By the Committee on Health and Human Services Appropriations; and Senator Peaden

603-03992-09 20091658c1

A bill to be entitled

An act relating to the health care; amending s. 408.040, F.S.; conforming a cross-reference; amending s. 409.814, F.S.; requiring an applicant for the Florida Kidcare program to provide verification of the child's citizenship status; amending s. 409.815, F.S.; revising behavioral health services and dental services coverage under the Kidcare program; revising methods by which payments are made to federally qualified health centers and rural health clinics; amending s. 409.818, F.S.; revising the manner by which quality assurance and access standards are monitored in the Kidcare program; amending s. 409.904, F.S.; extending the date that certain persons are eligible to receive optional Medicaid services; amending s. 409.905, F.S.; requiring prior authorization for certain home health services; establishing requirements for Medicaid reimbursed home health services; revising the criteria for adjusting a hospital's inpatient per diem rate; amending s. 409.908, F.S.; requiring increases in certain Medicaid provider rates to be authorized in the appropriations act; amending s. 409.9082, F.S.; authorizing an exemption from the nursing home quality assessment to a nursing facility that has a certain number of indigent census days; deleting an option for discontinuing the nursing home quality assessment; amending s. 409.911, F.S.; updating the data to be used in calculating disproportionate share; amending

s. 409.9112, F.S.; continuing the prohibition against distributing moneys under the perinatal intensive care centers disproportionate share program; amending s. 409.9113, F.S.; continuing authorization for the distribution of moneys to teaching hospitals under the disproportionate share program; amending s. 409.9117, F.S.; continuing the prohibition against distributing moneys for the primary care disproportionate share program; amending ss. 409.91195 and 409.91196, F.S.; conforming cross-references; amending s. 409.912, F.S.; deleting the fixed payment for delivery program for Medicaid recipients 60 years of age or older; requiring that a Medicaid managed care plan's costs to the state be adjusted for health status; amending s. 409.91211, F.S.; revising the timeline for phasing in financial risk for provider service networks; conforming cross-references; amending s. 430.04, F.S.; requiring the Department of Elderly Affairs to administer all Medicaid waivers and programs relating to elders; amending s. 641.386, F.S.; conforming a cross-reference; directing the Agency for Health Care Administration to establish pilot projects in Miami-Dade County relating to home health services; providing an effective date.

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

Section 1. Paragraph (d) of subsection (1) of section 408.040, Florida Statutes, is amended to read:

408.040 Conditions and monitoring.—

(1)

(d) If a nursing home is located in a county in which a long-term care community diversion pilot project has been implemented under s. 430.705 ~~or in a county in which an integrated, fixed-payment delivery program for Medicaid recipients who are 60 years of age or older or dually eligible for Medicare and Medicaid has been implemented under s. 409.912(5)~~, the nursing home may request a reduction in the percentage of annual patient days used by residents who are eligible for care under Title XIX of the Social Security Act, which is a condition of the nursing home's certificate of need. The agency shall automatically grant the nursing home's request if the reduction is not more than 15 percent of the nursing home's annual Medicaid-patient-days condition. A nursing home may submit only one request every 2 years for an automatic reduction. A requesting nursing home must notify the agency in writing at least 60 days in advance of its intent to reduce its annual Medicaid-patient-days condition by not more than 15 percent. The agency must acknowledge the request in writing and must change its records to reflect the revised certificate-of-need condition. This paragraph expires June 30, 2011.

Section 2. Paragraph (c) is added to subsection (8) of section 409.814, Florida Statutes, to read:

409.814 Eligibility.—A child who has not reached 19 years of age whose family income is equal to or below 200 percent of the federal poverty level is eligible for the Florida Kidcare program as provided in this section. For enrollment in the Children's Medical Services Network, a complete application

includes the medical or behavioral health screening. If, subsequently, an individual is determined to be ineligible for coverage, he or she must immediately be disenrolled from the respective Florida Kidcare program component.

(8) In determining the eligibility of a child, an assets test is not required. Each applicant shall provide written documentation during the application process and the redetermination process, including, but not limited to, the following:

(c) Effective January 1, 2010, verification of the child's citizenship status as required under Title XXI of the Social Security Act.

Section 3. Paragraphs (g) and (q) of section (2) of section 409.815, Florida Statutes, are amended, and paragraph (w) is added to that section, to read:

409.815 Health benefits coverage; limitations.—

(2) BENCHMARK BENEFITS.—In order for health benefits coverage to qualify for premium assistance payments for an eligible child under ss. 409.810-409.820, the health benefits coverage, except for coverage under Medicaid and Medikids, must include the following minimum benefits, as medically necessary.

(g) *Behavioral health services.*—

1. Mental health benefits include:

a. Inpatient services, limited to ~~not more than~~ 30 inpatient days per contract year for psychiatric admissions, or residential services in facilities licensed under s. 394.875(6) or s. 395.003 in lieu of inpatient psychiatric admissions; however, a minimum of 10 of the 30 days shall be available only for inpatient psychiatric services if ~~when~~ authorized by a

physician; and

b. Outpatient services, including outpatient visits for psychological or psychiatric evaluation, diagnosis, and treatment by a licensed mental health professional, limited to ~~a maximum of~~ 40 outpatient visits each contract year.

2. Substance abuse services include:

a. Inpatient services, limited to ~~not more than~~ 7 inpatient days per contract year for medical detoxification only and 30 days of residential services; and

b. Outpatient services, including evaluation, diagnosis, and treatment by a licensed practitioner, limited to ~~a maximum of~~ 40 outpatient visits per contract year.

Effective October 1, 2009, covered services include inpatient and outpatient services for mental and nervous disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. Such benefits include psychological or psychiatric evaluation, diagnosis, and treatment by a licensed mental health professional, and inpatient, outpatient, and residential treatment services for the diagnosis and treatment of substance abuse disorders. Any benefit limitations, including duration of services, number of visits, or number of days for hospitalization or residential services may not be any less favorable than those for physical illnesses generally for the care and treatment of schizophrenia and psychotic disorders, mood disorders, anxiety disorders, substance abuse disorders, eating disorders, and childhood attention deficit disorders. The program may also implement appropriate financial incentives,

peer review, utilization requirements, and other methods used for the management of benefits provided for other medical conditions in order to reduce service costs and utilization without compromising quality of care.

(q) *Dental services.*—Effective October 1, 2009, dental services shall be covered as required under federal law and may also include those dental benefits provided to children by the Florida Medicaid program under s. 409.906(6).

(w) *Reimbursement of federally qualified health centers and rural health clinics.*—Effective October 1, 2009, payments for services provided to enrollees by federally qualified health centers and rural health clinics under this section shall be reimbursed using the Medicaid Prospective Payment System as provided for under s. 2107(e)(1)(D) of the Social Security Act, as added by subsection (a). If such services are paid for by health insurers or health care providers under contract with the Florida Healthy Kids Corporation, such entities are responsible for this payment. The agency may seek any available federal grants to assist with this transition.

Section 4. Paragraph (c) of subsection (3) of section 409.818, Florida Statutes, is amended to read:

409.818 Administration.—In order to implement ss. 409.810-409.820, the following agencies shall have the following duties:

(3) The Agency for Health Care Administration, under the authority granted in s. 409.914(1), shall:

(c) Monitor compliance with quality assurance and access standards developed under s. 409.820 and in accordance with s. 2103(f) of the Social Security Act, 42 U.S.C. 1397bb(f).

The agency is designated the lead state agency for Title XXI of the Social Security Act for purposes of receipt of federal funds, for reporting purposes, and for ensuring compliance with federal and state regulations and rules.

Section 5. Subsection (1) and paragraph (a) of subsection (2) of section 409.904, Florida Statutes, are amended to read:

409.904 Optional payments for eligible persons.—The agency may make payments for medical assistance and related services on behalf of the following persons who are determined to be eligible subject to the income, assets, and categorical eligibility tests set forth in federal and state law. Payment on behalf of these Medicaid eligible persons is subject to the availability of moneys and any limitations established by the General Appropriations Act or chapter 216.

(1) ~~Effective January 1, 2006, and~~ Subject to federal waiver approval, a person who is age 65 or older or is determined to be disabled, whose income is at or below 88 percent of the federal poverty level, whose assets do not exceed established limitations, and who is not eligible for Medicare or, if eligible for Medicare, is also eligible for and receiving Medicaid-covered institutional care services, hospice services, or home and community-based services. The agency shall seek federal authorization through a waiver to provide this coverage. This subsection expires December 31, 2010 ~~June 30, 2009~~.

(2)(a) A family, a pregnant woman, a child under age 21, a person age 65 or over, or a blind or disabled person, who would be eligible under any group listed in s. 409.903(1), (2), or (3), except that the income or assets of such family or person exceed established limitations. For a family or person in one of

these coverage groups, medical expenses are deductible from income in accordance with federal requirements in order to make a determination of eligibility. A family or person eligible under the coverage known as the "medically needy," is eligible to receive the same services as other Medicaid recipients, with the exception of services in skilled nursing facilities and intermediate care facilities for the developmentally disabled. This subsection expires December 31, 2010 ~~June 30, 2009~~.

Section 6. Subsection (4) and paragraph (c) of subsection (5) of section 409.905, Florida Statutes, are amended to read:

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

(4) HOME HEALTH CARE SERVICES.—The agency shall pay for nursing and home health aide services, supplies, appliances, and durable medical equipment, necessary to assist a recipient living at home. An entity that provides services pursuant to

this subsection must ~~shall~~ be licensed under part III of chapter 400. These services, equipment, and supplies, or reimbursement therefor, may be limited as provided in the General Appropriations Act and do not include services, equipment, or supplies provided to a person residing in a hospital or nursing facility.

(a) In providing home health care services, the agency may require prior authorization of care based on diagnosis or utilization rates. Prior authorization is required for home health services visits not associated with a skilled nursing visit if the home health agency's utilization rates exceed the state average by 50 percent or more. The home health agency must submit documentation that supports the recipient's diagnosis and the recipient's plan of care to the agency when requesting prior authorization.

(b) The agency shall implement a comprehensive utilization management program that requires prior authorization of all private duty nursing services, an individualized treatment plan that includes information about medication and treatment orders, treatment goals, methods of care to be used, and plans for care coordination by nurses and other health professionals. The ~~utilization management~~ program shall also include a process for periodically reviewing the ongoing use of private duty nursing services. For a child, the assessment of need shall be based on a child's condition, family support and care supplements, a family's ability to provide care, and a family's and child's schedule regarding work, school, sleep, and care for other family dependents. When implemented, the private duty nursing utilization management program shall replace the current

authorization program used by the agency ~~for Health Care Administration~~ and the Children's Medical Services program of the Department of Health. The agency may competitively bid on a contract to select a qualified organization to provide utilization management of private duty nursing services. The agency is authorized to seek federal waivers to implement this initiative.

(c) The agency may provide reimbursement for only those home health services that are medically necessary and if:

1. The services are ordered by a physician.

2. The written prescription for services is signed and dated by the recipient's physician before the development of a plan of care and before any required request for prior authorization.

3. The physician ordering the services is not employed, under contract with, or otherwise affiliated with the home health agency rendering the services.

4. The physician ordering the services has examined the recipient within 30 days before the initial request for services and biannually thereafter.

5. The written prescription for the services includes the recipient's acute or chronic medical condition or diagnosis; the home health service required, including the minimum skill level required to perform the service; and the frequency and duration of services.

6. The national provider identifier, Medicaid identification number, or medical practitioner license number of the physician ordering the services is listed on the written prescription for the services, the claim for home health

reimbursement, and the prior authorization request.

(5) HOSPITAL INPATIENT SERVICES.—The agency shall pay for all covered services provided for the medical care and treatment of a recipient who is admitted as an inpatient by a licensed physician or dentist to a hospital licensed under part I of chapter 395. However, the agency shall limit the payment for inpatient hospital services for a Medicaid recipient 21 years of age or older to 45 days or the number of days necessary to comply with the General Appropriations Act.

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

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

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

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

By ~~No later than~~ October 1 of each year, the agency must provide estimated costs for any adjustment in a hospital inpatient per diem rate ~~pursuant to this paragraph~~ to the Executive Office of

the Governor, the House of Representatives General Appropriations Committee, and the Senate Appropriations Committee. Before the agency implements a change in a hospital's inpatient per diem rate pursuant to this paragraph, the Legislature must have specifically appropriated sufficient funds in the General Appropriations Act to support the increase in cost as estimated by the agency.

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

409.908 Reimbursement of Medicaid providers.—Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. If a provider is reimbursed based on cost reporting and submits a cost report late and that cost report would have been used to set a lower reimbursement rate for a rate semester, then the provider's rate for that semester shall be retroactively calculated using the new cost report, and full payment at the recalculated rate shall be effected retroactively. Medicare-granted extensions for filing cost reports, if applicable, shall also apply to Medicaid cost reports. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations or directions

provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(23) ~~(a) The agency shall establish rates at a level that ensures no increase in statewide expenditures resulting from a change in unit costs for 2 fiscal years effective July 1, 2009. Reimbursement rates for the 2 fiscal years shall be as provided in the General Appropriations Act.~~

(a) ~~(b) This subsection applies to~~ The following provider types may not receive an increase in reimbursement rate due to a change in unit cost unless specifically appropriated in the General Appropriations Act:

1. Inpatient hospitals.

2. Outpatient hospitals.

3. Nursing homes.

4. County health departments.

5. Community intermediate care facilities for the developmentally disabled.

6. Prepaid health plans.

7. Nursing home diversion programs.

~~The agency shall apply the effect of this subsection to the reimbursement rates for nursing home diversion programs.~~

(b) ~~(c)~~ The agency shall create a workgroup on hospital

reimbursement, a workgroup on nursing facility reimbursement, and a workgroup on managed care plan payment. The workgroups shall evaluate alternative reimbursement and payment methodologies for hospitals, nursing facilities, and managed care plans, including prospective payment methodologies for hospitals and nursing facilities. The nursing facility workgroup shall also consider price-based methodologies for indirect care and acuity adjustments for direct care. The agency shall submit a report on the evaluated alternative reimbursement methodologies to the relevant committees of the Senate and the House of Representatives by November 1, 2009.

(c) ~~(d)~~ This subsection expires June 30, 2011.

Section 8. Paragraph (d) is added to subsection (3) of section 409.9082, Florida Statutes, as created by section 1 of chapter 2009-4, Laws of Florida, and subsection (6) of that section is amended, to read:

409.9082 Quality assessment on nursing home facility providers; exemptions; purpose; federal approval required; remedies.—

(3)

(d) Effective July 1, 2009, the agency may exempt from the quality assessment or apply a lower quality assessment rate to a qualified public, nonstate owned or operated nursing home facility whose total annual indigent census days are greater than 25 percent of the facility's total annual census days.

(6) The quality assessment shall terminate and the agency shall discontinue the imposition, assessment, and collection of the nursing facility quality assessment if ~~any of the following occur:~~

~~(a)~~ the agency does not obtain necessary federal approval for the nursing home facility quality assessment or the payment rates required by subsection (4)~~; or~~

~~(b) The weighted average Medicaid rate paid to nursing home facilities is reduced below the weighted average Medicaid rate to nursing home facilities in effect on December 31, 2008, plus any future annual amount of the quality assessment and the applicable matching federal funds~~. Upon termination ~~of the quality assessment~~, all collected assessment revenues, less any amounts expended by the agency, shall be returned on a pro rata basis to the nursing facilities that paid them.

Section 9. Paragraph (a) of subsection (2) of section 409.911, Florida Statutes, is amended to read:

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

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

(a) The average of the ~~2002,~~ 2003, ~~and~~ 2004<u>, and 2005</u> audited disproportionate share data to determine each hospital's

Medicaid days and charity care for the 2009-2010 ~~2008-2009~~ state fiscal year.

Section 10. Section 409.9112, Florida Statutes, is amended to read:

409.9112 Disproportionate share program for regional perinatal intensive care centers.—In addition to the payments made under s. 409.911, the agency ~~for Health Care Administration~~ shall design and implement a system for ~~of~~ making disproportionate share payments to those hospitals that participate in the regional perinatal intensive care center program established pursuant to chapter 383. The ~~This~~ system of payments must ~~shall~~ conform to ~~with~~ federal requirements and ~~shall~~ distribute funds in each fiscal year for which an appropriation is made by making quarterly Medicaid payments. Notwithstanding ~~the provisions of~~ s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients. For the 2009-2010 state fiscal year ~~2008-2009~~, the agency may ~~shall~~ not distribute moneys under the regional perinatal intensive care centers disproportionate share program.

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

TAE = HDSP/THDSP

Where:

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

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

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

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

TAP = TAE x TA

Where:

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

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

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

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

(a) Agree to conform to all departmental and agency requirements to ensure high quality in the provision of services, including criteria adopted by departmental and agency rule concerning staffing ratios, medical records, standards of care, equipment, space, and such other standards and criteria as the department and agency deem appropriate as specified by rule.

(b) Agree to provide information to the department and

agency, in a form and manner to be prescribed by rule of the department and agency, concerning the care provided to all patients in neonatal intensive care centers and high-risk maternity care.

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

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

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

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

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

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

(4) Hospitals which fail to comply with any of the conditions in subsection (3) or the applicable rules of the department and agency <u>may</u> ~~shall~~ not receive any payments under

this section until full compliance is achieved. A hospital which is not in compliance in two or more consecutive quarters may ~~shall~~ not receive its share of the funds. Any forfeited funds shall be distributed by the remaining participating regional perinatal intensive care center program hospitals.

Section 11. Section 409.9113, Florida Statutes, is amended to read:

409.9113 Disproportionate share program for teaching hospitals.—In addition to the payments made under ss. 409.911 and 409.9112, the agency ~~for Health Care Administration~~ shall make disproportionate share payments to statutorily defined teaching hospitals for their increased costs associated with medical education programs and for tertiary health care services provided to the indigent. This system of payments must ~~shall~~ conform to ~~with~~ federal requirements and ~~shall~~ distribute funds in each fiscal year for which an appropriation is made by making quarterly Medicaid payments. Notwithstanding s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients. For the 2009-2010 state fiscal year ~~2008-2009~~, the agency shall distribute the moneys provided in the General Appropriations Act to statutorily defined teaching hospitals and family practice teaching hospitals under the teaching hospital disproportionate share program. The funds provided for statutorily defined teaching hospitals shall be distributed in the same proportion as the state fiscal year 2003-2004 teaching hospital disproportionate share funds were distributed or as otherwise provided in the General Appropriations Act. The funds provided for family practice

teaching hospitals shall be distributed equally among family practice teaching hospitals.

(1) On or before September 15 of each year, the agency ~~for Health Care Administration~~ shall calculate an allocation fraction to be used for distributing funds to state statutory teaching hospitals. Subsequent to the end of each quarter of the state fiscal year, the agency shall distribute to each statutory teaching hospital, as defined in s. 408.07, an amount determined by multiplying one-fourth of the funds appropriated for this purpose by the Legislature times such hospital's allocation fraction. The allocation fraction for each such hospital shall be determined by the sum of the following three primary factors, divided by three~~. The primary factors are~~:

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

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

1. The number of trainees enrolled in nationally accredited graduate medical education programs, as defined in paragraph (a). Full-time equivalents are computed using the fraction of

the year during which each trainee is primarily assigned to the given institution, over the state fiscal year preceding the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the hospital represents of the total number of full-time equivalent trainees enrolled in accredited graduate programs, where the total is computed for all state statutory teaching hospitals.

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

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

(c) A service index that comprises three components:

1. The Agency for Health Care Administration Service Index, computed by applying the standard Service Inventory Scores established by the agency ~~for Health Care Administration~~ to services offered by the given hospital, as reported on Worksheet A-2 for the last fiscal year reported to the agency before the date on which the allocation fraction is calculated. The

numerical value of this factor is the fraction that the given hospital represents of the total Agency for Health Care Administration Service Index values, where the total is computed for all state statutory teaching hospitals.

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

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

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

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

hospitals:

TAP = THAF x A

Where:

TAP = total additional payment.

THAF = teaching hospital allocation factor.

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

Section 12. Section 409.9117, Florida Statutes, is amended to read:

409.9117 Primary care disproportionate share program.—For the 2009-2010 state fiscal year ~~2008-2009~~, the agency shall not distribute moneys under the primary care disproportionate share program.

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

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

TAE = HDSP/THDSP

Where:

TAE = total amount earned by a hospital participating in the primary care disproportionate share program.

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

THDSP = the prior state fiscal year total primary care

disproportionate share payments to all hospitals.

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

TAP = TAE x TA

Where:

TAP = total additional payment for a primary care hospital.

TAE = total amount earned by a primary care hospital.

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

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

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

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

(c) Coordinate and provide primary care services free of charge, except copayments, to all persons with incomes up to 100 percent of the federal poverty level who are not otherwise covered by Medicaid or another program administered by a governmental entity, and to provide such services based on a sliding fee scale to all persons with incomes up to 200 percent of the federal poverty level who are not otherwise covered by Medicaid or another program administered by a governmental

entity, except that eligibility may be limited to persons who reside within a more limited area, as agreed to by the agency and the hospital.

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

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

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

(g) Provide inpatient services to residents within the area who are not eligible for Medicaid or Medicare, and who do not have private health insurance, regardless of ability to pay, on the basis of available space, except that <u>hospitals may not be prevented</u> ~~nothing shall prevent the hospital~~ from establishing

bill collection programs based on ability to pay.

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

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

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

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

Section 13. Subsection (4) of section 409.91195, Florida Statutes, is amended to read:

409.91195 Medicaid Pharmaceutical and Therapeutics Committee.—There is created a Medicaid Pharmaceutical and Therapeutics Committee within the agency for the purpose of developing a Medicaid preferred drug list.

(4) Upon recommendation of the committee, the agency shall adopt a preferred drug list as described in s. 409.912(38) ~~s.~~

~~409.912(39)~~. If ~~To the extent~~ feasible, the committee shall review all drug classes included on the preferred drug list every 12 months, and may recommend additions to and deletions from the ~~preferred drug~~ list, such that the preferred drug list provides for medically appropriate drug therapies for Medicaid patients which achieve cost savings contained in the General Appropriations Act.

Section 14. Subsection (1) of section 409.91196, Florida Statutes, is amended to read:

409.91196 Supplemental rebate agreements; public records and public meetings exemption.—

(1) The rebate amount, percent of rebate, manufacturer's pricing, and supplemental rebate, and other trade secrets as defined in s. 688.002 that the agency has identified for use in negotiations, held by the agency ~~for Health Care Administration~~ under s. 409.912(38)(a)7. ~~s. 409.912(39)(a)7.~~ are confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

Section 15. Present subsections (6) through (53) of section 409.912, Florida Statutes, are redesignated as subsections (5) through (52), respectively, and present subsections (5), (21), and (29) of that section, are amended to read:

409.912 Cost-effective purchasing of health care.—The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. To ensure that medical services are effectively utilized, the agency may, in any case, require a confirmation or second physician's opinion of the correct diagnosis for purposes of authorizing future services under the

Medicaid program. This section does not restrict access to emergency services or poststabilization care services as defined in 42 C.F.R. part 438.114. Such confirmation or second opinion shall be rendered in a manner approved by the agency. The agency shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services. The agency shall contract with a vendor to monitor and evaluate the clinical practice patterns of providers in order to identify trends that are outside the normal practice patterns of a provider’s professional peers or the national guidelines of a provider’s professional association. The vendor must be able to provide information and counseling to a provider whose practice patterns are outside the norms, in consultation with the agency, to improve patient care and reduce inappropriate utilization. The agency may mandate prior authorization, drug therapy management, or disease management participation for certain populations of Medicaid beneficiaries, certain drug classes, or particular drugs to prevent fraud, abuse, overuse, and possible dangerous drug interactions. The Pharmaceutical and Therapeutics Committee shall make recommendations to the agency on drugs for which prior authorization is required. The agency shall inform the Pharmaceutical and Therapeutics Committee of its decisions

regarding drugs subject to prior authorization. The agency is authorized to limit the entities it contracts with or enrolls as Medicaid providers by developing a provider network through provider credentialing. The agency may competitively bid single-source-provider contracts if procurement of goods or services results in demonstrated cost savings to the state without limiting access to care. The agency may limit its network based on the assessment of beneficiary access to care, provider availability, provider quality standards, time and distance standards for access to care, the cultural competence of the provider network, demographic characteristics of Medicaid beneficiaries, practice and provider-to-beneficiary standards, appointment wait times, beneficiary use of services, provider turnover, provider profiling, provider licensure history, previous program integrity investigations and findings, peer review, provider Medicaid policy and billing compliance records, clinical and medical record audits, and other factors. Providers shall not be entitled to enrollment in the Medicaid provider network. The agency shall determine instances in which allowing Medicaid beneficiaries to purchase durable medical equipment and other goods is less expensive to the Medicaid program than long-term rental of the equipment or goods. The agency may establish rules to facilitate purchases in lieu of long-term rentals in order to protect against fraud and abuse in the Medicaid program as defined in s. 409.913. The agency may seek federal waivers necessary to administer these policies.

~~(5) The Agency for Health Care Administration, in partnership with the Department of Elderly Affairs, shall create an integrated, fixed-payment delivery program for Medicaid~~

~~recipients who are 60 years of age or older or dually eligible for Medicare and Medicaid. The Agency for Health Care Administration shall implement the integrated program initially on a pilot basis in two areas of the state. The pilot areas shall be Area 7 and Area 11 of the Agency for Health Care Administration. Enrollment in the pilot areas shall be on a voluntary basis and in accordance with approved federal waivers and this section. The agency and its program contractors and providers shall not enroll any individual in the integrated program because the individual or the person legally responsible for the individual fails to choose to enroll in the integrated program. Enrollment in the integrated program shall be exclusively by affirmative choice of the eligible individual or by the person legally responsible for the individual. The integrated program must transfer all Medicaid services for eligible elderly individuals who choose to participate into an integrated-care management model designed to serve Medicaid recipients in the community. The integrated program must combine all funding for Medicaid services provided to individuals who are 60 years of age or older or dually eligible for Medicare and Medicaid into the integrated program, including funds for Medicaid home and community-based waiver services; all Medicaid services authorized in ss. 409.905 and 409.906, excluding funds for Medicaid nursing home services unless the agency is able to demonstrate how the integration of the funds will improve coordinated care for these services in a less costly manner; and Medicare coinsurance and deductibles for persons dually eligible for Medicaid and Medicare as prescribed in s. 409.908(13).~~

~~(a) Individuals who are 60 years of age or older or dually~~

~~eligible for Medicare and Medicaid and enrolled in the developmental disabilities waiver program, the family and supported-living waiver program, the project AIDS care waiver program, the traumatic brain injury and spinal cord injury waiver program, the consumer-directed care waiver program, and the program of all-inclusive care for the elderly program, and residents of institutional care facilities for the developmentally disabled, must be excluded from the integrated program.~~

~~(b) Managed care entities who meet or exceed the agency's minimum standards are eligible to operate the integrated program. Entities eligible to participate include managed care organizations licensed under chapter 641, including entities eligible to participate in the nursing home diversion program, other qualified providers as defined in s. 430.703(7), community care for the elderly lead agencies, and other state-certified community service networks that meet comparable standards as defined by the agency, in consultation with the Department of Elderly Affairs and the Office of Insurance Regulation, to be financially solvent and able to take on financial risk for managed care. Community service networks that are certified pursuant to the comparable standards defined by the agency are not required to be licensed under chapter 641. Managed care entities who operate the integrated program shall be subject to s. 408.7056. Eligible entities shall choose to serve enrollees who are dually eligible for Medicare and Medicaid, enrollees who are 60 years of age or older, or both.~~

~~(c) The agency must ensure that the capitation-rate-setting methodology for the integrated program is actuarially sound and~~

~~reflects the intent to provide quality care in the least restrictive setting. The agency must also require integrated-program providers to develop a credentialing system for service providers and to contract with all Gold Seal nursing homes, where feasible, and exclude, where feasible, chronically poor-performing facilities and providers as defined by the agency. The integrated program must develop and maintain an informal provider grievance system that addresses provider payment and contract problems. The agency shall also establish a formal grievance system to address those issues that were not resolved through the informal grievance system. The integrated program must provide that if the recipient resides in a noncontracted residential facility licensed under chapter 400 or chapter 429 at the time of enrollment in the integrated program, the recipient must be permitted to continue to reside in the noncontracted facility as long as the recipient desires. The integrated program must also provide that, in the absence of a contract between the integrated-program provider and the residential facility licensed under chapter 400 or chapter 429, current Medicaid rates must prevail. The integrated-program provider must ensure that electronic nursing home claims that contain sufficient information for processing are paid within 10 business days after receipt. Alternately, the integrated-program provider may establish a capitated payment mechanism to prospectively pay nursing homes at the beginning of each month. The agency and the Department of Elderly Affairs must jointly develop procedures to manage the services provided through the integrated program in order to ensure quality and recipient choice.~~

~~(d) The Office of Program Policy Analysis and Government Accountability, in consultation with the Auditor General, shall comprehensively evaluate the pilot project for the integrated, fixed-payment delivery program for Medicaid recipients created under this subsection. The evaluation shall begin as soon as Medicaid recipients are enrolled in the managed care pilot program plans and shall continue for 24 months thereafter. The evaluation must include assessments of each managed care plan in the integrated program with regard to cost savings; consumer education, choice, and access to services; coordination of care; and quality of care. The evaluation must describe administrative or legal barriers to the implementation and operation of the pilot program and include recommendations regarding statewide expansion of the pilot program. The office shall submit its evaluation report to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than December 31, 2009.~~

~~(e) The agency may seek federal waivers or Medicaid state plan amendments and adopt rules as necessary to administer the integrated program. The agency may implement the approved federal waivers and other provisions as specified in this subsection.~~

~~(f) No later than December 31, 2007, the agency shall provide a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives containing an analysis of the merits and challenges of seeking a waiver to implement a voluntary program that integrates payments and services for dually enrolled Medicare and Medicaid recipients who are 65 years of age or older.~~

(20)~~(21)~~ Any entity contracting with the agency pursuant to this section to provide health care services to Medicaid recipients is prohibited from engaging in any of the following practices or activities:

(c) Granting or offering of any monetary or other valuable consideration for enrollment, except as authorized by subsection (23) ~~(24)~~.

(28)~~(29)~~ The agency shall perform enrollments and disenrollments for Medicaid recipients who are eligible for MediPass or managed care plans. Notwithstanding the prohibition contained in paragraph (20)(f) ~~(21)(f)~~, managed care plans may perform preenrollments of Medicaid recipients under the supervision of the agency or its agents. For the purposes of this section, "preenrollment" means the provision of marketing and educational materials to a Medicaid recipient and assistance in completing the application forms, but does ~~shall~~ not include actual enrollment into a managed care plan. An application for enrollment is ~~shall~~ not ~~be~~ deemed complete until the agency or its agent verifies that the recipient made an informed, voluntary choice. The agency, in cooperation with the Department of Children and Family Services, may test new marketing initiatives to inform Medicaid recipients about their managed care options at selected sites. The agency shall report to the Legislature on the effectiveness of such initiatives. The agency may contract with a third party to perform managed care plan and MediPass enrollment and disenrollment services for Medicaid recipients and may ~~is authorized to~~ adopt rules to implement such services. The agency may adjust the capitation rate only to cover the costs of a third-party enrollment and disenrollment

contract, and for agency supervision and management of the managed care plan enrollment and disenrollment contract.

Section 16. Paragraphs (e), (l), (p), and (w) of subsection (3) and subsection (12) of section 409.91211, Florida Statutes, are amended to read:

409.91211 Medicaid managed care pilot program.—

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

(e) To implement policies and guidelines for phasing in financial risk for approved provider service networks over a 5-year ~~3-year~~ period. These policies and guidelines must include an option for a provider service network to be paid fee-for-service rates. For any provider service network established in a managed care pilot area, the option to be paid fee-for-service rates must ~~shall~~ include a savings-settlement mechanism that is consistent with s. 409.912(44). This model must ~~shall~~ be converted to a risk-adjusted capitated rate by ~~no later than~~ the beginning of the sixth ~~fourth~~ year of operation, and may be converted earlier at the option of the provider service network. Federally qualified health centers may be offered an opportunity to accept or decline a contract to participate in any provider network for prepaid primary care services.

(l) To implement a system that prohibits capitated managed care plans, their representatives, and providers employed by or contracted with the capitated managed care plans from recruiting persons eligible for or enrolled in Medicaid, from providing inducements to Medicaid recipients to select a particular capitated managed care plan, and from prejudicing Medicaid recipients against other capitated managed care plans. The

system must ~~shall~~ require the entity performing choice counseling to determine if the recipient has made a choice of a plan or has opted out because of duress, threats, payment to the recipient, or incentives promised to the recipient by a third party. If the choice counseling entity determines that the decision to choose a plan was unlawfully influenced or a plan violated any of the provisions of s. 409.912(20) ~~s. 409.912(21)~~, the choice counseling entity shall immediately report the violation to the agency's program integrity section for investigation. Verification of choice counseling by the recipient must ~~shall~~ include a stipulation that the recipient acknowledges the provisions of this subsection.

(p) To implement standards for plan compliance, including, but not limited to, standards for quality assurance and performance improvement, standards for peer or professional reviews, grievance policies, and policies for maintaining program integrity. The agency shall develop a data-reporting system, seek input from managed care plans in order to establish requirements for patient-encounter reporting, and ensure that the data reported is accurate and complete.

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

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

a. The Health Plan Employer Data and Information Set

(HEDIS) or measures that are similar to HEDIS.

b. Member satisfaction.

c. Provider satisfaction.

d. Report cards on plan performance and best practices.

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

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

3. The agency shall require the managed care plans that have contracted with the agency to establish a quality assurance system that incorporates the provisions of s. 409.912(26) ~~s. 409.912(27)~~ and any standards, rules, and guidelines developed by the agency.

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

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

(I) The demographic characteristics of the patient.

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

(III) The procedure performed.

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

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

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

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

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

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

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

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

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

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

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

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

demonstration project sites.

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

3. The agency shall ensure that the plan is in compliance with s. 409.912(20) and (21) ~~s. 409.912(21) and (22)~~.

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

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

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

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

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

(12) For purposes of this section, the term "capitated managed care plan" includes health insurers authorized under chapter 624, exclusive provider organizations authorized under chapter 627, health maintenance organizations authorized under chapter 641, the Children's Medical Services Network under chapter 391, and provider service networks that elect to be paid fee-for-service for up to 5 ~~3~~ years as authorized under this section.

Section 17. Subsection (18) is added to section 430.04, Florida Statutes, to read:

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

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

(a) The Alzheimer's Dementia-Specific Medicaid Waiver as established in s. 430.502(7), (8), and (9).

(b) The Assisted Living for the Frail Elderly Waiver.

(c) The Aged and Disabled Adult Waiver.

(d) The Adult Day Health Care Waiver.

(e) The Consumer Directed Care Plus Program as defined in s. 409.221.

(f) The Program for All-inclusive Care for the Elderly.

(g) The Long-Term Care Community-Based Diversion Pilot

Project as described in s. 430.705.

(h) The Channeling Services Waiver for Frail Elders.

Section 18. Subsection (4) of section 641.386, Florida Statutes, is amended to read:

641.386 Agent licensing and appointment required; exceptions.—

(4) All agents and health maintenance organizations must ~~shall~~ comply with and be subject to the applicable provisions of ss. 641.309 and 409.912(20) ~~409.912(21)~~, and all companies and entities appointing agents must ~~shall~~ comply with s. 626.451, when marketing for any health maintenance organization licensed pursuant to this part, including those organizations under contract with the Agency for Health Care Administration to provide health care services to Medicaid recipients or any private entity providing health care services to Medicaid recipients pursuant to a prepaid health plan contract with the Agency for Health Care Administration.

Section 19. The Agency for Health Care Administration shall develop and implement a home health agency monitoring pilot project in Miami-Dade County by January 1, 2010. The agency shall contract with a vendor to verify the utilization and the delivery of home health services and provide an electronic billing interface for such services. The contract must require the creation of a program to submit claims for the home health services electronically. The program must verify visits for the delivery of home health services telephonically using voice biometrics. The agency may seek amendments to the Medicaid state plan and waivers of federal laws, as necessary, to implement the pilot project. Notwithstanding s. 287.057(5)(f), Florida

Statutes, the agency must award the contract through the competitive solicitation process. The agency shall submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives evaluating the pilot project by February 1, 2011.

Section 20. The Agency for Health Care Administration shall implement a comprehensive care management pilot project in Miami-Dade County for home health services by January 1, 2010, which includes face-to-face assessments by a state-licensed nurse, consultation with physicians ordering services to substantiate the medical necessity for services, and on-site or desk reviews of recipients' medical records. The agency may enter into a contract with a qualified organization to implement the pilot project. The agency may seek amendments to the Medicaid state plan and waivers of federal laws, as necessary, to implement the pilot project.

Section 21. This act shall take effect upon becoming a law.