An act relating to health care services; amending s. 383.15, F.S.; revising legislative intent relating to funding for regional perinatal intensive care centers; amending s. 409.8132, F.S.; revising a cross-reference; amending s. 409.814, F.S.; deleting a prohibition preventing children who are eligible for coverage under a state health benefit plan from being eligible for services provided through the subsidized program; revising cross-references; requiring a completed application, including a clinical screening, for enrollment in the Children's Medical Services Network; amending s. 409.902, F.S.; creating, subject to an 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 the number of paid hospital emergency department visits for nonpregnant Medicaid recipients 21 years of age or older; authorizing the

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agency to submit a budget amendment to request approval of adjustments to hospital rates in cases of insufficient collection of intergovernmental transfers; amending the date by which the adjustments may be made to hospital rates; providing components for the agency's plan to convert inpatient hospital rates to a prospective payment system; requiring notice regarding certain budget amendments; revising dates for submitting the plan and implementing the system; amending s. 409.908, F.S.; conforming a cross-reference; amending s. 409.911, F.S.; updating references to data used for calculations in the disproportionate share program; repealing s. 409.9112, F.S., relating to the disproportionate share program for regional perinatal intensive care centers; amending s. 409.9113, F.S.; conforming a cross-reference; authorizing the agency to distribute moneys in the disproportionate share program for teaching hospitals; repealing s. 409.9117, F.S., relating to the primary care disproportionate share program; amending s. 409.9122, F.S.; expanding Medicaid managed care enrollment for recipients with HIV/AIDS; amending 409.915, F.S.; specifying criteria for determining a county's eligible recipients; providing for payment of billings that have been denied by the county from the county's tax revenues; providing conditions for refunds; requiring the agency to certify a percentage of certain funds to the Department of Revenue;

authorizing the Department of Revenue to reduce a county's distribution of revenue under certain circumstances; requiring the department to notify the agency of the amount of the decrease in distribution; requiring the agency, in consultation with the department and the Florida Association of Counties, to develop a process for managing refund requests; providing conditions for the transfer of certain refunds to the Lawton Chiles Endowment Fund; authorizing the agency to adopt rules; directing the agency and the Department of Children and Family Services to develop a process to update information regarding Medicaid recipients; 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 home health agency monitoring pilot project statewide; amending s. 32, ch. 2009-223, Laws of Florida, and redesignating the section as s. 409.9133, F.S.; expanding the comprehensive care management pilot project for home health services statewide and including new 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 for certain public hospitals to have their reimbursement rates adjusted under certain conditions; providing effective dates.

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

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

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

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

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

409.8132 Medikids program component.—

(6) ELIGIBILITY.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9. Domestic violence led to loss of coverage.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 4. 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 that is modular, interoperable, and scalable 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 Secretary of Children and Family Services shall have overall responsibility for the project.

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

(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 5. 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. Effective August 1, 2012, the agency shall limit payment for hospital emergency department visits for a nonpregnant Medicaid recipient 21 years of age or older to six visits per fiscal year.

(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.

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

2. Errors in cost reporting or calculation of rates discovered after October 31 ~~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 applies ~~shall apply~~ to actions by providers involving Medicaid claims for hospital services. Hospital rates are ~~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 Medicaid 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.

1. The plan must:

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

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

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

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

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

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

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

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

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

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

3. 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. The plan shall include a timeline necessary to complete full implementation by July 1, 2013. If, during implementation of this paragraph, the agency determines that these timeframes might not be achievable, the agency shall report to the Legislative Budget Commission the status of its implementation efforts, the reasons the timeframes might not be achievable, and proposals for new timeframes.

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

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

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

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

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

Section 7. Subsection (1), 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.

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

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

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

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

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

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

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

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

(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 8. Section 409.9112, Florida Statutes, is repealed.

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

409.9113 Disproportionate share program for teaching hospitals.—In addition to the payments made under s. ~~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 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 or programs accredited by the Council on Postdoctoral

Training of the American Osteopathic Association 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.

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 TAP = THAF x 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 (l) 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)

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

This subsection expires October 1, 2014.

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

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

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

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

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

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

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

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

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

1. For each county that files a petition on or before September 1, 2012, the amount certified under paragraph (a); and

2. For each county that does not file a petition on or before September 1, 2012, an amount equal to 85 percent of the amount certified under paragraph (a).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 14. 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 15. 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)~~(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.

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 16. 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 shall expand the ~~develop and implement a~~ home health agency monitoring pilot project in Miami-Dade County on a statewide basis effective July 1, 2012, except in counties in which the program will not be cost-effective, as determined by the agency ~~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 17. 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 shall expand the ~~implement a~~ comprehensive care management pilot project for home health services statewide and include private-duty nursing and personal care services effective July 1, 2012, except in counties in which the program will not be cost-effective, as determined by the agency. The program must include ~~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

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

the medical necessity for services, and on-site or desk reviews of recipients' medical records ~~in Miami-Dade County~~. The agency may ~~enter into a~~ contract with a qualified organization to implement or expand the pilot project. The agency shall 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 18. Notwithstanding s. 430.707, Florida Statutes, and subject to federal approval of an additional site for the Program of All-Inclusive Care for the Elderly (PACE), the Agency for Health Care Administration shall contract with a current PACE organization authorized to provide PACE services in Southeast Florida to develop and operate a PACE program in Broward County to serve frail elders who reside in Broward County. The organization shall be exempt from 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 enrollee slots in the Broward program established by the organization.

Section 19. 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 20. Effective upon this act becoming a law and for the 2011-2012 state fiscal year only, a public hospital located in trauma service area 2 which has local funds available for intergovernmental transfers that allow for exemptions from inpatient and outpatient reimbursement limitations may, notwithstanding s. 409.905(5)(c), Florida Statues, have its reimbursement rates adjusted after September 30 of the state fiscal year in which the rates take effect.

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