, and
756 DeSoto Counties which provide comprehensive services, including

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757 hospice and palliative care, to frail elders who reside in these
758 counties. The organization shall be exempt from the requirements
759 of chapter 641, Florida Statutes. The agency, in consultation
760 with the Department of Elderly Affairs and subject to an
761 appropriation, shall approve up to 150 initial enrollees in the
762 Program of All-inclusive Care for the Elderly established by
763 this organization to serve frail elders who reside in Manatee,
764 Sarasota, and DeSoto Counties.

765 Section 14. This act shall take effect July 1, 2012.