An act relating to health care; creating s. 395.7017, F.S.; authorizing the Agency for Health Care Administration to adopt rules related to the Public Medical Assistance Trust Fund; 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.; revising the expiration date of provisions authorizing the federal waiver for certain persons age 65 and over or who have a disability; revising the expiration date of provisions authorizing a specified medically needy program; amending s. 409.905, F.S.; authorizing the Agency for Health Care Administration to require prior authorization of care based on utilization rates; requiring a home health agency to submit a plan of care and documentation of a recipient's medical condition to the Agency for Health Care Administration when requesting prior authorization; prohibiting the Agency for Health Care Administration from paying for home health services unless specified requirements are satisfied; revising the criteria for adjusting a hospital's inpatient per diem rate; amending s. 409.906, F.S., relating to optional Medicaid services; providing limitations on

the provision of adult vision services; 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; revising the purposes of the use of quality assessment and federal matching funds; deleting an option for discontinuing the nursing home quality assessment; creating s. 409.9083, F.S.; providing definitions; providing for a quality assessment to be imposed upon privately operated intermediate care facility providers for the developmentally disabled; requiring the agency to calculate the quality assessment rate annually; providing requirements for reporting and collecting the assessment; specifying the purposes of the assessment and an order of priority; requiring that the agency seek federal authorization to implement the act; specifying circumstances requiring discontinuance of the quality assessment; authorizing the agency to impose certain penalties against providers that fail to pay the assessment; requiring the agency to adopt rules; providing for future repeal; amending s. 409.911, F.S.; updating the data to be used in calculating disproportionate share; providing a formula for payment of disproportionate share dollars to provider service network hospitals; 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 s. 409.9119, F.S.; authorizing the agency to make disproportionate share payments to certain hospitals; amending s. 409.912, F.S.; providing that the continuance of the integrated, fixed-payment delivery pilot program for certain elderly or dually eligible recipients is contingent upon an appropriation; providing that certain providers be paid in accordance with the appropriate fee schedule for services provided to eligible Medicaid recipients; authorizing the agency to seek waiver authority; amending s. 409.91211, F.S.; revising the timeline for phasing in financial risk for provider service networks; amending s. 409.9122, F.S.; revising and clarifying the procedure for a Medicaid recipient to change managed care plans or MediPass providers; amending s. 409.916, F.S.; requiring that quality assessment fees received from Medicaid providers be deposited into the Grants and Donations Trust Fund; amending s. 430.04, F.S.; requiring the Department of Elderly Affairs to administer all Medicaid waivers and programs relating to elders; amending s. 430.707, F.S.; requiring the agency, in consultation with the Department of Elderly Affairs, to accept and forward to the Centers for Medicare and Medicaid Services an application for

expansion of a pilot project from an entity that provides certain benefits under a federal program; requiring the agency, in consultation with the Department of Elderly Affairs, to contract with a hospice organization to be a site for the Program of All-inclusive Care for the Elderly; 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. Section 395.7017, Florida Statutes, is created to read:

395.7017 Rulemaking authority.—The agency may adopt rules pursuant to ss. 120.536 and 120.54 to implement the provisions of this part, which shall include the authority to define terms and determine the date of imposition and the determination of the process for determination, collection, and imposition of the Public Medical Assistance Trust Fund assessment and related fines.

Section 2. Paragraphs (g) and (q) of subsection (2) of section 409.815, Florida Statutes, are amended, and paragraph (w) is added to that subsection, 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 of substance abuse disorders. Any benefit limitations, including duration of services, number of visits, or number of days for hospitalization or residential services, shall not be any less favorable than those for physical illnesses generally. 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. 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 3. 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. 1397cc(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 4. Subsections (1) and (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 paragraph ~~subsection~~ expires December 31, 2010 ~~June 30, 2009~~.

(b) Effective January 1, 2011 ~~July 1, 2009~~, a pregnant woman or a child younger than 21 years of age who would be eligible under any group listed in s. 409.903, except that the income or assets of such group exceed established limitations. For a 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 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.

Section 5. Subsections (4) and (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 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, utilization rates, or billing rates. The agency shall require prior authorization for visits for home health services that are not associated with a skilled nursing visit when the home health

agency billing rates exceed the state average by 50 percent or more. The home health agency must submit the recipient's plan of care and documentation that supports the recipient's diagnosis 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. 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 not pay for home health services unless the services are medically necessary and:

1. The services are ordered by a physician.

2. The written prescription for the services is signed and

dated by the recipient's physician before the development of a plan of care and before any request requiring 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. However, this subparagraph does not apply to a home health agency affiliated with a retirement community, of which the parent corporation or a related legal entity owns a rural health clinic certified under 42 C.F.R. part 491, subpart A, ss. 1-11, a nursing home licensed under part II of chapter 400, or an apartment or single-family home for independent living. For purposes of this subparagraph, the agency may, on a case-by-case basis, provide an exception for medically fragile children who are younger than 21 years of age.

4. The physician ordering the services has examined the recipient within the 30 days preceding the initial request for the 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, and, for skilled nursing services, the frequency and duration of the 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 6. Subsection (23) of section 409.906, Florida Statutes, is amended to read:

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

(23) VISUAL SERVICES.—The agency may pay for visual

examinations, eyeglasses, and eyeglass repairs for a recipient if they are prescribed by a licensed physician specializing in diseases of the eye or by a licensed optometrist. Eyeglass frames ~~Eyeglasses~~ for adult recipients shall be limited to one pair ~~two pairs per year~~ per recipient every 2 years, except a second ~~third~~ pair may be provided during that period after prior authorization. Eyeglass lenses for adult recipients shall be limited to one pair per year except a second pair may be provided during that period after prior authorization.

Section 7. 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 subsections (4) and (6) of that section are 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.

(4) The purpose of the nursing home facility quality assessment is to ensure continued quality of care. Collected assessment funds shall be used to obtain federal financial participation through the Medicaid program to make Medicaid payments for nursing home facility services up to the amount of nursing home facility Medicaid rates as calculated in accordance with the approved state Medicaid plan in effect on December 31,

2007. The quality assessment and federal matching funds shall be used exclusively for the following purposes and in the following order of priority:

(a) To reimburse the Medicaid share of the quality assessment as a pass-through, Medicaid-allowable cost;

(b) To increase to each nursing home facility's Medicaid rate, as needed, an amount that restores the rate reductions implemented January 1, 2008, ~~and~~ January 1, 2009, and March 1, 2009;

(c) To increase to each nursing home facility's Medicaid rate, as needed, an amount that restores any rate reductions for the 2009-2010 ~~2008-2009~~ fiscal year; and

(d) To increase each nursing home facility's Medicaid rate that accounts for the portion of the total assessment not included in paragraphs (a)-(c) which begins a phase-in to a pricing model for the operating cost component.

(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 8. Section 409.9083, Florida Statutes, is created to read:

409.9083 Quality assessment on privately operated intermediate care facilities for the developmentally disabled; exemptions; purpose; federal approval required; remedies.—

(1) As used in this section, the term:

(a) "Intermediate care facility for the developmentally disabled" or "ICF/DD" means a privately operated intermediate care facility for the developmentally disabled licensed under part VIII of chapter 400.

(b) "Net patient service revenue" means gross revenues from services provided to ICF/DD facility residents, less reductions from gross revenue resulting from an inability to collect payment of charges. Net patient service revenue excludes nonresident care revenues such as gain or loss on asset disposal, prior year revenue, donations, and physician billings, and all outpatient revenues. Reductions from gross revenue include bad debts; contractual adjustments; uncompensated care; administrative, courtesy, and policy discounts and adjustments; and other such revenue deductions.

(c) "Resident day" means a calendar day of care provided to an ICF/DD facility resident, including the day of admission and excluding the day of discharge, except that, when admission and discharge occur on the same day, 1 day of care exists.

(2) Effective October 1, 2009, there is imposed upon each intermediate care facility for the developmentally disabled a quality assessment. The aggregated amount of assessments for all

ICF/DDs in a given year shall be an amount not exceeding the maximum percentage allowed under federal law of the total aggregate net patient service revenue of assessed facilities. The agency shall calculate the quality assessment rate annually on a per-resident-day basis as reported by the facilities. The per-resident-day assessment rate shall be uniform. Each facility shall report monthly to the agency its total number of resident days and shall remit an amount equal to the assessment rate times the reported number of days. The agency shall collect, and each facility shall pay, the quality assessment each month. The agency shall collect the assessment from facility providers no later than the 15th of the next succeeding calendar month. The agency shall notify providers of the quality assessment rate and provide a standardized form to complete and submit with payments. The collection of the quality assessment shall commence no sooner than 15 days after the agency's initial payment to the facilities that implement the increased Medicaid rates containing the elements prescribed in subsection (3) and monthly thereafter. Intermediate care facilities for the developmentally disabled may increase their rates to incorporate the assessment but may not create a separate line-item charge for the purpose of passing through the assessment to residents.

(3) The purpose of the facility quality assessment is to ensure continued quality of care. Collected assessment funds shall be used to obtain federal financial participation through the Medicaid program to make Medicaid payments for ICF/DD services up to the amount of the Medicaid rates for such facilities as calculated in accordance with the approved state Medicaid plan in effect on April 1, 2008. The quality assessment

and federal matching funds shall be used exclusively for the following purposes and in the following order of priority to:

(a) Reimburse the Medicaid share of the quality assessment as a pass-through, Medicaid-allowable cost.

(b) Increase each privately operated ICF/DD Medicaid rate, as needed, by an amount that restores the rate reductions implemented on October 1, 2008.

(c) Increase each ICF/DD Medicaid rate, as needed, by an amount that restores any rate reductions for the 2008-2009 fiscal year and the 2009-2010 fiscal year.

(d) Increase payments to such facilities to fund covered services to Medicaid beneficiaries.

(4) The agency shall seek necessary federal approval in the form of state plan amendments in order to implement the provisions of this section.

(5)(a) The quality assessment shall terminate and the agency shall discontinue the imposition, assessment, and collection of the quality assessment if the agency does not obtain necessary federal approval for the facility quality assessment or the payment rates required by subsection (3).

(b) 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 facilities that paid such assessments.

(6) The agency may seek any of the following remedies for failure of any ICF/DD provider to timely pay its assessment:

(a) Withholding any medical assistance reimbursement payments until the assessment amount is recovered.

(b) Suspending or revoking the facility’s license.

(c) Imposing a fine of up to $1,000 per day for each delinquent payment, not to exceed the amount of the assessment.

(7) The agency shall adopt rules necessary to administer this section.

(8) This section is repealed October 1, 2011.

Section 9. Paragraph (a) of subsection (2) of section 409.911, Florida Statutes, is amended, present subsections (5), (6), (7), (8), and (9) are renumbered as subsections (6), (7), (8), (9), and (10), respectively, and a new subsection (5) is added to that section, 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, and 2005 audited disproportionate share data to determine each hospital's Medicaid days and charity care for the 2009-2010 ~~2008-2009~~ state fiscal year.

(5) The following formula shall be used to pay

disproportionate share dollars to provider service network (PSN) hospitals:

DSHP = TAAPSNH X (IHPSND X THPSND)

Where:

DSHP = Disproportionate share hospital payments.

TAAPSNH = Total amount available for PSN hospitals.

IHPSND = Individual hospital PSN days.

THPSND = Total of all hospital PSN days.

For purposes of this paragraph, the PSN inpatient days shall be provided in the General Appropriations Act.

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 may ~~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:

$$TAP = TAE \times TA$$

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 hospitals may not be prevented ~~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. Section 409.9119, Florida Statutes, is amended to read:

409.9119 Disproportionate share program for specialty hospitals for children.—In addition to the payments made under s. 409.911, the Agency for Health Care Administration shall develop and implement a system under which disproportionate share payments are made to those hospitals that are licensed by the state as specialty hospitals for children and were licensed on January 1, 2000, as specialty hospitals for children. This system of payments must conform to federal requirements and must 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 that serve a disproportionate share of low-income patients. The agency may make disproportionate share payments to specialty hospitals for children as provided for ~~Payments are subject to specific appropriations~~ in the General Appropriations Act.

(1) Unless specified in the General Appropriations Act, the agency shall use the following formula to calculate the total amount earned for hospitals that participate in the specialty hospital for children disproportionate share program:

TAE = DSR x BMPD x MD

Where:

TAE = total amount earned by a specialty hospital for children.

DSR = disproportionate share rate.

BMPD = base Medicaid per diem.

MD = Medicaid days.

(2) The agency shall calculate the total additional payment for hospitals that participate in the specialty hospital for children disproportionate share program as follows:

$$TAP = \left(\frac{TAE \times TA}{STAE}\right)$$

Where:

TAP = total additional payment for a specialty hospital for children.

TAE = total amount earned by a specialty hospital for children.

TA = total appropriation for the specialty hospital for children disproportionate share program.

STAE = sum of total amount earned by each hospital that participates in the specialty hospital for children disproportionate share program.

(3) A hospital may not receive any payments under this section until it achieves full compliance with the applicable rules of the agency. A hospital that is not in compliance for two or more consecutive quarters may not receive its share of the funds. Any forfeited funds must be distributed to the remaining participating specialty hospitals for children that are in compliance.

Section 14. Paragraph (g) is added to subsection (5) of section 409.912, Florida Statutes, and subsection (8) of that

section, is 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).

(g) The implementation of the integrated, fixed-payment delivery program created under this subsection is subject to an appropriation in the General Appropriations Act.

(8)(a) The agency may contract on a prepaid or fixed-sum basis with an exclusive provider organization to provide health care services to Medicaid recipients provided that the exclusive provider organization meets applicable managed care plan requirements in this section, ss. 409.9122, 409.9123, 409.9128, and 627.6472, and other applicable provisions of law.

(b) For a period of no longer than 24 months after the effective date of this paragraph, when a member of an exclusive provider organization that is contracted by the agency to provide health care services to Medicaid recipients in rural areas without a health maintenance organization obtains services from a provider that participates in the Medicaid program in this state, the provider shall be paid in accordance with the appropriate fee schedule for services provided to eligible Medicaid recipients. The agency may seek waiver authority to implement this paragraph.

Section 15. Paragraph (e) 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 that, for purposes of this paragraph, include the Children's Medical Services Network, 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.

(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 16. Paragraph (e) of subsection (2) of section 409.9122, Florida Statutes, is amended to read:

409.9122 Mandatory Medicaid managed care enrollment; programs and procedures.—

(2)

(e) Medicaid recipients who are already enrolled in a managed care plan or MediPass shall be offered the opportunity to change managed care plans or MediPass providers on a staggered basis, as defined by the agency. All Medicaid recipients shall have 30 days in which to make a choice of managed care plans or MediPass providers. ~~In counties that have two or more managed care plans, a recipient already enrolled in MediPass who fails to make a choice during the annual period shall be assigned to a managed care plan if he or she is eligible for enrollment in the managed care plan. The agency shall apply for a state plan amendment or federal waiver authority, if necessary, to implement the provisions of this paragraph. All newly eligible Medicaid recipients shall have 30 days in which to make a choice of managed care plans or MediPass providers.~~ Those Medicaid recipients who do not make a choice shall be assigned in accordance with paragraph (f). To facilitate continuity of care, for a Medicaid recipient who is also a recipient of Supplemental Security Income (SSI), prior to assigning the SSI recipient to a managed care plan or MediPass, the agency shall determine whether the SSI recipient has an ongoing relationship with a MediPass provider or managed care plan, and if so, the agency shall assign the SSI recipient to that MediPass provider or managed care plan. ~~If the SSI recipient has an ongoing relationship with a managed care plan, the agency shall assign the recipient to that managed care plan.~~ Those SSI recipients who do not have such a provider

relationship shall be assigned to a managed care plan or MediPass provider in accordance with paragraph (f).

Section 17. Subsection (4) is added to section 409.916, Florida Statutes, to read:

409.916 Grants and Donations Trust Fund.—

(4) Quality assessment fees received from Medicaid providers shall be deposited into the Grants and Donations Trust Fund and used for purposes established by law and the General Appropriations Act.

Section 18. 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 19. Section 430.707, Florida Statutes, is amended to read:

430.707 Contracts.—

(1) The department, in consultation with the agency, shall select and contract with managed care organizations and, on a prepaid basis, with other qualified providers as defined in s. 430.703(7) to provide long-term care within community diversion pilot project areas. All providers shall report quarterly to the department regarding the entity's compliance with all the financial and quality assurance requirements of the contract.

(2) The department, in consultation with the agency, may contract with entities that ~~which~~ have submitted an application as a community nursing home diversion project as of July 1, 1998, to provide benefits pursuant to the "Program of All-inclusive Care for the Elderly" as established in Pub. L. No. 105-33. For the purposes of this community nursing home diversion project, such entities are ~~shall be~~ exempt from the requirements of chapter 641~~,~~ if the entity is a private, nonprofit, superior-rated nursing home and if ~~with~~ at least 50 percent of its residents are eligible for Medicaid. The agency, in consultation with the department, shall accept and forward to the Centers for Medicare and Medicaid Services an application for expansion of the pilot project from an entity that provides benefits pursuant to the Program of All-inclusive Care for the Elderly and that is in good standing with the agency, the department, and the Centers for Medicare and Medicaid Services.

Section 20. Notwithstanding s. 430.707, Florida Statutes, and subject to federal approval of the application to be a site for the Program of All-inclusive Care for the Elderly, the Agency for Health Care Administration shall contract with one private, not-for-profit hospice organization located in

Hillsborough County, which provides comprehensive services, including hospice care for frail and elderly persons. Such an entity shall be exempt from the requirements of chapter 641, Florida Statutes. The agency, in consultation with the Department of Elderly Affairs and subject to an appropriation, shall approve up to 100 initial enrollees in the Program of All-inclusive Care for the Elderly in Hillsborough County.

Section 21. 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 law, 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 22. 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 law, as necessary, to implement the pilot project.

Section 23. This act shall take effect July 1, 2009.