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LEGISLATIVE ACTION

Senate	.	House
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Floor: 1/RE/2R	.	
02/23/2012 10:02 PM	.	
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Senator Negron moved the following:

1 **Senate Amendment (with title amendment)**
2
3 Delete everything after the enacting clause
4 and insert:
5 Section 1. Section 383.15, Florida Statutes, is amended to
6 read:
7 383.15 Legislative intent; perinatal intensive care
8 services.—The Legislature finds ~~and declares~~ that many perinatal
9 diseases and disabilities have debilitating, costly, and often
10 fatal consequences if left untreated. Many of these debilitating
11 conditions could be prevented or ameliorated if services were
12 available to the public through a regional perinatal intensive
13 care centers program. Perinatal intensive care services are

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14 critical to the well-being and development of a healthy society
15 and represent a constructive, cost-beneficial, and essential
16 investment in the future of our state. Therefore, it is the
17 intent of the Legislature to develop a regional perinatal
18 intensive care centers program. The Legislature further intends
19 that development of such ~~a regional perinatal intensive care~~
20 ~~centers~~ program ~~shall~~ not reduce or dilute the current financial
21 commitment of the state, as indicated through appropriation, to
22 the existing regional perinatal intensive care centers. It is
23 also the intent of the Legislature that any additional centers
24 ~~regional perinatal intensive care center~~ authorized under s.
25 383.19 after July 1, 1993, ~~shall~~ not receive payments under a
26 disproportionate share program for regional perinatal intensive
27 care centers authorized under chapter 409 ~~s. 409.9112~~ unless
28 specific appropriations are provided to expand such payments to
29 additional hospitals.
30 Section 2. Paragraph (b) of subsection (6) of section
31 409.8132, Florida Statutes, is amended to read:
32 409.8132 Medikids program component.—
33 (6) ELIGIBILITY.—
34 (b) The provisions of s. 409.814 apply ~~409.814(3), (4),~~
35 ~~(5), and (6) shall be applicable~~ to the Medikids program.
36 Section 3. Section 409.814, Florida Statutes, is amended to
37 read:
38 409.814 Eligibility.—A child who has not reached 19 years
39 of age whose family income is equal to or below 200 percent of
40 the federal poverty level is eligible for the Florida Kidcare
41 program as provided in this section. ~~For enrollment in the~~
42 ~~Children's Medical Services Network, a complete application~~

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43 ~~includes the medical or behavioral health screening.~~ If~~,~~
44 ~~subsequently,~~ an enrolled individual is determined to be
45 ineligible for coverage, he or she must be immediately ~~be~~
46 disenrolled from the respective Florida Kidcare program
47 component.
48 (1) A child who is eligible for Medicaid coverage under s.
49 409.903 or s. 409.904 must be enrolled in Medicaid and is not
50 eligible to receive health benefits under any other health
51 benefits coverage authorized under the Florida Kidcare program.
52 (2) A child who is not eligible for Medicaid, but who is
53 eligible for the Florida Kidcare program, may obtain health
54 benefits coverage under any of the other components listed in s.
55 409.813 if such coverage is approved and available in the county
56 in which the child resides.
57 (3) A Title XXI-funded child who is eligible for the
58 Florida Kidcare program who is a child with special health care
59 needs, as determined through a medical or behavioral screening
60 instrument, is eligible for health benefits coverage from and
61 shall be assigned to and may opt out of the Children's Medical
62 Services Network.
63 (4) The following children are not eligible to receive
64 Title XXI-funded premium assistance for health benefits coverage
65 under the Florida Kidcare program, except under Medicaid if the
66 child would have been eligible for Medicaid under s. 409.903 or
67 s. 409.904 as of June 1, 1997:
68 ~~(a) A child who is eligible for coverage under a state~~
69 ~~health benefit plan on the basis of a family member's employment~~
70 ~~with a public agency in the state.~~
71 (a) ~~(b)~~ A child who is covered under a family member's group

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72 health benefit plan or under other private or employer health
73 insurance coverage, if the cost of the child’s participation is
74 not greater than 5 percent of the family’s income. If a child is
75 otherwise eligible for a subsidy under the Florida Kidcare
76 program and the cost of the child’s participation in the family
77 member’s health insurance benefit plan is greater than 5 percent
78 of the family’s income, the child may enroll in the appropriate
79 subsidized Kidcare program.
80 (b)~~(c)~~ A child who is seeking premium assistance for the
81 Florida Kidcare program through employer-sponsored group
82 coverage, if the child has been covered by the same employer’s
83 group coverage during the 60 days before the family submitted
84 ~~prior to the family’s submitting~~ an application for
85 determination of eligibility under the program.
86 (c)~~(d)~~ A child who is an alien, but who does not meet the
87 definition of qualified alien, in the United States.
88 (d)~~(e)~~ A child who is an inmate of a public institution or
89 a patient in an institution for mental diseases.
90 (e)~~(f)~~ A child who is otherwise eligible for premium
91 assistance for the Florida Kidcare program and has had his or
92 her coverage in an employer-sponsored or private health benefit
93 plan voluntarily canceled in the last 60 days, except those
94 children whose coverage was voluntarily canceled for good cause,
95 including, but not limited to, the following circumstances:
96 1. The cost of participation in an employer-sponsored
97 health benefit plan is greater than 5 percent of the family’s
98 income;
99 2. The parent lost a job that provided an employer-
100 sponsored health benefit plan for children;

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101 3. The parent who had health benefits coverage for the
102 child is deceased;
103 4. The child has a medical condition that, without medical
104 care, would cause serious disability, loss of function, or
105 death;
106 5. The employer of the parent canceled health benefits
107 coverage for children;
108 6. The child’s health benefits coverage ended because the
109 child reached the maximum lifetime coverage amount;
110 7. The child has exhausted coverage under a COBRA
111 continuation provision;
112 8. The health benefits coverage does not cover the child’s
113 health care needs; or
114 9. Domestic violence led to loss of coverage.
115 (5) A child who is otherwise eligible for the Florida
116 Kidcare program and who has a preexisting condition that
117 prevents coverage under another insurance plan as described in
118 paragraph <u>(4)(a)</u> ~~(4)(b)~~ which would have disqualified the child
119 for the Florida Kidcare program if the child were able to enroll
120 in the plan <u>is</u> ~~shall be~~ eligible for Florida Kidcare coverage
121 when enrollment is possible.
122 (6) A child whose family income is above 200 percent of the
123 federal poverty level or a child who is excluded under the
124 provisions of subsection (4) may participate in the Florida
125 Kidcare program as provided in s. 409.8132 or, if the child is
126 ineligible for Medikids by reason of age, in the Florida Healthy
127 Kids program, subject to the following ~~provisions~~:
128 (a) The family is not eligible for premium assistance
129 payments and must pay the full cost of the premium, including

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130 any administrative costs.
131 (b) The board of directors of the Florida Healthy Kids
132 Corporation may offer a reduced benefit package to these
133 children in order to limit program costs for such families.
134 (7) Once a child is enrolled in the Florida Kidcare
135 program, the child is eligible for coverage ~~under the program~~
136 for 12 months without a redetermination or reverification of
137 eligibility~~,~~ if the family continues to pay the applicable
138 premium. Eligibility for program components funded through Title
139 XXI of the Social Security Act terminates ~~shall terminate~~ when a
140 child attains the age of 19. A child who has not attained the
141 age of 5 and who has been determined eligible for the Medicaid
142 program is eligible for coverage for 12 months without a
143 redetermination or reverification of eligibility.
144 (8) When determining or reviewing a child's eligibility
145 under the Florida Kidcare program, the applicant shall be
146 provided with reasonable notice of changes in eligibility which
147 may affect enrollment in one or more of the program components.
148 If ~~When~~ a transition from one program component to another is
149 authorized, there shall be cooperation between the program
150 components and the affected family which promotes continuity of
151 health care coverage. Any authorized transfers must be managed
152 within the program's overall appropriated or authorized levels
153 of funding. Each component of the program shall establish a
154 reserve to ensure that transfers between components will be
155 accomplished within current year appropriations. These reserves
156 shall be reviewed by each convening of the Social Services
157 Estimating Conference to determine the adequacy of such reserves
158 to meet actual experience.

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159 (9) In determining the eligibility of a child, an assets
160 test is not required. Each applicant shall provide documentation
161 during the application process and the redetermination process,
162 including, but not limited to, the following:
163 (a) ~~Each applicant's~~ Proof of family income, which must
164 ~~shall~~ be verified electronically to determine financial
165 eligibility for the Florida Kidcare program. Written
166 documentation, which may include wages and earnings statements
167 or pay stubs, W-2 forms, or a copy of the applicant's most
168 recent federal income tax return, is ~~shall be~~ required only if
169 ~~the~~ electronic verification is not available or does not
170 substantiate the applicant's income.
171 (b) ~~Each applicant shall provide~~ A statement from all
172 applicable, employed family members that:
173 1. Their employers do not sponsor health benefit plans for
174 employees;
175 2. The potential enrollee is not covered by an employer-
176 sponsored health benefit plan; or
177 3. The potential enrollee is covered by an employer-
178 sponsored health benefit plan and the cost of the employer-
179 sponsored health benefit plan is more than 5 percent of the
180 family's income.
181 (c) To enroll in the Children's Medical Services Network, a
182 completed application, including a clinical screening.
183 (10) Subject to paragraph (4)(a) ~~(4)(b)~~, the Florida
184 Kidcare program shall withhold benefits from an enrollee if the
185 program obtains evidence that the enrollee is no longer
186 eligible, submitted incorrect or fraudulent information in order
187 to establish eligibility, or failed to provide verification of

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188 eligibility. The applicant or enrollee shall be notified that
189 because of such evidence program benefits will be withheld
190 unless the applicant or enrollee contacts a designated
191 representative of the program by a specified date, which must be
192 within 10 working days after the date of notice, to discuss and
193 resolve the matter. The program shall make every effort to
194 resolve the matter within a timeframe that will not cause
195 benefits to be withheld from an eligible enrollee.
196 (11) The following individuals may be subject to
197 prosecution in accordance with s. 414.39:
198 (a) An applicant obtaining or attempting to obtain benefits
199 for a potential enrollee under the Florida Kidcare program if
200 ~~when~~ the applicant knows or should have known that the potential
201 enrollee does not qualify for the ~~Florida Kidcare~~ program.
202 (b) An individual who assists an applicant in obtaining or
203 attempting to obtain benefits for a potential enrollee under the
204 Florida Kidcare program if ~~when~~ the individual knows or should
205 have known that the potential enrollee does not qualify for the
206 ~~Florida Kidcare~~ program.
207 Section 4. Section 409.902, Florida Statutes, is amended to
208 read:
209 409.902 Designated single state agency; eligibility
210 determinations ~~payment requirements; program title; release of~~
211 ~~medical records~~.—
212 (1) The Agency for Health Care Administration is designated
213 as the single state agency authorized to make payments for
214 medical assistance and related services under Title XIX of the
215 Social Security Act. These payments shall be made, subject to
216 any limitations or directions provided ~~for~~ in the General

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217 Appropriations Act, only for services included in the program,
218 ~~shall be made~~ only on behalf of eligible individuals, and ~~shall~~
219 ~~be made~~ only to qualified providers in accordance with federal
220 requirements for Title XIX of the Social Security Act and ~~the~~
221 ~~provisions of~~ state law. This program of medical assistance is
222 designated the “Medicaid program.”
223 (2) The Department of Children and Family Services is
224 responsible for determining Medicaid eligibility ~~determinations~~,
225 including, but not limited to, policy, rules, and the agreement
226 with the Social Security Administration for Medicaid eligibility
227 ~~determinations~~ for Supplemental Security Income recipients, as
228 well as the actual determination of eligibility. As a condition
229 of Medicaid eligibility, subject to federal approval, the agency
230 ~~for Health Care Administration~~ and the department must ~~of~~
231 ~~Children and Family Services shall~~ ensure that each recipient of
232 Medicaid consents to the release of her or his medical records
233 to the agency ~~for Health Care Administration~~ and the Medicaid
234 Fraud Control Unit of the Department of Legal Affairs.
235 (3) ~~(2)~~ Eligibility is restricted to United States citizens
236 and to lawfully admitted noncitizens who meet the criteria
237 provided in s. 414.095(3).
238 (a) Citizenship or immigration status must be verified. For
239 noncitizens, this includes verification of the validity of
240 documents with the United States Citizenship and Immigration
241 Services using the federal SAVE verification process.
242 (b) State funds may not be used to provide medical services
243 to individuals who do not meet the requirements of this
244 subsection unless the services are necessary to treat an
245 emergency medical condition or are for pregnant women. Such

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246 services are authorized only to the extent provided under
247 federal law and in accordance with federal regulations as
248 provided in 42 C.F.R. s. 440.255.
249 (4) To the extent funds are appropriated, the department
250 shall collaborate with the agency to develop an Internet-based
251 system for determining eligibility for the Medicaid and Kidcare
252 programs which complies with all applicable federal and state
253 laws and requirements.
254 (a) The system must accomplish the following primary
255 business objectives:
256 1. Provide individuals and families with a single access
257 point to information that explains benefits, premiums, and cost-
258 sharing available through Medicaid, Kidcare, or any other state
259 or federal health insurance exchange.
260 2. Enable timely, accurate, and efficient enrollment of
261 eligible persons into available assistance programs.
262 3. Prevent eligibility fraud.
263 4. Allow for detailed financial analysis of eligibility-
264 based cost drivers.
265 (b) The system must include, but need not be limited to,
266 the following business and functional requirements:
267 1. Allowing for the completion and submission of an online
268 application for determining eligibility which accepts the use of
269 electronic signatures.
270 2. Including a process that enables automatic enrollment of
271 qualified individuals into Medicaid, Kidcare, or any other state
272 or federal exchange that offers cost-sharing benefits for the
273 purchase of health insurance.
274 3. Allowing for the determination of Medicaid eligibility

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275 based on modified adjusted gross income by using information
276 submitted in the application and information accessed and
277 verified through automated and secure interfaces with authorized
278 databases.
279 4. Including the ability to determine specific categories
280 of Medicaid eligibility and interface with the Florida Medicaid
281 Management Information System to support such determination,
282 using federally approved assessment methodologies, of state and
283 federal financial participation rates for persons in each
284 eligibility category.
285 5. Allowing for the accurate and timely processing of
286 eligibility claims and adjudications.
287 6. Aligning with and incorporating all applicable state and
288 federal laws, requirements, and standards, including the
289 information technology security requirements established under
290 s. 282.318 and the accessibility standards established under
291 part II of chapter 282.
292 7. Producing transaction data, reports, and performance
293 information that contributes to an evaluation of the program,
294 continuous improvement in business operations, and increased
295 transparency and accountability.
296 (c) The department shall develop the system subject to
297 approval by the Legislative Budget Commission and as required by
298 the General Appropriations Act for the 2012-2013 fiscal year.
299 (d) The system must be completed by October 1, 2013, and
300 ready for implementation by January 1, 2014.
301 (e) The department shall implement the following project-
302 governance structure until the system is implemented:
303 1. The director of the department’s Economic Self-

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304 Sufficiency Services Program Office shall have overall
305 responsibility for the project.
306 2. The project shall be governed by an executive steering
307 committee composed of three department staff members appointed
308 by the Secretary of Children and Family Services; three agency
309 staff members, including at least two state Medicaid program
310 staff members, appointed by the Secretary of Health Care
311 Administration; and one staff member from Children's Medical
312 Services within the Department of Health appointed by the
313 Surgeon General.
314 3. The executive steering committee shall have overall
315 responsibility for ensuring that the project meets its primary
316 business objectives and shall:
317 a. Provide management direction and support to the project
318 management team.
319 b. Review and approve any changes to the project's scope,
320 schedule, and budget.
321 c. Review, approve, and determine whether to proceed with
322 any major deliverable project.
323 d. Recommend suspension or termination of the project to
324 the Governor, the President of the Senate, and the Speaker of
325 the House of Representatives if the committee determines that
326 the primary business objectives cannot be achieved.
327 4. A project management team shall be appointed by and work
328 under the direction of the executive steering committee. The
329 project management team shall:
330 a. Provide planning, management, and oversight of the
331 project.
332 b. Submit an operational work plan and provide quarterly

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333 updates to the plan to the executive steering committee. The
334 plan must specify project milestones, deliverables, and
335 expenditures.
336 c. Submit written monthly project status reports to the
337 executive steering committee.
338 Section 5. Subsection (5) of section 409.905, Florida
339 Statutes, is amended to read:
340 409.905 Mandatory Medicaid services.—The agency may make
341 payments for the following services, which are required of the
342 state by Title XIX of the Social Security Act, furnished by
343 Medicaid providers to recipients who are determined to be
344 eligible on the dates on which the services were provided. Any
345 service under this section shall be provided only when medically
346 necessary and in accordance with state and federal law.
347 Mandatory services rendered by providers in mobile units to
348 Medicaid recipients may be restricted by the agency. Nothing in
349 this section shall be construed to prevent or limit the agency
350 from adjusting fees, reimbursement rates, lengths of stay,
351 number of visits, number of services, or any other adjustments
352 necessary to comply with the availability of moneys and any
353 limitations or directions provided for in the General
354 Appropriations Act or chapter 216.
355 (5) HOSPITAL INPATIENT SERVICES.—The agency shall pay for
356 all covered services provided for the medical care and treatment
357 of a Medicaid recipient who is admitted as an inpatient by a
358 licensed physician or dentist to a hospital licensed under part
359 I of chapter 395. However, the agency shall limit the payment
360 for inpatient hospital services for a nonpregnant ~~Medicaid~~
361 recipient 21 years of age or older to 45 days per fiscal year ~~or~~

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362 ~~the number of days necessary to comply with the General~~
363 ~~Appropriations Act~~. Effective August 1, 2012, the agency shall
364 limit payment for hospital emergency department visits for a
365 nonpregnant recipient 21 years of age or older to six visits per
366 fiscal year.
367 (a) The agency may ~~is authorized to~~ implement reimbursement
368 and utilization management reforms in order to comply with any
369 limitations or directions in the General Appropriations Act,
370 which may include, but are not limited to: prior authorization
371 for inpatient psychiatric days; prior authorization for
372 nonemergency hospital inpatient admissions for individuals 21
373 years of age and older; authorization of emergency and urgent-
374 care admissions within 24 hours after admission; enhanced
375 utilization and concurrent review programs for highly utilized
376 services; reduction or elimination of covered days of service;
377 adjusting reimbursement ceilings for variable costs; adjusting
378 reimbursement ceilings for fixed and property costs; and
379 implementing target rates of increase. The agency may limit
380 prior authorization for hospital inpatient services to selected
381 diagnosis-related groups, based on an analysis of the cost and
382 potential for unnecessary hospitalizations represented by
383 certain diagnoses. Admissions for normal delivery and newborns
384 are exempt from ~~requirements for~~ prior authorization
385 requirements. In implementing ~~the provisions of~~ this section
386 related to prior authorization, the agency must ~~shall~~ ensure
387 that the process for authorization is accessible 24 hours per
388 day, 7 days per week and authorization is automatically granted
389 if ~~when~~ not denied within 4 hours after the request.
390 Authorization procedures must include steps for the review of

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391 denials. Upon implementing the prior authorization program for
392 hospital inpatient services, the agency shall discontinue its
393 hospital retrospective review program.
394 (b) A licensed hospital maintained primarily for the care
395 and treatment of patients having mental disorders or mental
396 diseases is not eligible to participate in the hospital
397 inpatient portion of the Medicaid program except as provided
398 under ~~in~~ federal law. However, the department shall apply for a
399 waiver, within 9 months after June 5, 1991, designed to provide
400 hospitalization services for mental health reasons to children
401 and adults in the most cost-effective and lowest cost setting
402 possible. Such waiver must ~~shall~~ include a request for the
403 opportunity to pay for care in hospitals known under federal law
404 as “institutions for mental disease” or “IMD’s.” The waiver
405 proposal may not ~~shall~~ propose ~~no~~ additional aggregate cost to
406 the state or Federal Government, and shall be conducted in
407 Hillsborough County, Highlands County, Hardee County, Manatee
408 County, and Polk County. The waiver proposal may incorporate
409 competitive bidding for hospital services, comprehensive
410 brokering, prepaid capitated arrangements, or other mechanisms
411 deemed by the department to show promise in reducing the cost of
412 acute care and increasing the effectiveness of preventive care.
413 When developing the waiver proposal, the department shall take
414 into account price, quality, accessibility, linkages of the
415 hospital to community services and family support programs,
416 plans of the hospital to ensure the earliest discharge possible,
417 and the comprehensiveness of the mental health and other health
418 care services offered by participating providers.
419 (c) The agency shall implement a methodology for

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420 establishing base reimbursement rates for each hospital based on
421 allowable costs~~,~~ as defined by the agency. Rates shall be
422 calculated annually and take effect July 1 of each year based on
423 the most recent complete and accurate cost report submitted by
424 each hospital. Adjustments may not be made to the rates after
425 September 30 of the state fiscal year in which the rate takes
426 effect, except that the agency may request that adjustments be
427 approved by the Legislative Budget Commission when needed due to
428 insufficient commitments or collections of intergovernmental
429 transfers under s. 409.908(1) or s. 409.908(4). Errors in cost
430 reporting or calculation of rates discovered after September 30
431 must be reconciled in a subsequent rate period. The agency may
432 not make any adjustment to a hospital's reimbursement rate more
433 than 5 years after a hospital is notified of an audited rate
434 established by the agency. The prohibition against ~~requirement~~
435 ~~that~~ the agency making ~~may not make~~ any adjustment to a
436 hospital's reimbursement rate more than 5 years after a hospital
437 is notified of an audited rate established by the agency is
438 remedial and applies ~~shall apply~~ to actions by providers
439 involving Medicaid claims for hospital services. Hospital rates
440 shall be subject to such limits or ceilings as may be
441 established in law or described in the agency's hospital
442 reimbursement plan. Specific exemptions to the limits or
443 ceilings may be provided in the General Appropriations Act.
444 (d) The agency shall implement a comprehensive utilization
445 management program for hospital neonatal intensive care stays in
446 certain high-volume participating hospitals, select counties, or
447 statewide, and replace existing hospital inpatient utilization
448 management programs for neonatal intensive care admissions. The

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449 program shall be designed to manage the lengths of stay for
450 children being treated in neonatal intensive care units and must
451 seek the earliest medically appropriate discharge to the child's
452 home or other less costly treatment setting. The agency may
453 competitively bid a contract for the selection of a qualified
454 organization to provide neonatal intensive care utilization
455 management services. The agency may seek federal waivers to
456 implement this initiative.
457 (e) The agency may develop and implement a program to
458 reduce the number of hospital readmissions among the non-
459 Medicare population eligible in areas 9, 10, and 11.
460 (f) The agency shall develop a plan to convert Medicaid
461 inpatient hospital rates to a prospective payment system that
462 categorizes each case into diagnosis-related groups (DRG) and
463 assigns a payment weight based on the average resources used to
464 treat Medicaid patients in that DRG. To the extent possible, the
465 agency shall propose an adaptation of an existing prospective
466 payment system, such as the one used by Medicare, and shall
467 propose such adjustments as are necessary for the Medicaid
468 population and to maintain budget neutrality for inpatient
469 hospital expenditures.
470 1. The plan must:
471 a. Define and describe DRGs for inpatient hospital care
472 specific to Medicaid in this state;
473 b. Develop the use of resources needed for each DRG;
474 c. Apply current statewide levels of funding to DRGs based
475 on the associated resource value of DRGs. Current statewide
476 funding levels shall be calculated both with and without the use
477 of intergovernmental transfers;

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478 d. Calculate the current number of services provided in the
479 Medicaid program based on DRGs defined under this subparagraph;
480 e. Estimate the number of cases in each DRG for future
481 years based on agency data and the official workload estimates
482 of the Social Services Estimating Conference;
483 f. Estimate potential funding for each hospital with a
484 Medicaid provider agreement, based on the DRGs and estimated
485 workload;
486 g. Propose supplemental DRG payments to augment hospital
487 reimbursements based on patient acuity and individual hospital
488 characteristics, including classification as a children's
489 hospital, rural hospital, trauma center, burn unit, and other
490 characteristics that could warrant higher reimbursements; and
491 h. Estimate potential funding for each hospital with a
492 Medicaid provider agreement for DRGs defined pursuant to this
493 subparagraph and supplemental DRG payments using current funding
494 levels, calculated both with and without the use of
495 intergovernmental transfers.
496 2. The agency, through a competitive procurement pursuant
497 to chapter 287, shall engage a consultant with expertise and
498 experience in the implementation of DRG systems for hospital
499 reimbursement to develop the DRG plan under subparagraph 1.
500 3. The agency shall submit the ~~Medicaid~~ DRG plan,
501 identifying all steps necessary for the transition and any costs
502 associated with plan implementation, to the Governor, the
503 President of the Senate, and the Speaker of the House of
504 Representatives no later than December 1, 2012 ~~January 1, 2013~~.
505 Upon receiving legislative authorization, the agency shall begin
506 making the necessary changes to fiscal agent coding by June 1,

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507 2013, with a target date of November 1, 2013, for full
508 implementation of the DRG system of hospital reimbursement. If,
509 during implementation of this paragraph, the agency determines
510 that these timeframes might not be achievable, the agency shall
511 report to the Legislative Budget Commission the status of its
512 implementation efforts, the reasons the timeframes might not be
513 achievable, and proposals for new timeframes.
514 Section 6. Paragraph (c) of subsection (1) of section
515 409.908, Florida Statutes, is amended, paragraph (e) is added to
516 that subsection, and subsections (4) and (21) of that section
517 are amended, to read:
518 409.908 Reimbursement of Medicaid providers.—Subject to
519 specific appropriations, the agency shall reimburse Medicaid
520 providers, in accordance with state and federal law, according
521 to methodologies set forth in the rules of the agency and in
522 policy manuals and handbooks incorporated by reference therein.
523 These methodologies may include fee schedules, reimbursement
524 methods based on cost reporting, negotiated fees, competitive
525 bidding pursuant to s. 287.057, and other mechanisms the agency
526 considers efficient and effective for purchasing services or
527 goods on behalf of recipients. If a provider is reimbursed based
528 on cost reporting and submits a cost report late and that cost
529 report would have been used to set a lower reimbursement rate
530 for a rate semester, then the provider's rate for that semester
531 shall be retroactively calculated using the new cost report, and
532 full payment at the recalculated rate shall be effected
533 retroactively. Medicare-granted extensions for filing cost
534 reports, if applicable, shall also apply to Medicaid cost
535 reports. Payment for Medicaid compensable services made on

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536 behalf of Medicaid eligible persons is subject to the
537 availability of moneys and any limitations or directions
538 provided for in the General Appropriations Act or chapter 216.
539 Further, nothing in this section shall be construed to prevent
540 or limit the agency from adjusting fees, reimbursement rates,
541 lengths of stay, number of visits, or number of services, or
542 making any other adjustments necessary to comply with the
543 availability of moneys and any limitations or directions
544 provided for in the General Appropriations Act, provided the
545 adjustment is consistent with legislative intent.
546 (1) Reimbursement to hospitals licensed under part I of
547 chapter 395 must be made prospectively or on the basis of
548 negotiation.
549 (c) Hospitals that provide services to a disproportionate
550 share of low-income Medicaid recipients, or that participate in
551 the regional perinatal intensive care center program under
552 chapter 383, or that participate in the statutory teaching
553 hospital disproportionate share program may receive additional
554 reimbursement. The total amount of payment for disproportionate
555 share hospitals shall be fixed by the General Appropriations
556 Act. The computation of these payments must be made in
557 compliance with all federal regulations and the methodologies
558 described in ss. 409.911~~, 409.9112,~~ and 409.9113.
559 (e) The agency may accept voluntary intergovernmental
560 transfers of local taxes and other qualified revenue from
561 counties, municipalities, or special taxing districts under
562 paragraphs (a) and (b) or the General Appropriations Act for the
563 purpose of funding the costs of special Medicaid payments to
564 hospitals, the costs of exempting hospitals from reimbursement

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565 ceilings, or the costs of buying back hospital Medicaid trend
566 adjustments authorized under the General Appropriations Act,
567 except that the use of these intergovernmental transfers for
568 fee-for-service payments to hospitals is limited to the
569 proportionate use of such funds accepted by the agency under
570 subsection (4). As used in this paragraph, the term
571 "proportionate use" means that the use of intergovernmental
572 transfer funds under this subsection must be in the same
573 proportion to the use of such funds under subsection (4)
574 relative to the need for funding hospital costs under each
575 subsection.
576 (4) Subject to any limitations or directions provided for
577 in the General Appropriations Act, alternative health plans,
578 health maintenance organizations, and prepaid health plans,
579 including health maintenance organizations, prepaid provider
580 service networks, and other capitated managed care plans, shall
581 be reimbursed a fixed, prepaid amount negotiated, or
582 competitively bid pursuant to s. 287.057, by the agency and
583 prospectively paid to the provider monthly for each Medicaid
584 recipient enrolled. The amount may not exceed the average amount
585 the agency determines it would have paid, based on claims
586 experience, for recipients in the same or similar category of
587 eligibility. The agency shall calculate capitation rates on a
588 regional basis and, beginning September 1, 1995, shall include
589 age-band differentials in such calculations.
590 (a) Effective September 1, 2012:
591 1. The costs of special Medicaid payments to hospitals, the
592 costs of exempting hospitals from reimbursement ceilings, and
593 the costs of buying back hospital Medicaid trend adjustments

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594 authorized under the General Appropriations Act, which are
595 funded through intergovernmental transfers, may not be included
596 as inpatient or outpatient costs in the calculation of prepaid
597 health plan capitations under this part. This provision must be
598 construed so that inpatient hospital costs included in the
599 calculation of prepaid health plan capitations are identical to
600 those represented by county billing rates under s. 409.915.
601 2. Prepaid health plans may not reimburse hospitals for the
602 costs described in subparagraph 1., except that plans may
603 contract with hospitals to pay inpatient per diems that are
604 between 95 percent and 105 percent of the county billing rate.
605 Hospitals and prepaid health plans may negotiate mutually
606 acceptable higher rates for medically complex care.
607 (b) Notwithstanding paragraph (a):
608 1. In order to fund the inclusion of costs described in
609 paragraph (a) in the calculation of capitations paid to prepaid
610 health plans, the agency may accept voluntary intergovernmental
611 transfers of local taxes and other qualified revenue from
612 counties, municipalities, or special taxing districts. After
613 securing commitments from counties, municipalities, or special
614 taxing districts to contribute intergovernmental transfers for
615 that purpose, the agency shall develop capitation payments for
616 prepaid health plans which include the costs described in
617 paragraph (a) if those components of the capitation are funded
618 through intergovernmental transfers and not with general
619 revenue. The rate-setting methodology must preserve federal
620 matching funds for the intergovernmental transfers collected
621 under this paragraph and result in actuarially sound rates. The
622 agency has the discretion to perform this function using

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623 supplemental capitation payments.
624 2. The amounts included in a prepaid health plan’s
625 capitations or supplemental capitations under this paragraph for
626 funding the costs described in paragraph (a) must be used
627 exclusively by the prepaid health plan to enhance hospital
628 payments and be calculated by the agency as accurately as
629 possible to equal the costs described in paragraph (a) which the
630 prepaid health plan actually incurs and for which
631 intergovernmental transfers have been secured.
632 (21) The agency shall reimburse school districts that ~~which~~
633 certify the state match pursuant to ss. 409.9071 and 1011.70 for
634 the federal portion of the school district’s allowable costs to
635 deliver the services, based on the reimbursement schedule. The
636 school district shall determine the costs for delivering
637 services as authorized in ss. 409.9071 and 1011.70 for which the
638 state match will be certified.
639 (a) School districts participating in the certified school
640 match program pursuant to this subsection and s. 1011.70 shall
641 be reimbursed by Medicaid, subject to the limitations of s.
642 1011.70(1), for a Medicaid-eligible child participating in the
643 services, as authorized under s. 1011.70 and as provided in s.
644 409.9071, regardless of whether the child is enrolled in
645 MediPass or a managed care plan. Managed care plans and school
646 districts shall make good faith efforts to execute agreements
647 regarding the coordinated provision of services authorized under
648 s. 1011.70. County health departments delivering school-based
649 services pursuant to ss. 381.0056 and 381.0057 shall be
650 reimbursed by Medicaid for the federal share for a Medicaid-
651 eligible child who receives Medicaid-covered services in a

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652 school setting, regardless of whether the child is enrolled in
653 MediPass or a managed care plan. Managed care plans and county
654 health departments shall make good faith efforts to execute
655 agreements regarding the coordinated provision of services to a
656 Medicaid-eligible child. To ensure continuity of care for
657 Medicaid patients, the agency, the Department of Health, and the
658 Department of Education shall develop procedures for ensuring
659 that a student's managed care plan or MediPass primary care
660 provider receives information relating to services provided in
661 accordance with ss. 381.0056, 381.0057, 409.9071, and 1011.70.
662 (b) Reimbursement of school-based providers is contingent
663 on such providers being enrolled as Medicaid providers and
664 meeting the qualifications contained in 42 C.F.R. s. 440.110,
665 unless otherwise waived by the federal Centers for Medicare and
666 Medicaid Services ~~Health Care Financing Administration~~. Speech
667 therapy providers who are certified through the Department of
668 Education pursuant to rule 6A-4.0176, Florida Administrative
669 Code, are eligible for reimbursement for services that are
670 provided on school premises. An ~~Any~~ employee of the school
671 district who has been fingerprinted and has received a criminal
672 background check in accordance with Department of Education
673 rules and guidelines is ~~shall be~~ exempt from any agency
674 requirements relating to criminal background checks.
675 Section 7. Subsection (1), paragraphs (a) and (b) of
676 subsection (2), and paragraph (d) of subsection (4) of section
677 409.911, Florida Statutes, are amended to read:
678 409.911 Disproportionate share program.—Subject to specific
679 allocations established within the General Appropriations Act
680 and any limitations established pursuant to chapter 216, the

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681 agency shall distribute, pursuant to this section, moneys to
682 hospitals providing a disproportionate share of Medicaid or
683 charity care services by making quarterly Medicaid payments as
684 required. Notwithstanding the provisions of s. 409.915, counties
685 are exempt from contributing toward the cost of this special
686 reimbursement for hospitals serving a disproportionate share of
687 low-income patients.
688 (1) DEFINITIONS.—As used in this section~~, s. 409.9112,~~ and
689 the Florida Hospital Uniform Reporting System manual:
690 (a) "Adjusted patient days" means the sum of acute care
691 patient days and intensive care patient days as reported to the
692 agency ~~for Health Care Administration~~, divided by the ratio of
693 inpatient revenues generated from acute, intensive, ambulatory,
694 and ancillary patient services to gross revenues.
695 (b) "Actual audited data" or "actual audited experience"
696 means data reported to the agency ~~for Health Care Administration~~
697 which has been audited in accordance with generally accepted
698 auditing standards by the agency or representatives under
699 contract with the agency.
700 (c) "Charity care" or "uncompensated charity care" means
701 that portion of hospital charges reported to the agency ~~for~~
702 ~~Health Care Administration~~ for which there is no compensation,
703 other than restricted or unrestricted revenues provided to a
704 hospital by local governments or tax districts, regardless of
705 the method of payment, for care provided to a patient whose
706 family income for the 12 months preceding the determination is
707 less than or equal to 200 percent of the federal poverty level,
708 unless the amount of hospital charges due from the patient
709 exceeds 25 percent of the annual family income. However, ~~in no~~

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710 ~~case shall~~ the hospital charges for a patient whose family
711 income exceeds four times the federal poverty level for a family
712 of four may not be considered charity.
713 (d) “Charity care days” means the sum of the deductions
714 from revenues for charity care minus 50 percent of restricted
715 and unrestricted revenues provided to a hospital by local
716 governments or tax districts, divided by gross revenues per
717 adjusted patient day.
718 (e) “Hospital” means a health care institution licensed as
719 a hospital pursuant to chapter 395, but does not include
720 ambulatory surgical centers.
721 (f) “Medicaid days” means the number of actual days
722 attributable to Medicaid recipients ~~patients~~ as determined by
723 the agency ~~for Health Care Administration~~.
724 (2) The agency ~~for Health Care Administration~~ shall use the
725 following actual audited data to determine the Medicaid days and
726 charity care to be used in calculating the disproportionate
727 share payment:
728 (a) The average of the 2004, 2005, and 2006 audited
729 disproportionate share data to determine each hospital’s
730 Medicaid days and charity care for the 2012-2013 ~~2011-2012~~ state
731 fiscal year.
732 (b) If the agency ~~for Health Care Administration~~ does not
733 have the prescribed 3 years of audited disproportionate share
734 data as noted in paragraph (a) for a hospital, the agency shall
735 use the average of the years of the audited disproportionate
736 share data as noted in paragraph (a) which is available.
737 (4) The following formulas shall be used to pay
738 disproportionate share dollars to public hospitals:

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739 (d) Any nonstate government owned or operated hospital
740 eligible for payments under this section on July 1, 2011,
741 remains eligible for payments during the 2012-2013 ~~2011-2012~~
742 state fiscal year.
743 Section 8. Section 409.9112, Florida Statutes, is repealed.
744 Section 9. Section 409.9113, Florida Statutes, is amended
745 to read:
746 409.9113 Disproportionate share program for teaching
747 hospitals.—In addition to the payments made under s. ~~ss.~~ 409.911
748 ~~and 409.9112~~, the agency shall make disproportionate share
749 payments to teaching hospitals, as defined in s. 408.07, for
750 their increased costs associated with medical education programs
751 and for tertiary health care services provided to the indigent.
752 This system of payments must conform to federal requirements and
753 distribute funds in each fiscal year for which an appropriation
754 is made by making quarterly Medicaid payments. Notwithstanding
755 s. 409.915, counties are exempt from contributing toward the
756 cost of this special reimbursement for hospitals serving a
757 disproportionate share of low-income patients. ~~For the 2011-2012~~
758 ~~state fiscal year,~~ The agency shall distribute the moneys
759 provided in the General Appropriations Act to statutorily
760 defined teaching hospitals and family practice teaching
761 hospitals, as defined in s. 395.805, pursuant to this section.
762 The funds provided for statutorily defined teaching hospitals
763 shall be distributed as provided in the General Appropriations
764 Act. The funds provided for family practice teaching hospitals
765 shall be distributed equally among family practice teaching
766 hospitals.
767 (1) On or before September 15 of each year, the agency

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768 shall calculate an allocation fraction to be used for
769 distributing funds to statutory teaching hospitals. Subsequent
770 to the end of each quarter of the state fiscal year, the agency
771 shall distribute to each statutory teaching hospital an amount
772 determined by multiplying one-fourth of the funds appropriated
773 for this purpose by the Legislature times such hospital's
774 allocation fraction. The allocation fraction for each such
775 hospital shall be determined by the sum of the following three
776 primary factors, divided by three:
777 (a) The number of nationally accredited graduate medical
778 education programs offered by the hospital, including programs
779 accredited by the Accreditation Council for Graduate Medical
780 Education and the combined Internal Medicine and Pediatrics
781 programs acceptable to both the American Board of Internal
782 Medicine and the American Board of Pediatrics at the beginning
783 of the state fiscal year preceding the date on which the
784 allocation fraction is calculated. The numerical value of this
785 factor is the fraction that the hospital represents of the total
786 number of programs, where the total is computed for all
787 statutory teaching hospitals.
788 (b) The number of full-time equivalent trainees in the
789 hospital, which comprises two components:
790 1. The number of trainees enrolled in nationally accredited
791 graduate medical education programs, as defined in paragraph
792 (a). Full-time equivalents are computed using the fraction of
793 the year during which each trainee is primarily assigned to the
794 given institution, over the state fiscal year preceding the date
795 on which the allocation fraction is calculated. The numerical
796 value of this factor is the fraction that the hospital

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797 represents of the total number of full-time equivalent trainees
798 enrolled in accredited graduate programs, where the total is
799 computed for all statutory teaching hospitals.
800 2. The number of medical students enrolled in accredited
801 colleges of medicine and engaged in clinical activities,
802 including required clinical clerkships and clinical electives.
803 Full-time equivalents are computed using the fraction of the
804 year during which each trainee is primarily assigned to the
805 given institution, over the course of the state fiscal year
806 preceding the date on which the allocation fraction is
807 calculated. The numerical value of this factor is the fraction
808 that the given hospital represents of the total number of full-
809 time equivalent students enrolled in accredited colleges of
810 medicine, where the total is computed for all statutory teaching
811 hospitals.
812
813 The primary factor for full-time equivalent trainees is computed
814 as the sum of these two components, divided by two.
815 (c) A service index that comprises three components:
816 1. The Agency for Health Care Administration Service Index,
817 computed by applying the standard Service Inventory Scores
818 established by the agency to services offered by the given
819 hospital, as reported on Worksheet A-2 for the last fiscal year
820 reported to the agency before the date on which the allocation
821 fraction is calculated. The numerical value of this factor is
822 the fraction that the given hospital represents of the total
823 index values, where the total is computed for all statutory
824 teaching hospitals.
825 2. A volume-weighted service index, computed by applying

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826 the standard Service Inventory Scores established by the agency
827 to the volume of each service, expressed in terms of the
828 standard units of measure reported on Worksheet A-2 for the last
829 fiscal year reported to the agency before the date on which the
830 allocation factor is calculated. The numerical value of this
831 factor is the fraction that the given hospital represents of the
832 total volume-weighted service index values, where the total is
833 computed for all statutory teaching hospitals.
834 3. Total Medicaid payments to each hospital for direct
835 inpatient and outpatient services during the fiscal year
836 preceding the date on which the allocation factor is calculated.
837 This includes payments made to each hospital for such services
838 by Medicaid prepaid health plans, whether the plan was
839 administered by the hospital or not. The numerical value of this
840 factor is the fraction that each hospital represents of the
841 total of such Medicaid payments, where the total is computed for
842 all statutory teaching hospitals.
843
844 The primary factor for the service index is computed as the sum
845 of these three components, divided by three.
846 (2) By October 1 of each year, the agency shall use the
847 following formula to calculate the maximum additional
848 disproportionate share payment for statutory teaching hospitals:
849
850 TAP = THAF x A
851
852 Where:
853 TAP = total additional payment.
854 THAF = teaching hospital allocation factor.

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855 A = amount appropriated for a teaching hospital
856 disproportionate share program.
857 Section 10. Section 409.9117, Florida Statutes, is
858 repealed.
859 Section 11. Paragraphs (b) and (d) of subsection (4) of
860 section 409.912, Florida Statutes, are amended to read:
861 409.912 Cost-effective purchasing of health care.—The
862 agency shall purchase goods and services for Medicaid recipients
863 in the most cost-effective manner consistent with the delivery
864 of quality medical care. To ensure that medical services are
865 effectively utilized, the agency may, in any case, require a
866 confirmation or second physician's opinion of the correct
867 diagnosis for purposes of authorizing future services under the
868 Medicaid program. This section does not restrict access to
869 emergency services or poststabilization care services as defined
870 in 42 C.F.R. part 438.114. Such confirmation or second opinion
871 shall be rendered in a manner approved by the agency. The agency
872 shall maximize the use of prepaid per capita and prepaid
873 aggregate fixed-sum basis services when appropriate and other
874 alternative service delivery and reimbursement methodologies,
875 including competitive bidding pursuant to s. 287.057, designed
876 to facilitate the cost-effective purchase of a case-managed
877 continuum of care. The agency shall also require providers to
878 minimize the exposure of recipients to the need for acute
879 inpatient, custodial, and other institutional care and the
880 inappropriate or unnecessary use of high-cost services. The
881 agency shall contract with a vendor to monitor and evaluate the
882 clinical practice patterns of providers in order to identify
883 trends that are outside the normal practice patterns of a

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884 provider's professional peers or the national guidelines of a
885 provider's professional association. The vendor must be able to
886 provide information and counseling to a provider whose practice
887 patterns are outside the norms, in consultation with the agency,
888 to improve patient care and reduce inappropriate utilization.
889 The agency may mandate prior authorization, drug therapy
890 management, or disease management participation for certain
891 populations of Medicaid beneficiaries, certain drug classes, or
892 particular drugs to prevent fraud, abuse, overuse, and possible
893 dangerous drug interactions. The Pharmaceutical and Therapeutics
894 Committee shall make recommendations to the agency on drugs for
895 which prior authorization is required. The agency shall inform
896 the Pharmaceutical and Therapeutics Committee of its decisions
897 regarding drugs subject to prior authorization. The agency is
898 authorized to limit the entities it contracts with or enrolls as
899 Medicaid providers by developing a provider network through
900 provider credentialing. The agency may competitively bid single-
901 source-provider contracts if procurement of goods or services
902 results in demonstrated cost savings to the state without
903 limiting access to care. The agency may limit its network based
904 on the assessment of beneficiary access to care, provider
905 availability, provider quality standards, time and distance
906 standards for access to care, the cultural competence of the
907 provider network, demographic characteristics of Medicaid
908 beneficiaries, practice and provider-to-beneficiary standards,
909 appointment wait times, beneficiary use of services, provider
910 turnover, provider profiling, provider licensure history,
911 previous program integrity investigations and findings, peer
912 review, provider Medicaid policy and billing compliance records,

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913 clinical and medical record audits, and other factors. Providers
914 are not entitled to enrollment in the Medicaid provider network.
915 The agency shall determine instances in which allowing Medicaid
916 beneficiaries to purchase durable medical equipment and other
917 goods is less expensive to the Medicaid program than long-term
918 rental of the equipment or goods. The agency may establish rules
919 to facilitate purchases in lieu of long-term rentals in order to
920 protect against fraud and abuse in the Medicaid program as
921 defined in s. 409.913. The agency may seek federal waivers
922 necessary to administer these policies.
923 (4) The agency may contract with:
924 (b) An entity that is providing comprehensive behavioral
925 health care services to certain Medicaid recipients through a
926 capitated, prepaid arrangement pursuant to the federal waiver
927 provided ~~for~~ by s. 409.905(5). Such entity must be licensed
928 under chapter 624, chapter 636, or chapter 641, or authorized
929 under paragraph (c) or paragraph (d), and must possess the
930 clinical systems and operational competence to manage risk and
931 provide comprehensive behavioral health care to Medicaid
932 recipients. As used in this paragraph, the term “comprehensive
933 behavioral health care services” means covered mental health and
934 substance abuse treatment services that are available to
935 Medicaid recipients. The secretary of the Department of Children
936 and Family Services shall approve provisions of procurements
937 related to children in the department’s care or custody before
938 enrolling such children in a prepaid behavioral health plan. Any
939 contract awarded under this paragraph must be competitively
940 procured. In developing the behavioral health care prepaid plan
941 procurement document, the agency must ~~shall~~ ensure that the

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942 ~~procurement~~ document requires the contractor to develop and
943 implement a plan <u>that ensures</u> ~~to ensure~~ compliance with s.
944 394.4574 related to services provided to residents of licensed
945 assisted living facilities that hold a limited mental health
946 license. Except as provided in subparagraph 5., and except in
947 counties where the Medicaid managed care pilot program is
948 authorized pursuant to s. 409.91211, the agency shall seek
949 federal approval to contract with a single entity meeting these
950 requirements to provide comprehensive behavioral health care
951 services to all Medicaid recipients not enrolled in a Medicaid
952 managed care plan authorized under s. 409.91211, a provider
953 service network authorized under paragraph (d), or a Medicaid
954 health maintenance organization in an AHCA area. In an AHCA area
955 where the Medicaid managed care pilot program is authorized
956 pursuant to s. 409.91211 in one or more counties, the agency may
957 procure a contract with a single entity to serve the remaining
958 counties as an AHCA area or the remaining counties may be
959 included with an adjacent AHCA area and are subject to this
960 paragraph. Each entity must offer a sufficient choice of
961 providers in its network to ensure recipient access to care and
962 the opportunity to select a provider with whom they are
963 satisfied. The network <u>must</u> ~~shall~~ include all public mental
964 health hospitals. To ensure unimpaired access to behavioral
965 health care services by Medicaid recipients, all contracts
966 issued pursuant to this paragraph must require 80 percent of the
967 capitation paid to the managed care plan, including health
968 maintenance organizations and capitated provider service
969 networks, to be expended for the provision of behavioral health
970 care services. If the managed care plan expends less than 80

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971 percent of the capitation paid for the provision of behavioral
972 health care services, the difference shall be returned to the
973 agency. The agency shall provide the plan with a certification
974 letter indicating the amount of capitation paid during each
975 calendar year for behavioral health care services pursuant to
976 this section. The agency may reimburse for substance abuse
977 treatment services on a fee-for-service basis until the agency
978 finds that adequate funds are available for capitated, prepaid
979 arrangements.
980 1. The agency shall modify the contracts with the entities
981 providing comprehensive inpatient and outpatient mental health
982 care services to Medicaid recipients in Hillsborough, Highlands,
983 Hardee, Manatee, and Polk Counties, to include substance abuse
984 treatment services.
985 2. Except as provided in subparagraph 5., the agency and
986 the Department of Children and Family Services shall contract
987 with managed care entities in each AHCA area except area 6 or
988 arrange to provide comprehensive inpatient and outpatient mental
989 health and substance abuse services through capitated prepaid
990 arrangements to all Medicaid recipients who are eligible to
991 participate in such plans under federal law and regulation. In
992 AHCA areas where eligible individuals number less than 150,000,
993 the agency shall contract with a single managed care plan to
994 provide comprehensive behavioral health services to all
995 recipients who are not enrolled in a Medicaid health maintenance
996 organization, a provider service network authorized under
997 paragraph (d), or a Medicaid capitated managed care plan
998 authorized under s. 409.91211. The agency may contract with more
999 than one comprehensive behavioral health provider to provide

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1000 care to recipients who are not enrolled in a Medicaid capitated
1001 managed care plan authorized under s. 409.91211, a provider
1002 service network authorized under paragraph (d), or a Medicaid
1003 health maintenance organization in AHCA areas where the eligible
1004 population exceeds 150,000. In an AHCA area where the Medicaid
1005 managed care pilot program is authorized pursuant to s.
1006 409.91211 in one or more counties, the agency may procure a
1007 contract with a single entity to serve the remaining counties as
1008 an AHCA area or the remaining counties may be included with an
1009 adjacent AHCA area and shall be subject to this paragraph.
1010 Contracts for comprehensive behavioral health providers awarded
1011 pursuant to this section shall be competitively procured. Both
1012 for-profit and not-for-profit corporations are eligible to
1013 compete. Managed care plans contracting with the agency under
1014 subsection (3) or paragraph (d) shall provide and receive
1015 payment for the same comprehensive behavioral health benefits as
1016 provided in AHCA rules, including handbooks incorporated by
1017 reference. In AHCA area 11, prior to any fiscal year for which
1018 the agency expects the number of MediPass enrollees in that area
1019 to exceed 150,000, the agency shall seek to contract with at
1020 least two comprehensive behavioral health care providers to
1021 provide behavioral health care to recipients in that area who
1022 are enrolled in, or assigned to, the MediPass program, and the
1023 agency must offer one~~. One~~ of the behavioral health care
1024 contracts to ~~must be with~~ the existing public hospital-operated
1025 provider service network ~~pilot project,~~ as described in
1026 paragraph (d), for the purpose of demonstrating the cost-
1027 effectiveness of the provision of quality mental health services
1028 through a public hospital-operated managed care model. Payment

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1029 shall be ~~at an agreed-upon~~ capitated ~~rate~~ to ensure cost
1030 savings. ~~Of the recipients in area 11 who are assigned to~~
1031 ~~MediPass under s. 409.9122(2)(k), a minimum of 50,000 of those~~
1032 ~~MediPass-enrolled recipients shall be assigned to the existing~~
1033 ~~provider service network in area 11 for their behavioral care.~~
1034 3. Children residing in a statewide inpatient psychiatric
1035 program, or in a Department of Juvenile Justice or a Department
1036 of Children and Family Services residential program approved as
1037 a Medicaid behavioral health overlay services provider may not
1038 be included in a behavioral health care prepaid health plan or
1039 any other Medicaid managed care plan pursuant to this paragraph.
1040 4. Traditional community mental health providers under
1041 contract with the Department of Children and Family Services
1042 pursuant to part IV of chapter 394, child welfare providers
1043 under contract with the Department of Children and Family
1044 Services in areas 1 and 6, and inpatient mental health providers
1045 licensed pursuant to chapter 395 must be offered an opportunity
1046 to accept or decline a contract to participate in a ~~any~~ provider
1047 network for prepaid behavioral health services.
1048 5. All Medicaid-eligible children, except children in area
1049 1 and children in Highlands County, Hardee County, Polk County,
1050 or Manatee County of area 6, which ~~that~~ are open for child
1051 welfare services in the statewide automated child welfare
1052 information system, shall receive their behavioral health care
1053 services through a specialty prepaid plan operated by community-
1054 based lead agencies through a single agency or formal agreements
1055 among several agencies. The agency shall work with the specialty
1056 plan to develop clinically effective, evidence-based
1057 alternatives as a downward substitution for the statewide

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1058 inpatient psychiatric program and similar residential care and
1059 institutional services. The specialty prepaid plan must result
1060 in savings to the state comparable to savings achieved in other
1061 Medicaid managed care and prepaid programs. Such plan must
1062 provide mechanisms to maximize state and local revenues. The
1063 specialty prepaid plan shall be developed by the agency and the
1064 Department of Children and Family Services. The agency may seek
1065 federal waivers to implement this initiative. Medicaid-eligible
1066 children whose cases are open for child welfare services in the
1067 statewide automated child welfare information system and who
1068 reside in AHCA area 10 shall be enrolled in a capitated provider
1069 service network or other capitated managed care plan, which, in
1070 coordination with available community-based care providers
1071 specified in s. 409.1671, must ~~shall~~ provide sufficient medical,
1072 developmental, and behavioral health services to meet the needs
1073 of these children.
1074
1075 This paragraph expires October 1, 2014.
1076 (d)1. A provider service network, which may be reimbursed
1077 on a fee-for-service or prepaid basis. Prepaid provider service
1078 networks shall receive per-member, per-month payments. A
1079 provider service network that does not choose to be a prepaid
1080 plan shall receive fee-for-service rates with a shared savings
1081 settlement. The fee-for-service option shall be available to a
1082 provider service network only for the first 2 years of the
1083 plan’s operation or until the contract year beginning September
1084 1, 2014, whichever is later. The agency shall annually conduct
1085 cost reconciliations to determine the amount of cost savings
1086 achieved by fee-for-service provider service networks for the

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1087 dates of service in the period being reconciled. Only payments
1088 for covered services for dates of service within the
1089 reconciliation period and paid within 6 months after the last
1090 date of service in the reconciliation period shall be included.
1091 The agency shall perform the necessary adjustments for the
1092 inclusion of claims incurred but not reported within the
1093 reconciliation for claims that could be received and paid by the
1094 agency after the 6-month claims processing time lag. The agency
1095 shall provide the results of the reconciliations to the fee-for-
1096 service provider service networks within 45 days after the end
1097 of the reconciliation period. The fee-for-service provider
1098 service networks shall review and provide written comments or a
1099 letter of concurrence to the agency within 45 days after receipt
1100 of the reconciliation results. This reconciliation shall be
1101 considered final.
1102 2. A provider service network that ~~which~~ is reimbursed by
1103 the agency on a prepaid basis is ~~shall be~~ exempt from parts I
1104 and III of chapter 641, but must comply with the solvency
1105 requirements in s. 641.2261(2) and meet appropriate financial
1106 reserve, quality assurance, and patient rights requirements ~~as~~
1107 established by the agency.
1108 3. The agency shall assign Medicaid recipients ~~assigned~~ to
1109 a provider service network in accordance with s. 409.9122 or s.
1110 409.91211, as applicable ~~shall be chosen equally from those who~~
1111 ~~would otherwise have been assigned to prepaid plans and~~
1112 ~~MediPass~~. The agency may ~~is authorized to~~ seek federal Medicaid
1113 waivers as necessary to implement ~~the provisions of~~ this
1114 section. This subparagraph expires October 1, 2014.
1115 4. A provider service network is a network established or

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1116 organized and operated by a health care provider, or group of
1117 affiliated health care providers, including minority physician
1118 networks and emergency room diversion programs that meet the
1119 requirements of s. 409.91211, which provides a substantial
1120 proportion of the health care items and services under a
1121 contract directly through the provider or affiliated group of
1122 providers and may make arrangements with physicians or other
1123 health care professionals, health care institutions, or any
1124 combination of such individuals or institutions to assume all or
1125 part of the financial risk on a prospective basis for the
1126 provision of basic health services by the physicians, by other
1127 health professionals, or through the institutions. The health
1128 care providers must have a controlling interest in the governing
1129 body of the provider service network organization.
1130 Section 12. Section 409.9121, Florida Statutes, is amended
1131 to read:
1132 409.9121 Legislative findings and intent.—The Legislature
1133 ~~hereby~~ finds that the Medicaid program ~~has experienced an annual~~
1134 ~~growth rate of approximately 28 percent per year for the past 5~~
1135 ~~years, and is consuming more than half of all new general~~
1136 ~~revenue growth. The present Medicaid system~~ must be reoriented
1137 to emphasize, to the maximum extent possible, the delivery of
1138 health care through entities and mechanisms that ~~which~~ are
1139 designed to contain costs, to emphasize preventive and primary
1140 care, and to promote access and continuity of care. The
1141 Legislature further finds that the concept of “managed care”
1142 best encompasses these multiple goals. ~~The Legislature also~~
1143 ~~finds that, with the cooperation of the physician community,~~
1144 ~~MediPass, the Medicaid primary care case management program, is~~

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1145 ~~responsible for ensuring that there is a sufficient supply of~~
1146 ~~primary care to provide access to preventive and primary care~~
1147 ~~services to Medicaid recipients.~~ Therefore, the Legislature
1148 declares its intent that the Medicaid program require, to the
1149 maximum extent practicable and permitted by federal law, that
1150 all Medicaid recipients be enrolled in a managed care program.
1151 Section 13. Subsections (1), (2), (4), (5), and (12) of
1152 section 409.9122, Florida Statutes, are amended to read:
1153 409.9122 Mandatory Medicaid managed care enrollment;
1154 programs and procedures.—
1155 (1) It is the intent of the Legislature that Medicaid
1156 managed care ~~the MediPass program~~ be cost-effective, provide
1157 quality health care, ~~and~~ improve access to health services, and
1158 ~~that the program~~ be implemented statewide. Medicaid managed care
1159 shall consist of the enrollment of Medicaid recipients in the
1160 MediPass program or managed care plans for comprehensive medical
1161 services. This subsection expires October 1, 2014.
1162 (2)~~(a)~~ The agency shall enroll all Medicaid recipients in a
1163 managed care plan or MediPass ~~all Medicaid recipients~~, except
1164 those ~~Medicaid~~ recipients who are~~:~~ in an institution,~~;~~ enrolled
1165 in the Medicaid medically needy program,~~;~~ or eligible for both
1166 Medicaid and Medicare. Upon enrollment, recipients may
1167 ~~individuals will be able to~~ change their managed care option
1168 during the 90-day opt out period required by federal Medicaid
1169 regulations. The agency may ~~is authorized to~~ seek the necessary
1170 Medicaid state plan amendment to implement this policy. ~~However,~~
1171 (a) To the extent permitted by federal law, the agency may
1172 enroll a recipient in a managed care plan or MediPass ~~a Medicaid~~
1173 ~~recipient~~ who is exempt from mandatory managed care enrollment

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1174 if~~, provided that~~:
1175 1. The recipient's decision to enroll in a managed care
1176 plan or MediPass is voluntary;
1177 2. ~~If~~ The recipient chooses to enroll in a managed care
1178 plan and~~,~~ the agency has determined that the managed care plan
1179 provides specific programs and services that ~~which~~ address the
1180 special health needs of the recipient; and
1181 3. The agency receives any necessary waivers from the
1182 federal Centers for Medicare and Medicaid Services.
1183
1184 ~~School districts participating in the certified school match~~
1185 ~~program pursuant to ss. 409.908(21) and 1011.70 shall be~~
1186 ~~reimbursed by Medicaid, subject to the limitations of s.~~
1187 ~~1011.70(1), for a Medicaid-eligible child participating in the~~
1188 ~~services as authorized in s. 1011.70, as provided for in s.~~
1189 ~~409.9071, regardless of whether the child is enrolled in~~
1190 ~~MediPass or a managed care plan. Managed care plans shall make a~~
1191 ~~good faith effort to execute agreements with school districts~~
1192 ~~regarding the coordinated provision of services authorized under~~
1193 ~~s. 1011.70. County health departments delivering school-based~~
1194 ~~services pursuant to ss. 381.0056 and 381.0057 shall be~~
1195 ~~reimbursed by Medicaid for the federal share for a Medicaid-~~
1196 ~~eligible child who receives Medicaid-covered services in a~~
1197 ~~school setting, regardless of whether the child is enrolled in~~
1198 ~~MediPass or a managed care plan. Managed care plans shall make a~~
1199 ~~good faith effort to execute agreements with county health~~
1200 ~~departments regarding the coordinated provision of services to a~~
1201 ~~Medicaid-eligible child. To ensure continuity of care for~~
1202 ~~Medicaid patients, the agency, the Department of Health, and the~~

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1203 ~~Department of Education shall develop procedures for ensuring~~
1204 ~~that a student's managed care plan or MediPass provider receives~~
1205 ~~information relating to services provided in accordance with ss.~~
1206 ~~381.0056, 381.0057, 409.9071, and 1011.70.~~
1207 (b) A Medicaid recipient may ~~shall~~ not be enrolled in or
1208 assigned to a managed care plan or MediPass unless the managed
1209 care plan or MediPass has complied with the quality-of-care
1210 standards specified in paragraphs (3)(a) and (b), respectively.
1211 (c) A Medicaid recipient eligible for managed care
1212 enrollment ~~recipients~~ shall have a choice of managed care
1213 options ~~plans or MediPass~~. The Agency for Health Care
1214 Administration, the Department of Health, the Department of
1215 Children and Family Services, and the Department of Elderly
1216 Affairs shall cooperate to ensure that each ~~Medicaid~~ recipient
1217 receives clear and easily understandable information that meets
1218 the following requirements:
1219 1. Explains the concept of managed care~~, including~~
1220 ~~MediPass~~.
1221 2. Provides information on the comparative performance of
1222 managed care options available to the recipient ~~plans and~~
1223 ~~MediPass~~ in the areas of quality, credentialing, preventive
1224 health programs, network size and availability, and patient
1225 satisfaction.
1226 3. Explains where additional information on each managed
1227 care option ~~plan and MediPass~~ in the recipient's area can be
1228 obtained.
1229 4. Explains that recipients have the right to choose their
1230 managed care coverage at the time they first enroll in Medicaid
1231 and again at regular intervals set by the agency. However, if a

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1232 recipient does not choose a managed care option ~~plan or~~
1233 ~~MediPass~~, the agency shall ~~will~~ assign the recipient ~~to a~~
1234 ~~managed care plan or MediPass~~ according to the criteria
1235 specified in this section.
1236 5. Explains the recipient’s right to complain, file a
1237 grievance, or change his or her managed care option as specified
1238 in this section ~~plans or MediPass providers if the recipient is~~
1239 ~~not satisfied with the managed care plan or MediPass~~.
1240 (d) The agency shall develop a mechanism for providing
1241 information to Medicaid recipients for the purpose of choosing
1242 ~~making~~ a managed care option ~~plan or MediPass selection~~.
1243 Examples of such mechanisms ~~may~~ include, but are not ~~be~~ limited
1244 to, interactive information systems, mailings, and mass
1245 marketing materials. Managed care plans and MediPass providers
1246 may not provide ~~are prohibited from providing~~ inducements to
1247 ~~Medicaid~~ recipients to select their plans or prejudice ~~from~~
1248 ~~prejudicing Medicaid~~ recipients against other managed care plans
1249 or MediPass providers.
1250 (e) Medicaid recipients who are already enrolled in a
1251 managed care plan or MediPass shall be offered the opportunity
1252 to change managed care plans or MediPass providers, as
1253 applicable, on a staggered basis, as defined by the agency. All
1254 ~~Medicaid~~ recipients shall have 30 days in which to choose a
1255 managed care option ~~make a choice of managed care plans or~~
1256 ~~MediPass providers~~. Those ~~Medicaid~~ recipients who do not make a
1257 choice shall be assigned in accordance with paragraph (f). ~~To~~
1258 ~~facilitate continuity of care, for a Medicaid recipient who is~~
1259 ~~also a recipient of Supplemental Security Income (SSI), prior to~~
1260 ~~assigning the SSI recipient to a managed care plan or MediPass,~~

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1261 ~~the agency shall determine whether the SSI recipient has an~~
1262 ~~ongoing relationship with a MediPass provider or managed care~~
1263 ~~plan, and if so, the agency shall assign the SSI recipient to~~
1264 ~~that MediPass provider or managed care plan. Those SSI~~
1265 ~~recipients who do not have such a provider relationship shall be~~
1266 ~~assigned to a managed care plan or MediPass provider in~~
1267 ~~accordance with paragraph (f).~~
1268 1. During the 30-day choice period:
1269 a. A recipient residing in a county in which two or more
1270 managed care plans are eligible to accept Medicaid enrollees,
1271 including a recipient who was enrolled in MediPass at the
1272 commencement of his or her 30-day choice period, shall choose
1273 from those managed care plans. A recipient may opt out of his or
1274 her choice and choose a different managed care plan during the
1275 90-day opt out period.
1276 b. A recipient residing in a county in which only one
1277 managed care plan is eligible to accept Medicaid enrollees shall
1278 choose the managed care plan or a MediPass provider. A recipient
1279 who chooses the managed care plan may opt out of the plan and
1280 choose a MediPass provider during the 90-day opt out period.
1281 c. A recipient residing in a county in which no managed
1282 care plan is accepting Medicaid enrollees shall choose a
1283 MediPass provider.
1284 2. For the purposes of recipient choice, if a managed care
1285 plan reaches its enrollment capacity, as determined by the
1286 agency, the plan may not accept additional Medicaid enrollees
1287 until the agency determines that the plan’s enrollment is
1288 sufficiently less than its enrollment capacity, due to a decline
1289 in enrollment or by an increase in enrollment capacity. If a

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1290 managed care plan notifies the agency of its intent to exit a
1291 county, the plan may not accept additional Medicaid enrollees in
1292 that county before the exit date.
1293 3. As used in this paragraph, when referring to recipient
1294 choice, the term "managed care plans" includes health
1295 maintenance organizations, exclusive provider organizations,
1296 provider service networks, minority physician networks,
1297 Children's Medical Services Networks, and pediatric emergency
1298 department diversion programs authorized by this chapter or the
1299 General Appropriations Act.
1300 4. The agency shall seek federal waiver authority or a
1301 state plan amendment consistent with 42 U.S.C. 1396u-2(a)(1), as
1302 needed, to implement this paragraph.
1303 (f) If a Medicaid recipient does not choose a managed care
1304 option:
1305 1. If the recipient resides in a county in which two or
1306 more managed care plans are accepting Medicaid enrollees, the
1307 agency shall assign the recipient, including a recipient who was
1308 enrolled in MediPass at the commencement of his or her 30-day
1309 choice period, to one of those managed care plans. A recipient
1310 assigned to a managed care plan under this subparagraph may opt
1311 out of the managed care plan and enroll in a different managed
1312 care plan during the 90-day opt out period. The agency shall
1313 seek to make assignments among the managed care plans on an even
1314 basis under the criteria in subparagraph 6.
1315 2. If the recipient resides in a county in which only one
1316 managed care plan is accepting Medicaid enrollees, the agency
1317 shall assign the recipient, including a recipient who was
1318 enrolled in MediPass at the commencement of his or her 30-day

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1319 choice period, to the managed care plan. A recipient assigned to
1320 a managed care plan under this subparagraph may opt out of the
1321 managed care plan and choose a MediPass provider during the 90-
1322 day opt out period.
1323 3. If the recipient resides in a county in which no managed
1324 care plan is accepting Medicaid enrollees, the agency shall
1325 assign the recipient to a MediPass provider.
1326 4. For the purpose of assignment, if a managed care plan
1327 reaches its enrollment capacity, as determined by the agency,
1328 the plan may not accept additional Medicaid enrollees until the
1329 agency determines that the plan's enrollment is sufficiently
1330 less than its enrollment capacity, due to a decline in
1331 enrollment or by an increase in enrollment capacity. If a
1332 managed care plan notifies the agency of its intent to exit a
1333 county, the agency may not assign additional Medicaid enrollees
1334 to the plan in that county before the exit date. ~~plan or~~
1335 ~~MediPass provider, the agency shall assign the Medicaid~~
1336 ~~recipient to a managed care plan or MediPass provider. Medicaid~~
1337 ~~recipients eligible for managed care plan enrollment who are~~
1338 ~~subject to mandatory assignment but who fail to make a choice~~
1339 ~~shall be assigned to managed care plans until an enrollment of~~
1340 ~~35 percent in MediPass and 65 percent in managed care plans, of~~
1341 ~~all those eligible to choose managed care, is achieved. Once~~
1342 ~~this enrollment is achieved, the assignments shall be divided in~~
1343 ~~order to maintain an enrollment in MediPass and managed care~~
1344 ~~plans which is in a 35 percent and 65 percent proportion,~~
1345 ~~respectively. Thereafter, assignment of Medicaid recipients who~~
1346 ~~fail to make a choice shall be based proportionally on the~~
1347 ~~preferences of recipients who have made a choice in the previous~~

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1348 ~~period. Such proportions shall be revised at least quarterly to~~
1349 ~~reflect an update of the preferences of Medicaid recipients. The~~
1350 ~~agency shall disproportionately assign Medicaid-eligible~~
1351 ~~recipients who are required to but have failed to make a choice~~
1352 ~~of managed care plan or MediPass to the Children's Medical~~
1353 ~~Services Network as defined in s. 391.021, exclusive provider~~
1354 ~~organizations, provider service networks, minority physician~~
1355 ~~networks, and pediatric emergency department diversion programs~~
1356 ~~authorized by this chapter or the General Appropriations Act, in~~
1357 ~~such manner as the agency deems appropriate, until the agency~~
1358 ~~has determined that the networks and programs have sufficient~~
1359 ~~numbers to be operated economically.~~
1360 5. As used in ~~For purposes of~~ this paragraph, when
1361 referring to assignment, the term "managed care plans" includes
1362 health maintenance organizations, exclusive provider
1363 organizations, provider service networks, minority physician
1364 networks, Children's Medical Services Network, and pediatric
1365 emergency department diversion programs authorized by this
1366 chapter or the General Appropriations Act.
1367 6. When making assignments, the agency shall consider ~~take~~
1368 ~~into account~~ the following criteria, as applicable:
1369 a.~~1.~~ Whether a managed care plan has sufficient network
1370 capacity to meet the need of members.
1371 b.~~2.~~ Whether the managed care plan ~~or MediPass~~ has
1372 previously enrolled the recipient as a member, or one of the
1373 managed care plan's primary care providers or a MediPass primary
1374 care provider ~~providers~~ has previously provided health care to
1375 the recipient.
1376 c.~~3.~~ Whether the agency has knowledge that the recipient

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1377 ~~member~~ has previously expressed a preference for a particular
1378 managed care plan or MediPass primary care provider ~~as indicated~~
1379 ~~by Medicaid fee-for-service claims data,~~ but has failed to make
1380 a choice.
1381 d.~~4.~~ Whether the managed care plan’s or MediPass primary
1382 care providers are geographically accessible to the recipient’s
1383 residence.
1384 e. If the recipient was already enrolled in a managed care
1385 plan at the commencement of his or her 30-day choice period and
1386 fails to choose a different option, the recipient must remain
1387 enrolled in that same managed care plan.
1388 f. To facilitate continuity of care for a Medicaid
1389 recipient who is also a recipient of Supplemental Security
1390 Income (SSI), before assigning the SSI recipient, the agency
1391 shall determine whether the SSI recipient has an ongoing
1392 relationship with a managed care plan or a MediPass primary care
1393 provider, and if so, the agency shall assign the SSI recipient
1394 to that managed care plan or MediPass provider, as applicable.
1395 However, if the recipient has an ongoing relationship with a
1396 MediPass primary care provider who is included in the provider
1397 network of one or more managed care plans, the agency shall
1398 assign the recipient to one of those managed care plans.
1399 g. If the recipient is diagnosed with HIV/AIDS and resides
1400 in Broward County, Miami-Dade County, or Palm Beach County, the
1401 agency shall assign the Medicaid recipient to a managed care
1402 plan that is a health maintenance organization authorized under
1403 chapter 641, that was under contract with the agency on July 1,
1404 2011, and that offers a delivery system in partnership with a
1405 university-based teaching and research-oriented organization

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1406 specializing in providing health care services and treatment for
1407 individuals diagnosed with HIV/AIDS. Recipients not diagnosed
1408 with HIV/AIDS may not be assigned under this paragraph to a
1409 managed care plan that specializes in HIV/AIDS.
1410 7. The agency shall seek federal waiver authority or a
1411 state plan amendment consistent with 42 U.S.C. 1396u-2(a)(4)(D),
1412 as needed, to implement this paragraph.
1413 (g) When more than one managed care plan or MediPass
1414 provider meets the criteria specified in paragraph (f), the
1415 agency shall make recipient assignments consecutively by family
1416 unit.
1417 (h) The agency may not engage in practices that ~~are~~
1418 ~~designed to~~ favor one managed care plan over another or that ~~are~~
1419 ~~designed to~~ influence Medicaid recipients to enroll in MediPass
1420 rather than in a managed care plan or to enroll in a managed
1421 care plan rather than in MediPass, as applicable. This
1422 subsection does not prohibit the agency from reporting on the
1423 performance of MediPass or any managed care plan, as measured by
1424 performance criteria developed by the agency.
1425 (i) After a recipient has made his or her selection or ~~has~~
1426 been enrolled in a managed care plan or MediPass, the recipient
1427 shall have 90 days to exercise the opportunity to voluntarily
1428 disenroll and select another managed care option ~~plan or~~
1429 ~~MediPass~~. After 90 days, no further changes may be made except
1430 for good cause. Good cause includes, but is not limited to, poor
1431 quality of care, lack of access to necessary specialty services,
1432 an unreasonable delay or denial of service, or fraudulent
1433 enrollment. The agency shall develop criteria for good cause
1434 disenrollment for chronically ill and disabled populations who

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1435 are assigned to managed care plans if more appropriate care is
1436 available through the MediPass program. The agency must make a
1437 determination as to whether good cause exists. However, the
1438 agency may require a recipient to use the managed care plan’s or
1439 MediPass grievance process prior to the agency’s determination
1440 of good cause, except in cases in which immediate risk of
1441 permanent damage to the recipient’s health is alleged. The
1442 grievance process, if used ~~when utilized~~, must be completed in
1443 time to permit the recipient to disenroll by the first day of
1444 the second month after the month the disenrollment request was
1445 made. If the managed care plan or MediPass, as a result of the
1446 grievance process, approves an enrollee’s request to disenroll,
1447 the agency is not required to make a determination in the case.
1448 The agency must make a determination and take final action on a
1449 recipient’s request so that disenrollment occurs by ~~no later~~
1450 ~~than~~ the first day of the second month after the month the
1451 request was made. If the agency fails to act within the
1452 specified timeframe, the recipient’s request to disenroll is
1453 deemed to be approved as of the date agency action was required.
1454 Recipients who disagree with the agency’s finding that good
1455 cause does not exist for disenrollment shall be advised of their
1456 right to pursue a Medicaid fair hearing to dispute the agency’s
1457 finding.
1458 (j) Consistent with 42 U.S.C. 1396u-2(a)(4)(A) or under
1459 federal waiver authority, as needed, the agency shall ~~apply for~~
1460 ~~a federal waiver from the Centers for Medicare and Medicaid~~
1461 ~~Services to~~ lock eligible Medicaid recipients into a managed
1462 care plan or MediPass for 12 months after an ~~open~~ enrollment
1463 period, except for the 90-day opt out period and good cause

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1464 disenrollment. After 12 months' enrollment, a recipient may
1465 select another managed care ~~plan or MediPass provider~~. However,
1466 ~~nothing shall prevent~~ a Medicaid recipient may not be prevented
1467 from changing primary care providers within the managed care
1468 plan or MediPass program, as applicable, during the 12-month
1469 period.
1470 (k) The agency shall maintain MediPass provider networks in
1471 all counties, including those counties in which two or more
1472 managed care plans are accepting Medicaid enrollees. ~~When a~~
1473 ~~Medicaid recipient does not choose a managed care plan or~~
1474 ~~MediPass provider, the agency shall assign the Medicaid~~
1475 ~~recipient to a managed care plan, except in those counties in~~
1476 ~~which there are fewer than two managed care plans accepting~~
1477 ~~Medicaid enrollees, in which case assignment shall be to a~~
1478 ~~managed care plan or a MediPass provider. Medicaid recipients in~~
1479 ~~counties with fewer than two managed care plans accepting~~
1480 ~~Medicaid enrollees who are subject to mandatory assignment but~~
1481 ~~who fail to make a choice shall be assigned to managed care~~
1482 ~~plans until an enrollment of 35 percent in MediPass and 65~~
1483 ~~percent in managed care plans, of all those eligible to choose~~
1484 ~~managed care, is achieved. Once that enrollment is achieved, the~~
1485 ~~assignments shall be divided in order to maintain an enrollment~~
1486 ~~in MediPass and managed care plans which is in a 35 percent and~~
1487 ~~65 percent proportion, respectively. For purposes of this~~
1488 ~~paragraph, when referring to assignment, the term "managed care~~
1489 ~~plans" includes exclusive provider organizations, provider~~
1490 ~~service networks, Children's Medical Services Network, minority~~
1491 ~~physician networks, and pediatric emergency department diversion~~
1492 ~~programs authorized by this chapter or the General~~

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1493 ~~Appropriations Act. When making assignments, the agency shall~~
1494 ~~take into account the following criteria:~~
1495 ~~1. A managed care plan has sufficient network capacity to~~
1496 ~~meet the need of members.~~
1497 ~~2. The managed care plan or MediPass has previously~~
1498 ~~enrolled the recipient as a member, or one of the managed care~~
1499 ~~plan's primary care providers or MediPass providers has~~
1500 ~~previously provided health care to the recipient.~~
1501 ~~3. The agency has knowledge that the member has previously~~
1502 ~~expressed a preference for a particular managed care plan or~~
1503 ~~MediPass provider as indicated by Medicaid fee-for-service~~
1504 ~~claims data, but has failed to make a choice.~~
1505 ~~4. The managed care plan's or MediPass primary care~~
1506 ~~providers are geographically accessible to the recipient's~~
1507 ~~residence.~~
1508 ~~5. The agency has authority to make mandatory assignments~~
1509 ~~based on quality of service and performance of managed care~~
1510 ~~plans.~~
1511 ~~(l) If the Medicaid recipient is diagnosed with HIV/AIDS~~
1512 ~~and resides in Broward County, Miami-Dade County, or Palm Beach~~
1513 ~~County, the agency shall assign the Medicaid recipient to a~~
1514 ~~managed care plan that is a health maintenance organization~~
1515 ~~authorized under chapter 641, is under contract with the agency~~
1516 ~~on July 1, 2011, and which offers a delivery system through a~~
1517 ~~university-based teaching and research-oriented organization~~
1518 ~~that specializes in providing health care services and treatment~~
1519 ~~for individuals diagnosed with HIV/AIDS.~~
1520 (l) ~~(m)~~ Notwithstanding ~~the provisions of~~ chapter 287, the
1521 agency may~~, at its discretion,~~ renew cost-effective contracts

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1522 for choice counseling services once or more for such periods as
1523 the agency may decide. However, all such renewals may not
1524 combine to exceed a total period longer than the term of the
1525 original contract.
1526
1527 This subsection expires October 1, 2014.
1528 (4)(a) Each female recipient may select as her primary care
1529 provider an obstetrician/gynecologist who has agreed to
1530 participate within a managed care plan's provider network or as
1531 a MediPass primary care case manager, as applicable.
1532 (b) The agency shall establish a complaints and grievance
1533 process to assist Medicaid recipients enrolled in the MediPass
1534 program to resolve complaints and grievances. The agency shall
1535 investigate reports of quality-of-care grievances which remain
1536 unresolved to the satisfaction of the enrollee.
1537
1538 This subsection expires October 1, 2014.
1539 (5)(a) The agency shall work cooperatively with the Social
1540 Security Administration to identify recipients ~~beneficiaries~~ who
1541 are jointly eligible for Medicare and Medicaid and shall develop
1542 cooperative programs to encourage these recipients ~~beneficiaries~~
1543 to enroll in a Medicare participating health maintenance
1544 organization or prepaid health plans.
1545 (b) The agency shall work cooperatively with the Department
1546 of Elderly Affairs to assess the potential cost-effectiveness of
1547 providing managed care enrollment ~~MediPass~~ to recipients
1548 ~~beneficiaries~~ who are jointly eligible for Medicare and Medicaid
1549 on a voluntary choice basis. If the agency determines that
1550 enrollment of these recipients ~~beneficiaries~~ in managed care

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1551 ~~MediPass~~ has the potential for being cost-effective for the
1552 state, the agency shall offer managed care enrollment ~~MediPass~~
1553 to these recipients ~~beneficiaries~~ on a voluntary choice basis in
1554 the counties where managed care is available ~~MediPass operates~~.
1555
1556 This subsection expires October 1, 2014.
1557 (12) The agency shall include in its calculation of the
1558 hospital inpatient component of a Medicaid health maintenance
1559 organization’s capitation rate any special payments, including,
1560 but not limited to, upper payment limit or disproportionate
1561 share hospital payments, made to qualifying hospitals through
1562 the fee-for-service program. The agency may seek federal waiver
1563 approval or state plan amendment as needed to implement this
1564 adjustment. This subsection expires September 1, 2012.
1565 Section 14. Section 409.9123, Florida Statutes, is amended
1566 to read:
1567 409.9123 Quality-of-care reporting.~~—In order to promote~~
1568 ~~competition between Medicaid managed care plans and MediPass~~
1569 ~~based on quality-of-care indicators,~~ The agency shall annually
1570 develop and publish a set of measures of managed care plan
1571 performance based on quality-of-care indicators. This
1572 information shall be made available to each Medicaid recipient
1573 who makes a choice of a managed care plan in her or his area.
1574 This information must ~~shall~~ be easily understandable to the
1575 ~~Medicaid~~ recipient and ~~shall~~ use nationally recognized standards
1576 wherever possible. In formulating this information, the agency
1577 shall, at a minimum, consider ~~take into account at least~~ the
1578 following:
1579 (1) The recommendations of the National Committee for

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1580 Quality Assurance Medicaid HEDIS Task Force.
1581 (2) Requirements and recommendations of the Centers for
1582 Medicare and Medicaid Services ~~Health Care Financing~~
1583 ~~Administration~~.
1584 (3) Recommendations of the managed care industry.
1585 Section 15. For the purpose of incorporating the amendment
1586 made by this act to section 409.9122, Florida Statutes, in a
1587 reference thereto, subsection (1) of section 409.9126, Florida
1588 Statutes, is reenacted to read:
1589 409.9126 Children with special health care needs.—
1590 (1) Except as provided in subsection (4), children eligible
1591 for Children’s Medical Services who receive Medicaid benefits,
1592 and other Medicaid-eligible children with special health care
1593 needs, shall be exempt from the provisions of s. 409.9122 and
1594 shall be served through the Children’s Medical Services network
1595 established in chapter 391.
1596 Section 16. Effective upon this act becoming a law,
1597 subsections (4) through (6) of section 409.915, Florida
1598 Statutes, are amended, and subsections (7) through (11) are
1599 added to that section, to read:
1600 409.915 County contributions to Medicaid.—Although the
1601 state is responsible for the full portion of the state share of
1602 the matching funds required for the Medicaid program, in order
1603 to acquire a certain portion of these funds, the state shall
1604 charge the counties for certain items of care and service as
1605 provided in this section.
1606 (4) Each county shall contribute ~~pay into the General~~
1607 ~~Revenue Fund, unallocated,~~ its pro rata share of the total
1608 county participation based upon statements rendered by the

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1609 agency ~~in consultation with the counties~~. The agency shall
1610 render such statements monthly based on each county's eligible
1611 recipients. For purposes of this section, each county's eligible
1612 recipients shall be determined by the recipients' address
1613 information contained in the federally approved Medicaid
1614 eligibility system within the Department of Children and Family
1615 Services. The process developed under subsection (10) may be
1616 used for cases in which the Medicaid eligibility system's
1617 address information may indicate a need for revision.
1618 ~~(5) The Department of Financial Services shall withhold~~
1619 ~~from the cigarette tax receipts or any other funds to be~~
1620 ~~distributed to the counties the individual county share that has~~
1621 ~~not been remitted within 60 days after billing.~~
1622 (5)~~(6)~~ In any county in which a special taxing district or
1623 authority is located which will benefit from the medical
1624 assistance programs covered by this section, the board of county
1625 commissioners may divide the county's financial responsibility
1626 for this purpose proportionately, and each such district or
1627 authority must furnish its share to the board of county
1628 commissioners in time for the board to comply with ~~the~~
1629 ~~provisions of~~ subsection (3). Any appeal of the proration made
1630 by the board of county commissioners must be made to the
1631 Department of Financial Services, which shall then set the
1632 proportionate share of each party.
1633 (6)~~(7)~~ Counties are exempt from contributing toward the
1634 cost of new exemptions on inpatient ceilings for statutory
1635 teaching hospitals, specialty hospitals, and community hospital
1636 education program hospitals that came into effect July 1, 2000,
1637 and for special Medicaid payments that came into effect on or

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1638 after July 1, 2000.
1639 (7) By September 1, 2012, the agency shall certify to the
1640 Department of Revenue, for each county, an amount equal to 85
1641 percent of each county’s billings through April 30, 2012, which
1642 remain unpaid.
1643 (8)(a) Beginning with the October 2012 distribution, the
1644 Department of Revenue shall reduce each county’s distributions
1645 pursuant to s. 218.26 by one thirty-sixth of the amount
1646 certified by the agency under subsection (7) for that county.
1647 However, the amount of the reduction may not exceed 50 percent
1648 of each county’s distribution. If, after 36 months, the
1649 reductions for each county do not equal the total amount
1650 initially certified by the agency, the Department of Revenue
1651 shall continue to reduce each distribution by up to 50 percent
1652 until the total amount certified is reached. The amounts by
1653 which the distributions are reduced shall be transferred to the
1654 General Revenue Fund.
1655 (b) As an assurance to holders of bonds issued before the
1656 effective date of this act to which distributions made pursuant
1657 to s. 218.26 are pledged, or bonds issued to refund such bonds
1658 which mature no later than the bonds they refunded and which
1659 result in a reduction of debt service payable in each fiscal
1660 year, the amount available for distribution to a county shall
1661 remain as provided by law and continue to be subject to any lien
1662 or claim on behalf of the bondholders. The Department of Revenue
1663 must ensure that any reduction in amounts distributed pursuant
1664 to paragraph (a) does not reduce the amount of distribution to a
1665 county below the amount necessary for the payment of principal
1666 and interest on the bonds and the amount necessary to comply

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1667 with any covenant under the bond resolution or other documents
1668 relating to the issuance of the bonds.
1669 (9)(a) Beginning May 1, 2012, and each month thereafter,
1670 the agency shall certify to the Department of Revenue the amount
1671 of the monthly statement rendered to each county pursuant to
1672 subsection (4). The department shall reduce each county's
1673 monthly distribution pursuant to s. 218.61 by the amount
1674 certified. The amounts by which the distributions are reduced
1675 shall be transferred to the General Revenue Fund.
1676 (b) As an assurance to holders of bonds issued before the
1677 effective date of this act to which distributions made pursuant
1678 to s. 218.61 are pledged, or bonds issued to refund such bonds
1679 which mature no later than the bonds they refunded and which
1680 result in a reduction of debt service payable in each fiscal
1681 year, the amount available for distribution to a county shall
1682 remain as provided by law and continue to be subject to any lien
1683 or claim on behalf of the bondholders. The Department of Revenue
1684 must ensure that any reductions in amounts distributed pursuant
1685 to paragraph (a) does not reduce the amount of distribution to a
1686 county below the amount necessary for the payment of principal
1687 and interest on the bonds and the amount necessary to comply
1688 with any covenant under the bond resolution or other documents
1689 relating to the issuance of the bonds.
1690 (10) The Department of Revenue shall pay certified refund
1691 requests in accordance with a process developed by the agency
1692 and the department which:
1693 (a) Allows counties to submit to the agency written
1694 requests for refunds of any amounts by which the distributions
1695 were reduced as provided in subsection (9) and which set forth

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1696 the reasons for the refund requests.
1697 (b) Requires the agency to make a determination as to
1698 whether a refund request is appropriate and should be approved,
1699 in which case the agency shall certify the amount of the refund
1700 to the department.
1701 (c) Requires the department to issue the refund for the
1702 certified amount to the county from the General Revenue Fund.
1703 (11) Beginning in the 2013-2014 fiscal year and each year
1704 thereafter until the 2020-2021 fiscal year, the Chief Financial
1705 Officer shall transfer from the General Revenue Fund to the
1706 Lawton Chiles Endowment Fund an amount equal to the amounts
1707 transferred to the General Revenue Fund in the previous fiscal
1708 year pursuant to subsections (8) and (9), reduced by the amount
1709 of refunds paid pursuant to subsection (10), which are in excess
1710 of the official estimate for medical hospital fees for such
1711 previous fiscal year adopted by the Revenue Estimating
1712 Conference on January 12, 2012, as reflected in the conference's
1713 workpapers. By July 20 of each year, the Office of Economic and
1714 Demographic Research shall certify the amount to be transferred
1715 to the Chief Financial Officer. Such transfers must be made
1716 before July 31 of each year until the total transfers for all
1717 years equal $265 million. The Office of Economic and Demographic
1718 Research shall publish the official estimates reflected in the
1719 conference's workpapers on its website.
1720 Section 17. Subsection (2) of section 409.979, Florida
1721 Statutes, is amended to read:
1722 409.979 Eligibility.—
1723 (2) Medicaid recipients who, on the date long-term care
1724 managed care plans become available in their region, reside in a

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1725 nursing home facility or are enrolled in one of the following
1726 long-term care Medicaid waiver programs are eligible to
1727 participate in the long-term care managed care program for up to
1728 12 months without being reevaluated for their need for nursing
1729 facility care as defined in s. 409.985(3):
1730 (a) The Assisted Living for the Frail Elderly Waiver.
1731 (b) The Aged and Disabled Adult Waiver.
1732 ~~(c) The Adult Day Health Care Waiver.~~
1733 (c) ~~(d)~~ The Consumer-Directed Care Plus Program as described
1734 in s. 409.221.
1735 (d) ~~(e)~~ The Program of All-inclusive Care for the Elderly.
1736 (e) ~~(f)~~ The long-term care community-based diversion pilot
1737 project as described in s. 430.705.
1738 (f) ~~(g)~~ The Channeling Services Waiver for Frail Elders.
1739 Section 18. Subsection (15) of section 430.04, Florida
1740 Statutes, is amended to read:
1741 430.04 Duties and responsibilities of the Department of
1742 Elderly Affairs.—The Department of Elderly Affairs shall:
1743 (15) Administer all Medicaid waivers and programs relating
1744 to elders and their appropriations. The waivers include, but are
1745 not limited to:
1746 (a) The Assisted Living for the Frail Elderly Waiver.
1747 (b) The Aged and Disabled Adult Waiver.
1748 ~~(c) The Adult Day Health Care Waiver.~~
1749 (c) ~~(d)~~ The Consumer-Directed Care Plus Program as defined
1750 in s. 409.221.
1751 (d) ~~(e)~~ The Program of All-inclusive Care for the Elderly.
1752 (e) ~~(f)~~ The Long-Term Care Community-Based Diversion Pilot
1753 Project as described in s. 430.705.

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1754 (f) ~~(g)~~ The Channeling Services Waiver for Frail Elders.
1755
1756 The department shall develop a transition plan for recipients
1757 receiving services in long-term care Medicaid waivers for elders
1758 or disabled adults on the date eligible plans become available
1759 in each recipient's region defined in s. 409.981(2) to enroll
1760 those recipients in eligible plans. This subsection expires
1761 October 1, 2014.
1762 Section 19. Section 31 of chapter 2009-223, Laws of
1763 Florida, as amended by section 44 of chapter 2010-151, Laws of
1764 Florida, is redesignated as section 409.9132, Florida Statutes,
1765 and amended to read:
1766 409.9132 ~~Section 31.~~ Pilot project to monitor home health
1767 services.—The agency ~~for Health Care Administration~~ shall expand
1768 the ~~develop and implement a~~ home health agency monitoring pilot
1769 project in Miami-Dade County on a statewide basis effective July
1770 1, 2012, except in counties in which the program will not be
1771 cost-effective, as determined by the agency ~~by January 1, 2010~~.
1772 The agency shall contract with a vendor to verify the
1773 utilization and delivery of home health services and provide an
1774 electronic billing interface for home health services. The
1775 contract must require the creation of a program to submit claims
1776 electronically for the delivery of home health services. The
1777 program must verify telephonically visits for the delivery of
1778 home health services using voice biometrics. The agency may seek
1779 amendments to the Medicaid state plan and waivers of federal
1780 laws, as necessary, to implement or expand the pilot project.
1781 Notwithstanding s. 287.057(3)(f), ~~Florida Statutes,~~ the agency
1782 must award the contract through the competitive solicitation

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1783 process and may use the current contract to expand the home
1784 health agency monitoring pilot project to include additional
1785 counties as authorized under this section. ~~The agency shall~~
1786 ~~submit a report to the Governor, the President of the Senate,~~
1787 ~~and the Speaker of the House of Representatives evaluating the~~
1788 ~~pilot project by February 1, 2011.~~
1789 Section 20. Section 32 of chapter 2009-223, Laws of
1790 Florida, is redesignated as section 409.9133, Florida Statutes,
1791 and amended to read:
1792 409.9133 ~~Section 32.~~ Pilot project for home health care
1793 management.—The agency ~~for Health Care Administration~~ shall
1794 expand the ~~implement a~~ comprehensive care management pilot
1795 project for home health services statewide and include private-
1796 duty nursing and personal care services effective July 1, 2012,
1797 except in counties in which the program will not be cost-
1798 effective, as determined by the agency ~~by January 1, 2010~~. The
1799 program must include~~, which includes~~ face-to-face assessments by
1800 a nurse licensed pursuant to chapter 464, ~~Florida Statutes,~~
1801 consultation with physicians ordering services to substantiate
1802 the medical necessity for services, and on-site or desk reviews
1803 of recipients' medical records ~~in Miami-Dade County~~. The agency
1804 may ~~enter into a~~ contract with a qualified organization to
1805 implement or expand the pilot project. The agency may use the
1806 current contract to expand the comprehensive care management
1807 pilot project to include the additional services and counties
1808 authorized under this section. The agency may seek amendments to
1809 the Medicaid state plan and waivers of federal laws, as
1810 necessary, to implement or expand the pilot project.
1811 Section 21. Notwithstanding s. 430.707, Florida Statutes,

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1812 and subject to federal approval of an additional site for the
1813 Program of All-Inclusive Care for the Elderly (PACE), the Agency
1814 for Health Care Administration shall contract with a current
1815 PACE organization authorized to provide PACE services in
1816 Southeast Florida to develop and operate a PACE program in
1817 Broward County to serve frail elders who reside in Broward
1818 County. The organization shall be exempt from chapter 641,
1819 Florida Statutes. The agency, in consultation with the
1820 Department of Elderly Affairs and subject to an appropriation,
1821 shall approve up to 150 initial enrollee slots in the Broward
1822 program established by the organization.
1823 Section 22. Effective upon this act becoming a law and for
1824 the 2011-2012 state fiscal year only, a public hospital located
1825 in trauma service area 2 which has local funds available for
1826 intergovernmental transfers that allow for exemptions from
1827 inpatient and outpatient reimbursement limitations may,
1828 notwithstanding s. 409.905(5)(c), Florida Statues, have its
1829 reimbursement rates adjusted after September 30 of the state
1830 fiscal year in which the rates take effect.
1831 Section 23. Except as otherwise expressly provided in this
1832 act and except for this section, which shall take effect upon
1833 this act becoming a law, this act shall take effect July 1,
1834 2012.
1835
1836 ================ T I T L E A M E N D M E N T ================
1837 And the title is amended as follows:
1838 Delete everything before the enacting clause
1839 and insert:
1840 A bill to be entitled

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1841 An act relating to Medicaid; amending s. 383.15, F.S.;
1842 revising legislative intent relating to funding for
1843 regional perinatal intensive care centers; amending s.
1844 409.8132, F.S.; revising a cross-reference; amending
1845 s. 409.814, F.S.; deleting a prohibition preventing
1846 children who are eligible for coverage under a state
1847 health benefit plan from being eligible for services
1848 provided through the subsidized program; revising
1849 cross-references; requiring a completed application,
1850 including a clinical screening, for enrollment in the
1851 Children's Medical Services Network; amending s.
1852 409.902, F.S.; providing for the creation of an
1853 Internet-based system for determining eligibility for
1854 the Medicaid and Kidcare programs, contingent on the
1855 appropriation; providing system business objectives
1856 and requirements; requiring the Department of Children
1857 and Family Services to develop the system; requiring
1858 the system to be completed and implemented by
1859 specified dates; providing a governance structure
1860 pending implementation of the program, including an
1861 executive steering committee and a project management
1862 team; amending s. 409.905, F.S.; limiting the number
1863 of paid hospital emergency department visits for
1864 nonpregnant adults; authorizing the Agency for Health
1865 Care Administration to request approval by the
1866 Legislative Budget Commission of hospital rate
1867 adjustments; providing components for the agency's
1868 plan to convert inpatient hospital rates to a
1869 prospective payment system; revising dates for

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1870 submitting the plan and implementing the system;
1871 amending s. 409.908, F.S.; conforming a cross-
1872 reference; authorizing the Agency for Health Care
1873 Administration to accept voluntary intergovernmental
1874 transfers of local taxes and other qualified revenue
1875 from counties, municipalities, or special taxing
1876 districts in order to fund certain costs; limiting the
1877 use of intergovernmental transfer funds for hospital
1878 reimbursements; prohibiting the inclusion of certain
1879 hospital costs in the capitation rates for prepaid
1880 health plans; providing for the inclusion of certain
1881 hospital costs in capitation rates for prepaid health
1882 plans if funded by intergovernmental transfers;
1883 incorporating a transferred provision; amending s.
1884 409.911, F.S.; updating references to data used for
1885 calculations in the disproportionate share program;
1886 repealing s. 409.9112, F.S., relating to the
1887 disproportionate share program for regional perinatal
1888 intensive care centers; amending s. 409.9113, F.S.;
1889 conforming a cross-reference; authorizing the agency
1890 to distribute moneys in the disproportionate share
1891 program for teaching hospitals; repealing s. 409.9117,
1892 F.S., relating to the primary care disproportionate
1893 share program; amending s. 409.912, F.S.; revising the
1894 conditions for contracting with certain managed care
1895 plans for behavioral health care services; deleting
1896 requirements for assigning certain MediPass recipients
1897 to managed care plans for behavioral health care
1898 services; requiring the assignment of recipients to

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1899 provider service networks; amending s. 409.9121, F.S.;
1900 revising legislative findings relating to the Medicaid
1901 program; amending s. 409.9122, F.S.; providing
1902 criteria and procedures relating to recipient
1903 enrollment choice and assignment among Medicaid
1904 managed care plans and MediPass; deleting transferred
1905 provisions relating to school districts; amending s.
1906 409.9123, F.S.; revising provisions relating to the
1907 publication of quality measures for managed care
1908 plans; reenacting s. 409.9126, F.S., relating to
1909 children with special health care needs; amending s.
1910 409.915, F.S.; specifying criteria for determining a
1911 county's eligible recipients; providing for payment of
1912 billings that have been denied by the county from the
1913 county's tax revenues; providing for refunds;
1914 providing for the transfer of certain refunds to the
1915 Lawton Chiles Endowment Fund; amending ss. 409.979 and
1916 430.04, F.S.; deleting references to the Adult Day
1917 Health Care Waiver in provisions relating to Medicaid
1918 eligibility and duties and responsibilities of the
1919 Department of Elderly Affairs; amending s. 31, chapter
1920 2009-223, Laws of Florida, as amended, and
1921 redesignating that section as s. 409.9132, F.S.;
1922 expanding the home health agency monitoring pilot
1923 project statewide; amending s. 32, chapter 2009-223,
1924 Laws of Florida, and redesignating that section as s.
1925 409.9133, F.S.; expanding the comprehensive care
1926 management pilot project for home health services
1927 statewide and including private-duty nursing and

1928 personal care services; providing an additional site
1929 in Broward County for the Program of All-Inclusive
1930 Care for the Elderly; providing that a public hospital
1931 located in trauma service area 2 which has local funds
1932 available for intergovernmental transfers may have its
1933 reimbursement rates adjusted after a certain date;
1934 providing effective dates.