

1 A bill to be entitled
2 An act relating to health care services; amending s.
3 383.15, F.S.; revising legislative intent relating to
4 funding for regional perinatal intensive care centers;
5 amending s. 409.8132, F.S.; revising a cross-
6 reference; amending s. 409.814, F.S.; deleting a
7 prohibition preventing children who are eligible for
8 coverage under a state health benefit plan from being
9 eligible for services provided through the subsidized
10 program; revising cross-references; requiring a
11 completed application, including a clinical screening,
12 for enrollment in the Children's Medical Services
13 Network; amending s. 409.902, F.S.; creating, subject
14 to an appropriation, an Internet-based system for
15 eligibility determination for Medicaid and the
16 Children's Health Insurance Program; requiring the
17 system to accomplish specified business objectives;
18 requiring the Department of Children and Family
19 Services to develop the system contingent upon an
20 appropriation; requiring the system to be completed
21 and implemented by specified dates; requiring the
22 department to implement a governance structure pending
23 implementation of the program; providing for the
24 membership and duties of an executive steering
25 committee and a project management team; amending s.
26 409.905, F.S.; limiting the number of paid hospital
27 emergency department visits for nonpregnant Medicaid
28 recipients 21 years of age or older; authorizing the

29 | agency to submit a budget amendment to request
30 | approval of adjustments to hospital rates in cases of
31 | insufficient collection of intergovernmental
32 | transfers; amending the date by which the adjustments
33 | may be made to hospital rates; providing components
34 | for the agency's plan to convert inpatient hospital
35 | rates to a prospective payment system; requiring
36 | notice regarding certain budget amendments; revising
37 | dates for submitting the plan and implementing the
38 | system; amending s. 409.908, F.S.; conforming a cross-
39 | reference; amending s. 409.911, F.S.; updating
40 | references to data used for calculations in the
41 | disproportionate share program; repealing s. 409.9112,
42 | F.S., relating to the disproportionate share program
43 | for regional perinatal intensive care centers;
44 | amending s. 409.9113, F.S.; conforming a cross-
45 | reference; authorizing the agency to distribute moneys
46 | in the disproportionate share program for teaching
47 | hospitals; repealing s. 409.9117, F.S., relating to
48 | the primary care disproportionate share program;
49 | amending s. 409.9122, F.S.; expanding Medicaid managed
50 | care enrollment for recipients with HIV/AIDS; amending
51 | 409.915, F.S.; specifying criteria for determining a
52 | county's eligible recipients; providing for payment of
53 | billings that have been denied by the county from the
54 | county's tax revenues; providing conditions for
55 | refunds; requiring the agency to certify a percentage
56 | of certain funds to the Department of Revenue;

57 | authorizing the Department of Revenue to reduce a
58 | county's distribution of revenue under certain
59 | circumstances; requiring the department to notify the
60 | agency of the amount of the decrease in distribution;
61 | requiring the agency, in consultation with the
62 | department and the Florida Association of Counties, to
63 | develop a process for managing refund requests;
64 | providing conditions for the transfer of certain
65 | refunds to the Lawton Chiles Endowment Fund;
66 | authorizing the agency to adopt rules; directing the
67 | agency and the Department of Children and Family
68 | Services to develop a process to update information
69 | regarding Medicaid recipients; amending ss. 409.979
70 | and 430.04, F.S.; deleting references to the Adult Day
71 | Health Care Waiver in provisions relating to Medicaid
72 | eligibility and duties and responsibilities of the
73 | Department of Elderly Affairs; amending s. 31, ch.
74 | 2009-223, Laws of Florida, as amended, and
75 | redesignating the section as s. 409.9132, F.S.;
76 | expanding the home health agency monitoring pilot
77 | project statewide; amending s. 32, ch. 2009-223, Laws
78 | of Florida, and redesignating the section as s.
79 | 409.9133, F.S.; expanding the comprehensive care
80 | management pilot project for home health services
81 | statewide and including new services; authorizing the
82 | Agency for Health Care Administration to contract with
83 | certain organizations to provide services under the
84 | federal Program of All-inclusive Care for the Elderly

85 | in specified counties; exempting such organizations
 86 | from ch. 641, F.S., relating to health care services
 87 | programs; authorizing, subject to appropriation,
 88 | enrollment slots for the program in such counties;
 89 | providing for certain public hospitals to have their
 90 | reimbursement rates adjusted under certain conditions;
 91 | providing effective dates.

92 |

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

94 |

95 | Section 1. Section 383.15, Florida Statutes, is amended to
 96 | read:

97 | 383.15 Legislative intent; perinatal intensive care
 98 | services.—The Legislature finds ~~and declares~~ that many perinatal
 99 | diseases and disabilities have debilitating, costly, and often
 100 | fatal consequences if left untreated. Many of these debilitating
 101 | conditions could be prevented or ameliorated if services were
 102 | available to the public through a regional perinatal intensive
 103 | care centers program. Perinatal intensive care services are
 104 | critical to the well-being and development of a healthy society
 105 | and represent a constructive, cost-beneficial, and essential
 106 | investment in the future of our state. Therefore, it is the
 107 | intent of the Legislature to develop a regional perinatal
 108 | intensive care centers program. The Legislature further intends
 109 | that development of such a regional perinatal intensive care
 110 | ~~centers~~ program ~~shall~~ not reduce or dilute the current financial
 111 | commitment of the state, as indicated through appropriation, to
 112 | the existing regional perinatal intensive care centers. It is

113 also the intent of the Legislature that any additional centers
 114 ~~regional perinatal intensive care center~~ authorized under s.
 115 383.19 after July 1, 1993, ~~shall~~ not receive payments under a
 116 disproportionate share program for regional perinatal intensive
 117 care centers authorized under chapter 409 ~~s. 409.9112~~ unless
 118 specific appropriations are provided to expand such payments to
 119 additional hospitals.

120 Section 2. Paragraph (b) of subsection (6) of section
 121 409.8132, Florida Statutes, is amended to read:

122 409.8132 Medikids program component.—

123 (6) ELIGIBILITY.—

124 (b) The provisions of s. 409.814 ~~apply 409.814(3), (4),~~
 125 ~~(5), and (6) shall be applicable~~ to the Medikids program.

126 Section 3. Section 409.814, Florida Statutes, is amended
 127 to read:

128 409.814 Eligibility.—A child who has not reached 19 years
 129 of age whose family income is equal to or below 200 percent of
 130 the federal poverty level is eligible for the Florida Kidcare
 131 program as provided in this section. ~~For enrollment in the~~
 132 ~~Children's Medical Services Network, a complete application~~
 133 ~~includes the medical or behavioral health screening. If,~~
 134 ~~subsequently,~~ an enrolled individual is determined to be
 135 ineligible for coverage, he or she must be immediately ~~be~~
 136 disenrolled from the respective Florida Kidcare program
 137 component.

138 (1) A child who is eligible for Medicaid coverage under s.
 139 409.903 or s. 409.904 must be enrolled in Medicaid and is not

140 eligible to receive health benefits under any other health
 141 benefits coverage authorized under the Florida Kidcare program.

142 (2) A child who is not eligible for Medicaid, but who is
 143 eligible for the Florida Kidcare program, may obtain health
 144 benefits coverage under any of the other components listed in s.
 145 409.813 if such coverage is approved and available in the county
 146 in which the child resides.

147 (3) A Title XXI-funded child who is eligible for the
 148 Florida Kidcare program who is a child with special health care
 149 needs, as determined through a medical or behavioral screening
 150 instrument, is eligible for health benefits coverage from and
 151 shall be assigned to and may opt out of the Children's Medical
 152 Services Network.

153 (4) The following children are not eligible to receive
 154 Title XXI-funded premium assistance for health benefits coverage
 155 under the Florida Kidcare program, except under Medicaid if the
 156 child would have been eligible for Medicaid under s. 409.903 or
 157 s. 409.904 as of June 1, 1997:

158 ~~(a) A child who is eligible for coverage under a state~~
 159 ~~health benefit plan on the basis of a family member's employment~~
 160 ~~with a public agency in the state.~~

161 (a) ~~(b)~~ A child who is covered under a family member's
 162 group health benefit plan or under other private or employer
 163 health insurance coverage, if the cost of the child's
 164 participation is not greater than 5 percent of the family's
 165 income. If a child is otherwise eligible for a subsidy under the
 166 Florida Kidcare program and the cost of the child's
 167 participation in the family member's health insurance benefit

168 plan is greater than 5 percent of the family's income, the child
169 may enroll in the appropriate subsidized Kidcare program.

170 (b)~~(e)~~ A child who is seeking premium assistance for the
171 Florida Kidcare program through employer-sponsored group
172 coverage, if the child has been covered by the same employer's
173 group coverage during the 60 days before the family submitted
174 ~~prior to the family's submitting~~ an application for
175 determination of eligibility under the program.

176 (c)~~(d)~~ A child who is an alien, but who does not meet the
177 definition of qualified alien, in the United States.

178 (d)~~(e)~~ A child who is an inmate of a public institution or
179 a patient in an institution for mental diseases.

180 (e)~~(f)~~ A child who is otherwise eligible for premium
181 assistance for the Florida Kidcare program and has had his or
182 her coverage in an employer-sponsored or private health benefit
183 plan voluntarily canceled in the last 60 days, except those
184 children whose coverage was voluntarily canceled for good cause,
185 including, but not limited to, the following circumstances:

186 1. The cost of participation in an employer-sponsored
187 health benefit plan is greater than 5 percent of the family's
188 income;

189 2. The parent lost a job that provided an employer-
190 sponsored health benefit plan for children;

191 3. The parent who had health benefits coverage for the
192 child is deceased;

193 4. The child has a medical condition that, without medical
194 care, would cause serious disability, loss of function, or
195 death;

196 5. The employer of the parent canceled health benefits
 197 coverage for children;

198 6. The child's health benefits coverage ended because the
 199 child reached the maximum lifetime coverage amount;

200 7. The child has exhausted coverage under a COBRA
 201 continuation provision;

202 8. The health benefits coverage does not cover the child's
 203 health care needs; or

204 9. Domestic violence led to loss of coverage.

205 (5) A child who is otherwise eligible for the Florida
 206 Kidcare program and who has a preexisting condition that
 207 prevents coverage under another insurance plan as described in
 208 paragraph (4) (a) ~~(4) (b)~~ which would have disqualified the child
 209 for the Florida Kidcare program if the child were able to enroll
 210 in the plan is ~~shall be~~ eligible for Florida Kidcare coverage
 211 when enrollment is possible.

212 (6) A child whose family income is above 200 percent of
 213 the federal poverty level or a child who is excluded under the
 214 provisions of subsection (4) may participate in the Florida
 215 Kidcare program as provided in s. 409.8132 or, if the child is
 216 ineligible for Medikids by reason of age, in the Florida Healthy
 217 Kids program, subject to the following ~~provisions~~:

218 (a) The family is not eligible for premium assistance
 219 payments and must pay the full cost of the premium, including
 220 any administrative costs.

221 (b) The board of directors of the Florida Healthy Kids
 222 Corporation may offer a reduced benefit package to these
 223 children in order to limit program costs for such families.

224 (7) Once a child is enrolled in the Florida Kidcare
225 program, the child is eligible for coverage ~~under the program~~
226 for 12 months without a redetermination or reverification of
227 eligibility, if the family continues to pay the applicable
228 premium. Eligibility for program components funded through Title
229 XXI of the Social Security Act terminates ~~shall terminate~~ when a
230 child attains the age of 19. A child who has not attained the
231 age of 5 and who has been determined eligible for the Medicaid
232 program is eligible for coverage for 12 months without a
233 redetermination or reverification of eligibility.

234 (8) When determining or reviewing a child's eligibility
235 under the Florida Kidcare program, the applicant shall be
236 provided with reasonable notice of changes in eligibility which
237 may affect enrollment in one or more of the program components.
238 If ~~When~~ a transition from one program component to another is
239 authorized, there shall be cooperation between the program
240 components and the affected family which promotes continuity of
241 health care coverage. Any authorized transfers must be managed
242 within the program's overall appropriated or authorized levels
243 of funding. Each component of the program shall establish a
244 reserve to ensure that transfers between components will be
245 accomplished within current year appropriations. These reserves
246 shall be reviewed by each convening of the Social Services
247 Estimating Conference to determine the adequacy of such reserves
248 to meet actual experience.

249 (9) In determining the eligibility of a child, an assets
250 test is not required. Each applicant shall provide documentation

251 during the application process and the redetermination process,
 252 including, but not limited to, the following:

253 (a) ~~Each applicant's~~ Proof of family income, which must
 254 ~~shall~~ be verified electronically to determine financial
 255 eligibility for the Florida Kidcare program. Written
 256 documentation, which may include wages and earnings statements
 257 or pay stubs, W-2 forms, or a copy of the applicant's most
 258 recent federal income tax return, is ~~shall be~~ required only if
 259 the electronic verification is not available or does not
 260 substantiate the applicant's income.

261 (b) ~~Each applicant shall provide~~ A statement from all
 262 applicable, employed family members that:

263 1. Their employers do not sponsor health benefit plans for
 264 employees;

265 2. The potential enrollee is not covered by an employer-
 266 sponsored health benefit plan; or

267 3. The potential enrollee is covered by an employer-
 268 sponsored health benefit plan and the cost of the employer-
 269 sponsored health benefit plan is more than 5 percent of the
 270 family's income.

271 (c) To enroll in the Children's Medical Services Network,
 272 a completed application, including a clinical screening.

273 (10) Subject to paragraph (4) (a) ~~(4) (b)~~, the Florida
 274 Kidcare program shall withhold benefits from an enrollee if the
 275 program obtains evidence that the enrollee is no longer
 276 eligible, submitted incorrect or fraudulent information in order
 277 to establish eligibility, or failed to provide verification of
 278 eligibility. The applicant or enrollee shall be notified that

279 | because of such evidence program benefits will be withheld
 280 | unless the applicant or enrollee contacts a designated
 281 | representative of the program by a specified date, which must be
 282 | within 10 working days after the date of notice, to discuss and
 283 | resolve the matter. The program shall make every effort to
 284 | resolve the matter within a timeframe that will not cause
 285 | benefits to be withheld from an eligible enrollee.

286 | (11) The following individuals may be subject to
 287 | prosecution in accordance with s. 414.39:

288 | (a) An applicant obtaining or attempting to obtain
 289 | benefits for a potential enrollee under the Florida Kidcare
 290 | program when the applicant knows or should have known the
 291 | potential enrollee does not qualify for the Florida Kidcare
 292 | program.

293 | (b) An individual who assists an applicant in obtaining or
 294 | attempting to obtain benefits for a potential enrollee under the
 295 | Florida Kidcare program when the individual knows or should have
 296 | known the potential enrollee does not qualify for the Florida
 297 | Kidcare program.

298 | Section 4. Subsections (3) through (8) are added to
 299 | section 409.902, Florida Statutes, to read:

300 | 409.902 Designated single state agency; payment
 301 | requirements; program title; release of medical records.—

302 | (3) To the extent that funds are appropriated, the
 303 | department shall collaborate with the Agency for Health Care
 304 | Administration to develop an Internet-based system that is
 305 | modular, interoperable, and scalable for eligibility
 306 | determination for Medicaid and the Children's Health Insurance

307 Program (CHIP) that complies with all applicable federal and
 308 state laws and requirements.

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

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

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

318 (c) Prevent eligibility fraud.

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

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

323 (a) Allow for the completion and submission of an online
 324 application for eligibility determination that accepts the use
 325 of electronic signatures.

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

331 (c) Allow for the determination of Medicaid eligibility
 332 based on modified adjusted gross income by using information
 333 submitted in the application and information accessed and

334 verified through automated and secure interfaces with authorized
335 databases.

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

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

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

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

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

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

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

361 (a) The Secretary of Children and Family Services shall
362 have overall responsibility for the project.

363 (b) The project shall be governed by an executive steering
364 committee composed of three department staff members appointed
365 by the Secretary of Children and Family Services; three agency
366 staff members, including at least two state Medicaid program
367 staff members, appointed by the Secretary of the Agency for
368 Health Care Administration; one staff member from Children's
369 Medical Services within the Department of Health appointed by
370 the Surgeon General; and a representative from the Florida
371 Healthy Kids Corporation.

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

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

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

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

381 4. Recommend suspension or termination of the project to
382 the Governor, the President of the Senate, and the Speaker of
383 the House of Representatives if the committee determines that
384 the primary business objectives cannot be achieved.

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

387 The project management team shall:

388 | 1. Provide planning, management, and oversight of the
 389 | project.

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

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

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

398 | 409.905 Mandatory Medicaid services.—The agency may make
 399 | payments for the following services, which are required of the
 400 | state by Title XIX of the Social Security Act, furnished by
 401 | Medicaid providers to recipients who are determined to be
 402 | eligible on the dates on which the services were provided. Any
 403 | service under this section shall be provided only when medically
 404 | necessary and in accordance with state and federal law.

405 | Mandatory services rendered by providers in mobile units to
 406 | Medicaid recipients may be restricted by the agency. Nothing in
 407 | this section shall be construed to prevent or limit the agency
 408 | from adjusting fees, reimbursement rates, lengths of stay,
 409 | number of visits, number of services, or any other adjustments
 410 | necessary to comply with the availability of moneys and any
 411 | limitations or directions provided for in the General
 412 | Appropriations Act or chapter 216.

413 | (5) HOSPITAL INPATIENT SERVICES.—The agency shall pay for
 414 | all covered services provided for the medical care and treatment
 415 | of a recipient who is admitted as an inpatient by a licensed

416 physician or dentist to a hospital licensed under part I of
417 chapter 395. However, the agency shall limit the payment for
418 inpatient hospital services for a Medicaid recipient 21 years of
419 age or older to 45 days or the number of days necessary to
420 comply with the General Appropriations Act. Effective August 1,
421 2012, the agency shall limit payment for hospital emergency
422 department visits for a nonpregnant Medicaid recipient 21 years
423 of age or older to six visits per fiscal year.

424 (a) The agency may ~~is authorized to~~ implement
425 reimbursement and utilization management reforms in order to
426 comply with any limitations or directions in the General
427 Appropriations Act, which may include, but are not limited to:
428 prior authorization for inpatient psychiatric days; prior
429 authorization for nonemergency hospital inpatient admissions for
430 individuals 21 years of age and older; authorization of
431 emergency and urgent-care admissions within 24 hours after
432 admission; enhanced utilization and concurrent review programs
433 for highly utilized services; reduction or elimination of
434 covered days of service; adjusting reimbursement ceilings for
435 variable costs; adjusting reimbursement ceilings for fixed and
436 property costs; and implementing target rates of increase. The
437 agency may limit prior authorization for hospital inpatient
438 services to selected diagnosis-related groups, based on an
439 analysis of the cost and potential for unnecessary
440 hospitalizations represented by certain diagnoses. Admissions
441 for normal delivery and newborns are exempt from requirements
442 for prior authorization. In implementing the provisions of this
443 section related to prior authorization, the agency shall ensure

444 that the process for authorization is accessible 24 hours per
445 day, 7 days per week and authorization is automatically granted
446 when not denied within 4 hours after the request. Authorization
447 procedures must include steps for review of denials. Upon
448 implementing the prior authorization program for hospital
449 inpatient services, the agency shall discontinue its hospital
450 retrospective review program.

451 (b) A licensed hospital maintained primarily for the care
452 and treatment of patients having mental disorders or mental
453 diseases is not eligible to participate in the hospital
454 inpatient portion of the Medicaid program except as provided in
455 federal law. However, the department shall apply for a waiver,
456 within 9 months after June 5, 1991, designed to provide
457 hospitalization services for mental health reasons to children
458 and adults in the most cost-effective and lowest cost setting
459 possible. Such waiver shall include a request for the
460 opportunity to pay for care in hospitals known under federal law
461 as "institutions for mental disease" or "IMD's." The waiver
462 proposal shall propose no additional aggregate cost to the state
463 or Federal Government, and shall be conducted in Hillsborough
464 County, Highlands County, Hardee County, Manatee County, and
465 Polk County. The waiver proposal may incorporate competitive
466 bidding for hospital services, comprehensive brokering, prepaid
467 capitated arrangements, or other mechanisms deemed by the
468 department to show promise in reducing the cost of acute care
469 and increasing the effectiveness of preventive care. When
470 developing the waiver proposal, the department shall take into
471 account price, quality, accessibility, linkages of the hospital

472 to community services and family support programs, plans of the
 473 hospital to ensure the earliest discharge possible, and the
 474 comprehensiveness of the mental health and other health care
 475 services offered by participating providers.

476 (c) The agency shall implement a methodology for
 477 establishing base reimbursement rates for each hospital based on
 478 allowable costs, as defined by the agency. Rates shall be
 479 calculated annually and take effect July 1 of each year based on
 480 the most recent complete and accurate cost report submitted by
 481 each hospital.

482 1. Adjustments may not be made to the rates after October
 483 31 ~~September 30~~ of the state fiscal year in which the rates take
 484 rate takes effect, except for cases of insufficient collections
 485 of intergovernmental transfers authorized under s. 409.908(1) or
 486 the General Appropriations Act. In such cases, the agency shall
 487 submit a budget amendment or amendments under chapter 216
 488 requesting approval of rate reductions by amounts necessary for
 489 the aggregate reduction to equal the dollar amount of
 490 intergovernmental transfers not collected and the corresponding
 491 federal match. Notwithstanding the \$1 million limitation on
 492 increases to an approved operating budget contained in ss.
 493 216.181(11) and 216.292(3), a budget amendment exceeding that
 494 dollar amount is subject to notice and objection procedures set
 495 forth in s. 216.177.

496 2. Errors in cost reporting or calculation of rates
 497 discovered after October 31 ~~September 30~~ must be reconciled in a
 498 subsequent rate period. The agency may not make any adjustment
 499 to a hospital's reimbursement rate more than 5 years after a

500 hospital is notified of an audited rate established by the
501 agency. The requirement that the agency may not make any
502 adjustment to a hospital's reimbursement rate more than 5 years
503 after a hospital is notified of an audited rate established by
504 the agency is remedial and applies ~~shall apply~~ to actions by
505 providers involving Medicaid claims for hospital services.
506 Hospital rates are ~~shall be~~ subject to such limits or ceilings
507 as may be established in law or described in the agency's
508 hospital reimbursement plan. Specific exemptions to the limits
509 or ceilings may be provided in the General Appropriations Act.

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

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

526 (f) The agency shall develop a plan to convert Medicaid
527 inpatient hospital rates to a prospective payment system that

528 categorizes each case into diagnosis-related groups (DRG) and
529 assigns a payment weight based on the average resources used to
530 treat Medicaid patients in that DRG. To the extent possible, the
531 agency shall propose an adaptation of an existing prospective
532 payment system, such as the one used by Medicare, and shall
533 propose such adjustments as are necessary for the Medicaid
534 population and to maintain budget neutrality for inpatient
535 hospital expenditures.

536 1. The plan must:

537 a. Define and describe DRGs for inpatient hospital care
538 specific to Medicaid in this state;

539 b. Determine the use of resources needed for each DRG;

540 c. Apply current statewide levels of funding to DRGs based
541 on the associated resource value of DRGs. Current statewide
542 funding levels shall be calculated both with and without the use
543 of intergovernmental transfers;

544 d. Calculate the current number of services provided in
545 the Medicaid program based on DRGs defined under this
546 subparagraph;

547 e. Estimate the number of cases in each DRG for future
548 years based on agency data and the official workload estimates
549 of the Social Services Estimating Conference;

550 f. Calculate the expected total Medicaid payments in the
551 current year for each hospital with a Medicaid provider
552 agreement, based on the DRGs and estimated workload;

553 g. Propose supplemental DRG payments to augment hospital
554 reimbursements based on patient acuity and individual hospital
555 characteristics, including classification as a children's

556 hospital, rural hospital, trauma center, burn unit, and other
557 characteristics that could warrant higher reimbursements, while
558 maintaining budget neutrality; and

559 h. Estimate potential funding for each hospital with a
560 Medicaid provider agreement for DRGs defined pursuant to this
561 subparagraph and supplemental DRG payments using current funding
562 levels, calculated both with and without the use of
563 intergovernmental transfers.

564 2. The agency shall engage a consultant with expertise and
565 experience in the implementation of DRG systems for hospital
566 reimbursement to develop the DRG plan under subparagraph 1.

567 3. The agency shall submit the ~~Medicaid~~ DRG plan,
568 identifying all steps necessary for the transition and any costs
569 associated with plan implementation, to the Governor, the
570 President of the Senate, and the Speaker of the House of
571 Representatives no later than January 1, 2013. The plan shall
572 include a timeline necessary to complete full implementation by
573 July 1, 2013. If, during implementation of this paragraph, the
574 agency determines that these timeframes might not be achievable,
575 the agency shall report to the Legislative Budget Commission the
576 status of its implementation efforts, the reasons the timeframes
577 might not be achievable, and proposals for new timeframes.

578 Section 6. Paragraph (c) of subsection (1) of section
579 409.908, Florida Statutes, is amended to read:

580 409.908 Reimbursement of Medicaid providers.—Subject to
581 specific appropriations, the agency shall reimburse Medicaid
582 providers, in accordance with state and federal law, according
583 to methodologies set forth in the rules of the agency and in

584 policy manuals and handbooks incorporated by reference therein.
585 These methodologies may include fee schedules, reimbursement
586 methods based on cost reporting, negotiated fees, competitive
587 bidding pursuant to s. 287.057, and other mechanisms the agency
588 considers efficient and effective for purchasing services or
589 goods on behalf of recipients. If a provider is reimbursed based
590 on cost reporting and submits a cost report late and that cost
591 report would have been used to set a lower reimbursement rate
592 for a rate semester, then the provider's rate for that semester
593 shall be retroactively calculated using the new cost report, and
594 full payment at the recalculated rate shall be effected
595 retroactively. Medicare-granted extensions for filing cost
596 reports, if applicable, shall also apply to Medicaid cost
597 reports. Payment for Medicaid compensable services made on
598 behalf of Medicaid eligible persons is subject to the
599 availability of moneys and any limitations or directions
600 provided for in the General Appropriations Act or chapter 216.
601 Further, nothing in this section shall be construed to prevent
602 or limit the agency from adjusting fees, reimbursement rates,
603 lengths of stay, number of visits, or number of services, or
604 making any other adjustments necessary to comply with the
605 availability of moneys and any limitations or directions
606 provided for in the General Appropriations Act, provided the
607 adjustment is consistent with legislative intent.

608 (1) Reimbursement to hospitals licensed under part I of
609 chapter 395 must be made prospectively or on the basis of
610 negotiation.

611 (c) Hospitals that provide services to a disproportionate
 612 share of low-income Medicaid recipients, or that participate in
 613 the regional perinatal intensive care center program under
 614 chapter 383, or that participate in the statutory teaching
 615 hospital disproportionate share program may receive additional
 616 reimbursement. The total amount of payment for disproportionate
 617 share hospitals shall be fixed by the General Appropriations
 618 Act. The computation of these payments must be made in
 619 compliance with all federal regulations and the methodologies
 620 described in ss. 409.911, ~~409.9112~~, and 409.9113.

621 Section 7. Subsection (1), paragraph (a) of subsection
 622 (2), and paragraph (d) of subsection (4) of section 409.911,
 623 Florida Statutes, are amended to read:

624 409.911 Disproportionate share program.—Subject to
 625 specific allocations established within the General
 626 Appropriations Act and any limitations established pursuant to
 627 chapter 216, the agency shall distribute, pursuant to this
 628 section, moneys to hospitals providing a disproportionate share
 629 of Medicaid or charity care services by making quarterly
 630 Medicaid payments as required. Notwithstanding the provisions of
 631 s. 409.915, counties are exempt from contributing toward the
 632 cost of this special reimbursement for hospitals serving a
 633 disproportionate share of low-income patients.

634 (1) DEFINITIONS.—As used in this section, ~~s. 409.9112~~, and
 635 the Florida Hospital Uniform Reporting System manual:

636 (a) "Adjusted patient days" means the sum of acute care
 637 patient days and intensive care patient days as reported to the
 638 Agency for Health Care Administration, divided by the ratio of

639 inpatient revenues generated from acute, intensive, ambulatory,
640 and ancillary patient services to gross revenues.

641 (b) "Actual audited data" or "actual audited experience"
642 means data reported to the Agency for Health Care Administration
643 which has been audited in accordance with generally accepted
644 auditing standards by the agency or representatives under
645 contract with the agency.

646 (c) "Charity care" or "uncompensated charity care" means
647 that portion of hospital charges reported to the Agency for
648 Health Care Administration for which there is no compensation,
649 other than restricted or unrestricted revenues provided to a
650 hospital by local governments or tax districts regardless of the
651 method of payment, for care provided to a patient whose family
652 income for the 12 months preceding the determination is less
653 than or equal to 200 percent of the federal poverty level,
654 unless the amount of hospital charges due from the patient
655 exceeds 25 percent of the annual family income. However, in no
656 case shall the hospital charges for a patient whose family
657 income exceeds four times the federal poverty level for a family
658 of four be considered charity.

659 (d) "Charity care days" means the sum of the deductions
660 from revenues for charity care minus 50 percent of restricted
661 and unrestricted revenues provided to a hospital by local
662 governments or tax districts, divided by gross revenues per
663 adjusted patient day.

664 (e) "Hospital" means a health care institution licensed as
665 a hospital pursuant to chapter 395, but does not include
666 ambulatory surgical centers.

667 (f) "Medicaid days" means the number of actual days
 668 attributable to Medicaid patients as determined by the Agency
 669 for Health Care Administration.

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

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

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

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

684 Section 8. Section 409.9112, Florida Statutes, is
 685 repealed.

686 Section 9. Section 409.9113, Florida Statutes, is amended
 687 to read:

688 409.9113 Disproportionate share program for teaching
 689 hospitals.—In addition to the payments made under s. ss. 409.911
 690 ~~and 409.9112~~, the agency shall make disproportionate share
 691 payments to teaching hospitals, as defined in s. 408.07, for
 692 their increased costs associated with medical education programs
 693 and for tertiary health care services provided to the indigent.
 694 This system of payments must conform to federal requirements and

695 distribute funds in each fiscal year for which an appropriation
696 is made by making quarterly Medicaid payments. Notwithstanding
697 s. 409.915, counties are exempt from contributing toward the
698 cost of this special reimbursement for hospitals serving a
699 disproportionate share of low-income patients. ~~For the 2011-2012~~
700 ~~state fiscal year,~~ The agency shall distribute the moneys
701 provided in the General Appropriations Act to statutorily
702 defined teaching hospitals and family practice teaching
703 hospitals, as defined in s. 395.805, pursuant to this section.
704 The funds provided for statutorily defined teaching hospitals
705 shall be distributed as provided in the General Appropriations
706 Act. The funds provided for family practice teaching hospitals
707 shall be distributed equally among family practice teaching
708 hospitals.

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

719 (a) The number of nationally accredited graduate medical
720 education programs offered by the hospital, including programs
721 accredited by the Accreditation Council for Graduate Medical
722 Education or programs accredited by the Council on Postdoctoral

723 Training of the American Osteopathic Association and the
724 combined Internal Medicine and Pediatrics programs acceptable to
725 both the American Board of Internal Medicine and the American
726 Board of Pediatrics at the beginning of the state fiscal year
727 preceding the date on which the allocation fraction is
728 calculated. The numerical value of this factor is the fraction
729 that the hospital represents of the total number of programs,
730 where the total is computed for all statutory teaching
731 hospitals.

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

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

745 2. The number of medical students enrolled in accredited
746 colleges of medicine and engaged in clinical activities,
747 including required clinical clerkships and clinical electives.
748 Full-time equivalents are computed using the fraction of the
749 year during which each trainee is primarily assigned to the
750 given institution, over the course of the state fiscal year

751 preceding the date on which the allocation fraction is
752 calculated. The numerical value of this factor is the fraction
753 that the given hospital represents of the total number of full-
754 time equivalent students enrolled in accredited colleges of
755 medicine, where the total is computed for all statutory teaching
756 hospitals.

757

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

760 (c) A service index that comprises three components:

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

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

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

788
 789 The primary factor for the service index is computed as the sum
 790 of these three components, divided by three.

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

$$794 \text{ TAP} = \text{THAF} \times \text{A}$$

795 Where:

796 TAP = total additional payment.

797 THAF = teaching hospital allocation factor.

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

800 Section 10. Section 409.9117, Florida Statutes, is
 801 repealed.

802 Section 11. Paragraph (1) of subsection (2) of section
 803 409.9122, Florida Statutes, is amended to read:

804 409.9122 Mandatory Medicaid managed care enrollment;
 805 programs and procedures.—

806 (2)

807 (1) If the Medicaid recipient is diagnosed with HIV/AIDS
 808 ~~and resides in Broward County, Miami-Dade County, or Palm Beach~~
 809 ~~County~~, the agency shall assign the Medicaid recipient to a
 810 managed care plan that is a health maintenance organization
 811 authorized under chapter 641, is under contract with the agency
 812 on July 1, 2011, and which offers a delivery system through a
 813 university-based teaching and research-oriented organization
 814 that specializes in providing health care services and treatment
 815 for individuals diagnosed with HIV/AIDS.

816
 817 This subsection expires October 1, 2014.

818 Section 12. Effective upon this act becoming a law,
 819 subsections (4), (5), and (6) of section 409.915, Florida
 820 Statutes, are amended, present subsection (7) is renumbered as
 821 subsection (6), and new subsections (7) through (12) are added
 822 to that section, to read:

823 409.915 County contributions to Medicaid.—Although the
 824 state is responsible for the full portion of the state share of
 825 the matching funds required for the Medicaid program, in order
 826 to acquire a certain portion of these funds, the state shall
 827 charge the counties for certain items of care and service as
 828 provided in this section.

829 (4) Each county shall contribute ~~pay into the General~~
 830 ~~Revenue Fund, unallocated,~~ its pro rata share of the total
 831 county participation based upon statements rendered by the
 832 agency ~~in consultation with the counties.~~ The agency shall
 833 render such statements monthly based on each county's eligible
 834 recipients. For purposes of this section, each county's eligible

835 recipients shall be determined by the recipient's address
836 information contained in the federally approved Medicaid
837 eligibility system within the Department of Children and Family
838 Services. A county may use the process developed under
839 subsection (10) to request a refund if it determines that the
840 statement rendered by the agency contains errors.

841 ~~(5) The Department of Financial Services shall withhold~~
842 ~~from the cigarette tax receipts or any other funds to be~~
843 ~~distributed to the counties the individual county share that has~~
844 ~~not been remitted within 60 days after billing.~~

845 (5)~~(6)~~ In any county in which a special taxing district or
846 authority is located which will benefit from the medical
847 assistance programs covered by this section, the board of county
848 commissioners may divide the county's financial responsibility
849 for this purpose proportionately, and each such district or
850 authority must furnish its share to the board of county
851 commissioners in time for the board to comply with ~~the~~
852 ~~provisions of~~ subsection (3). Any appeal of the proration made
853 by the board of county commissioners must be made to the
854 Department of Financial Services, which shall then set the
855 proportionate share of each party.

856 (6)~~(7)~~ Counties are exempt from contributing toward the
857 cost of new exemptions on inpatient ceilings for statutory
858 teaching hospitals, specialty hospitals, and community hospital
859 education program hospitals that came into effect July 1, 2000,
860 and for special Medicaid payments that came into effect on or
861 after July 1, 2000.

862 (7) (a) By August 1, 2012, the agency shall certify to each
863 county the amount of such county's billings from November 1,
864 2001, through April 30, 2012, which remain unpaid. A county may
865 contest the amount certified by filing a petition under the
866 applicable provisions of chapter 120 on or before September 1,
867 2012. This procedure is the exclusive method to challenge the
868 amount certified. In order to successfully challenge the amount
869 certified, a county must show, by a preponderance of the
870 evidence, that a recipient was not an eligible recipient of that
871 county or that the amount certified was otherwise in error.

872 (b) By September 15, 2012, the agency shall certify to the
873 Department of Revenue:

- 874 1. For each county that files a petition on or before
875 September 1, 2012, the amount certified under paragraph (a); and
- 876 2. For each county that does not file a petition on or
877 before September 1, 2012, an amount equal to 85 percent of the
878 amount certified under paragraph (a).

879 (c) The filing of a petition under paragraph (a) shall not
880 stay or stop the Department of Revenue from reducing
881 distributions in accordance with paragraph (b) and subsection
882 (8). If a county that files a petition under paragraph (a) is
883 able to demonstrate that the amount certified should be reduced,
884 the agency shall notify the Department of Revenue of the amount
885 of the reduction. The Department of Revenue shall adjust all
886 future monthly distribution reductions under subsection (8) in a
887 manner that results in the remaining total distribution
888 reduction being applied in equal monthly amounts.

889 (8) (a) Beginning with the October 2012 distribution, the
890 Department of Revenue shall reduce each county's distributions
891 pursuant to s. 218.26 by one thirty-sixth of the amount
892 certified by the agency under subsection (7) for that county,
893 minus any amount required under paragraph (b). Beginning with
894 the October 2013 distribution, the Department of Revenue shall
895 reduce each county's distributions pursuant to s. 218.26 by one
896 forty-eighth of two-thirds of the amount certified by the agency
897 under subsection (7) for that county, minus any amount required
898 under paragraph (b). However, the amount of the reduction may
899 not exceed 50 percent of each county's distribution. If, after
900 60 months, the reductions for any county do not equal the total
901 amount initially certified by the agency, the Department of
902 Revenue shall continue to reduce such county's distribution by
903 up to 50 percent until the total amount certified is reached.
904 The amounts by which the distributions are reduced shall be
905 transferred to the General Revenue Fund.

906 (b) As an assurance to holders of bonds issued before the
907 effective date of this act to which distributions made pursuant
908 to s. 218.26 are pledged, or bonds issued to refund such bonds
909 which mature no later than the bonds they refunded and which
910 result in a reduction of debt service payable in each fiscal
911 year, the amount available for distribution to a county shall
912 remain as provided by law and continue to be subject to any lien
913 or claim on behalf of the bondholders. The Department of Revenue
914 must ensure, based on information provided by an affected
915 county, that any reduction in amounts distributed pursuant to
916 paragraph (a) does not reduce the amount of distribution to a

917 county below the amount necessary for the timely payment of
 918 principal and interest when due on the bonds and the amount
 919 necessary to comply with any covenant under the bond resolution
 920 or other documents relating to the issuance of the bonds. If a
 921 reduction to a county's monthly distribution must be decreased
 922 in order to comply with this paragraph, the Department of
 923 Revenue must notify the agency of the amount of the decrease and
 924 the agency must send a bill for payment of such amount to the
 925 affected county.

926 (9) (a) Beginning May 1, 2012, and each month thereafter,
 927 the agency shall certify to the Department of Revenue by the 7th
 928 day of each month the amount of the monthly statement rendered
 929 to each county pursuant to subsection (4). Beginning with the
 930 May 2012 distribution, the Department of Revenue shall reduce
 931 each county's monthly distribution pursuant to s. 218.61 by the
 932 amount certified by the agency minus any amount required under
 933 paragraph (b). The amounts by which the distributions are
 934 reduced shall be transferred to the General Revenue Fund.

935 (b) As an assurance to holders of bonds issued before the
 936 effective date of this act to which distributions made pursuant
 937 to s. 218.61 are pledged, or bonds issued to refund such bonds
 938 which mature no later than the bonds they refunded and which
 939 result in a reduction of debt service payable in each fiscal
 940 year, the amount available for distribution to a county shall
 941 remain as provided by law and continue to be subject to any lien
 942 or claim on behalf of the bondholders. The Department of Revenue
 943 must ensure, based on information provided by an affected
 944 county, that any reduction in amounts distributed pursuant to

945 paragraph (a) does not reduce the amount of distribution to a
946 county below the amount necessary for the timely payment of
947 principal and interest when due on the bonds and the amount
948 necessary to comply with any covenant under the bond resolution
949 or other documents relating to the issuance of the bonds. If a
950 reduction to a county's monthly distribution must be decreased
951 in order to comply with this paragraph, the Department of
952 Revenue must notify the agency of the amount of the decrease and
953 the agency must send a bill for payment of such amount to the
954 affected county.

955 (10) The agency, in consultation with the Department of
956 Revenue and the Florida Association of Counties, shall develop a
957 process for refund requests which:

958 (a) Allows counties to submit to the agency written
959 requests for refunds of any amounts by which the distributions
960 were reduced as provided in subsection (9) and which set forth
961 the reasons for the refund requests.

962 (b) Requires the agency to make a determination as to
963 whether a refund request is appropriate and should be approved,
964 in which case the agency shall certify the amount of the refund
965 to the department.

966 (c) Requires the department to issue the refund for the
967 certified amount to the county from the General Revenue Fund.
968 The Department of Revenue may issue the refund in the form of a
969 credit against reductions to be applied to subsequent monthly
970 distributions.

971 (11) Beginning in the 2013-2014 fiscal year and each year
972 thereafter through the 2020-2021 fiscal year, the Chief

973 Financial Officer shall transfer from the General Revenue Fund
 974 to the Lawton Chiles Endowment Fund an amount equal to the
 975 amounts transferred to the General Revenue Fund in the previous
 976 fiscal year pursuant to subsections (8) and (9), reduced by the
 977 amount of refunds paid pursuant to subsection (10), which are in
 978 excess of the official estimate for medical hospital fees for
 979 such previous fiscal year adopted by the Revenue Estimating
 980 Conference on January 12, 2012, as reflected in the conference's
 981 workpapers. By July 20 of each year, the Office of Economic and
 982 Demographic Research shall certify the amount to be transferred
 983 to the Chief Financial Officer. Such transfers must be made
 984 before July 31 of each year until the total transfers for all
 985 years equal \$350 million. In the event that such transfers do
 986 not total \$350 million by July 1, 2021, the Legislature shall
 987 provide for the transfer of amounts necessary to total \$350
 988 million. The Office of Economic and Demographic Research shall
 989 publish the official estimates reflected in the conference's
 990 workpapers on its website.

991 (12) The agency may adopt rules to administer this
 992 section.

993 Section 13. The Agency for Health Care Administration and
 994 the Department of Children and Family Services, in consultation
 995 with hospitals and nursing homes that serve Medicaid recipients,
 996 shall develop a process to update a recipient's address in the
 997 Medicaid eligibility system at the time a recipient is admitted
 998 to a hospital or nursing home. If a recipient's address
 999 information in the Medicaid eligibility system needs to be

1000 updated, the update shall be completed within 10 days after the
 1001 recipient's admission to a hospital or nursing home.

1002 Section 14. Subsection (2) of section 409.979, Florida
 1003 Statutes, is amended to read:

1004 409.979 Eligibility.—

1005 (2) Medicaid recipients who, on the date long-term care
 1006 managed care plans become available in their region, reside in a
 1007 nursing home facility or are enrolled in one of the following
 1008 long-term care Medicaid waiver programs are eligible to
 1009 participate in the long-term care managed care program for up to
 1010 12 months without being reevaluated for their need for nursing
 1011 facility care as defined in s. 409.985(3):

1012 (a) The Assisted Living for the Frail Elderly Waiver.

1013 (b) The Aged and Disabled Adult Waiver.

1014 ~~(c) The Adult Day Health Care Waiver.~~

1015 (c)~~(d)~~ The Consumer-Directed Care Plus Program as
 1016 described in s. 409.221.

1017 (d)~~(e)~~ The Program of All-inclusive Care for the Elderly.

1018 (e)~~(f)~~ The long-term care community-based diversion pilot
 1019 project as described in s. 430.705.

1020 (f)~~(g)~~ The Channeling Services Waiver for Frail Elders.

1021 Section 15. Subsection (15) of section 430.04, Florida
 1022 Statutes, is amended to read:

1023 430.04 Duties and responsibilities of the Department of
 1024 Elderly Affairs.—The Department of Elderly Affairs shall:

1025 (15) Administer all Medicaid waivers and programs relating
 1026 to elders and their appropriations. The waivers include, but are
 1027 not limited to:

- 1028 (a) The Assisted Living for the Frail Elderly Waiver.
- 1029 (b) The Aged and Disabled Adult Waiver.
- 1030 ~~(c) The Adult Day Health Care Waiver.~~
- 1031 (c)~~(d)~~ The Consumer-Directed Care Plus Program as defined
- 1032 in s. 409.221.
- 1033 (d)~~(e)~~ The Program of All-inclusive Care for the Elderly.
- 1034 (e)~~(f)~~ The Long-Term Care Community-Based Diversion Pilot
- 1035 Project as described in s. 430.705.
- 1036 (f)~~(g)~~ The Channeling Services Waiver for Frail Elders.

1037

1038 The department shall develop a transition plan for recipients

1039 receiving services in long-term care Medicaid waivers for elders

1040 or disabled adults on the date eligible plans become available

1041 in each recipient's region defined in s. 409.981(2) to enroll

1042 those recipients in eligible plans. This subsection expires

1043 October 1, 2014.

1044 Section 16. Section 31 of chapter 2009-223, Laws of

1045 Florida, as amended by section 44 of chapter 2010-151, Laws of

1046 Florida, is redesignated as section 409.9132, Florida Statutes,

1047 and amended to read:

1048 409.9132 ~~Section 31.~~ Pilot project to monitor home health

1049 services.—The Agency for Health Care Administration shall expand

1050 the develop and implement a home health agency monitoring pilot

1051 project in Miami-Dade County on a statewide basis effective July

1052 1, 2012, except in counties in which the program will not be

1053 cost-effective, as determined by the agency by January 1, 2010.

1054 The agency shall contract with a vendor to verify the

1055 utilization and delivery of home health services and provide an

1056 electronic billing interface for home health services. The
 1057 contract must require the creation of a program to submit claims
 1058 electronically for the delivery of home health services. The
 1059 program must verify telephonically visits for the delivery of
 1060 home health services using voice biometrics. The agency may seek
 1061 amendments to the Medicaid state plan and waivers of federal
 1062 laws, as necessary, to implement or expand the pilot project.
 1063 Notwithstanding s. 287.057(3)(f), ~~Florida Statutes,~~ the agency
 1064 must award the contract through the competitive solicitation
 1065 process and may use the current contract to expand the home
 1066 health agency monitoring pilot project to include additional
 1067 counties as authorized under this section. ~~The agency shall~~
 1068 ~~submit a report to the Governor, the President of the Senate,~~
 1069 ~~and the Speaker of the House of Representatives evaluating the~~
 1070 ~~pilot project by February 1, 2011.~~

1071 Section 17. Section 32 of chapter 2009-223, Laws of
 1072 Florida, is redesignated as section 409.9133, Florida Statutes,
 1073 and amended to read:

1074 409.9133 Section 32. Pilot project for home health care
 1075 management.—The Agency for Health Care Administration shall
 1076 expand the ~~implement a~~ comprehensive care management pilot
 1077 project for home health services statewide and include private-
 1078 duty nursing and personal care services effective July 1, 2012,
 1079 except in counties in which the program will not be cost-
 1080 effective, as determined by the agency. The program must include
 1081 by January 1, 2010, which includes face-to-face assessments by a
 1082 nurse licensed pursuant to chapter 464, ~~Florida Statutes,~~
 1083 consultation with physicians ordering services to substantiate

1084 the medical necessity for services, and on-site or desk reviews
 1085 of recipients' medical records ~~in Miami-Dade County~~. The agency
 1086 may ~~enter into a~~ contract with a qualified organization to
 1087 implement or expand the pilot project. The agency shall use the
 1088 current contract to expand the comprehensive care management
 1089 pilot project to include the additional services and counties as
 1090 authorized under this section. The agency may seek amendments to
 1091 the Medicaid state plan and waivers of federal laws, as
 1092 necessary, to implement or expand the pilot project.

1093 Section 18. Notwithstanding s. 430.707, Florida Statutes,
 1094 and subject to federal approval of an additional site for the
 1095 Program of All-Inclusive Care for the Elderly (PACE), the Agency
 1096 for Health Care Administration shall contract with a current
 1097 PACE organization authorized to provide PACE services in
 1098 Southeast Florida to develop and operate a PACE program in
 1099 Broward County to serve frail elders who reside in Broward
 1100 County. The organization shall be exempt from chapter 641,
 1101 Florida Statutes. The agency, in consultation with the
 1102 Department of Elderly Affairs and subject to an appropriation,
 1103 shall approve up to 150 initial enrollee slots in the Broward
 1104 program established by the organization.

1105 Section 19. Notwithstanding s. 430.707, Florida Statutes,
 1106 and subject to federal approval of the application to be a site
 1107 for the Program of All-inclusive Care for the Elderly (PACE),
 1108 the Agency for Health Care Administration shall contract with
 1109 one private health care organization, the sole member of which
 1110 is a private, not-for-profit corporation that owns and manages
 1111 health care organizations licensed in Manatee, Sarasota, and

1112 DeSoto Counties which provide comprehensive services, including
1113 hospice and palliative care, to frail elders who reside in these
1114 counties. The organization shall be exempt from the requirements
1115 of chapter 641, Florida Statutes. The agency, in consultation
1116 with the Department of Elderly Affairs and subject to an
1117 appropriation, shall approve up to 150 initial enrollees in the
1118 Program of All-inclusive Care for the Elderly established by
1119 this organization to serve frail elders who reside in Manatee,
1120 Sarasota, and DeSoto Counties.

1121 Section 20. Effective upon this act becoming a law and for
1122 the 2011-2012 state fiscal year only, a public hospital located
1123 in trauma service area 2 which has local funds available for
1124 intergovernmental transfers that allow for exemptions from
1125 inpatient and outpatient reimbursement limitations may,
1126 notwithstanding s. 409.905(5)(c), Florida Statutes, have its
1127 reimbursement rates adjusted after September 30 of the state
1128 fiscal year in which the rates take effect.

1129 Section 21. Except as otherwise expressly provided in this
1130 act and except for this section, which shall take effect upon
1131 this act becoming a law, this act shall take effect July 1,
1132 2012.