A bill to be entitled

An act relating to Medicaid services; amending s. 409.902, F.S.; creating, subject to appropriation, an Internet-based system for eligibility determination for Medicaid and the Children's Health Insurance Program; requiring the system to accomplish specified business objectives; requiring the Department of Children and Family Services to develop the system contingent upon an appropriation; requiring the system to be completed and implemented by specified dates; requiring the department to implement a governance structure pending implementation of the program; providing for the membership and duties of an executive steering committee and a project management team; amending s. 409.905, F.S.; limiting payment for emergency room services for a nonpregnant Medicaid recipient 21 years of age or older under certain circumstances; amending s. 409.906, F.S.; eliminating Medicaid optional coverage for chiropractic services for a Medicaid recipient 21 years of age or older by a specified date; eliminating Medicaid optional coverage for podiatric services for a Medicaid recipient 21 years of age or older by a specified date; amending s. 409.911, F.S.; continuing the audited data specified for use in calculating amounts due to hospitals under the disproportionate share program; amending s. 409.9112, F.S.; continuing the prohibition against distributing moneys under the disproportionate share

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

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

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

409.902 Designated single state agency; payment requirements; program title; release of medical records.—

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

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

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

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

(c) Prevent eligibility fraud.

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

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

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

of electronic signatures.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Disabled." Optional services may include:

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

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

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

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

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

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

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

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

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

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

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

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

TAE = HDSP/THDSP

Where:

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

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

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

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

TAP = TAE x TA

Where:

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

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

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

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

(a) Agree to conform to all departmental and agency

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) A service index that comprises three components:

1. The Agency for Health Care Administration Service Index, computed by applying the standard Service Inventory Scores established by the agency to services offered by the given hospital, as reported on Worksheet A-2 for the last fiscal year reported to the agency before the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the given hospital represents of the total index values, where the total is computed for all statutory teaching hospitals.

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

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

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

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

TAP = THAF x A

Where:

TAP = total additional payment.

THAF = teaching hospital allocation factor.

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

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

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

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

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

TAE = HDSP/THDSP

Where:

TAE = total amount earned by a hospital participating in

the primary care disproportionate share program.

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

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

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

TAP = TAE x TA

Where:

TAP = total additional payment for a primary care hospital.

TAE = total amount earned by a primary care hospital.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

409.979 Eligibility.—

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

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

(b) The Aged and Disabled Adult Waiver.

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

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

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

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

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

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

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

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

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

(b) The Aged and Disabled Adult Waiver.

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

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

in s. 409.221.

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

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

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

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

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

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

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

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

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

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

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

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

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

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