FOR CONSIDERATION By the Committee on Budget

576-02536E-12 20127094__

1 A bill to be entitled
2 An act relating to Medicaid; amending s. 383.15, F.S.;
3 revising legislative intent relating to funding for
4 regional perinatal intensive care centers; amending s.
5 409.902, F.S.; providing for the creation an Internet-
6 based system for determining eligibility for the
7 Medicaid and Kidcare programs, contingent on the
8 appropriation; providing system business objectives
9 and requirements; requiring the Department of Children
10 and Family Services to develop the system; requiring
11 the system to be completed and implemented by
12 specified dates; providing a governance structure
13 pending implementation of the program, including an
14 executive steering committee and a project management
15 team; amending s. 409.905, F.S.; limiting the number
16 of paid hospital emergency department visits for
17 nonpregnant adults; authorizing the Agency for Health
18 Care Administration to request approval by the
19 Legislative Budget Commission of hospital rate
20 adjustments; providing components for the agency's
21 plan to convert inpatient hospital rates to a
22 prospective payment system; revising dates for
23 submitting the plan and implementing the system;
24 amending 409.908, F.S.; conforming a cross-reference;
25 authorizing the Agency for Health Care Administration
26 to accept voluntary intergovernmental transfers of
27 local taxes and other qualified revenue from counties,
28 municipalities, or special taxing districts in order
29 to fund certain costs; limiting the use of

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30 intergovernmental transfer funds for hospital
31 reimbursements; prohibiting the inclusion of certain
32 hospital costs in the capitation rates for prepaid
33 health plans; providing for the inclusion of certain
34 hospital costs in capitation rates for prepaid health
35 plans if funded by intergovernmental transfers;
36 incorporating a transferred provision; amending s.
37 409.911, F.S.; updating references to data used for
38 calculations in the disproportionate share program;
39 repealing s. 409.9112, F.S., relating to the
40 disproportionate share program for regional perinatal
41 intensive care centers; amending s. 409.9113, F.S.;
42 conforming a cross-reference; authorizing the agency
43 to distribute moneys in the disproportionate share
44 program for teaching hospitals; repealing s. 409.9117,
45 F.S., relating to the primary care disproportionate
46 share program; amending s. 409.912, F.S.; revising the
47 conditions for contracting with certain managed care
48 plans for behavioral health care services; deleting
49 requirements for assigning certain MediPass recipients
50 to managed care plans for behavioral health care
51 services; requiring the assignment of recipients to
52 provider service networks; amending s. 409.9121, F.S.;
53 revising legislative findings relating to the Medicaid
54 program; amending s. 409.9122, F.S.; providing
55 criteria and procedures relating to recipient
56 enrollment choice and assignment among Medicaid
57 managed care plans and MediPass; deleting transferred
58 provisions relating to school districts; amending s.

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59 409.9123, F.S.; revising provisions relating to the
60 publication of quality measures for managed care
61 plans; reenacting s. 409.9126, F.S., relating to
62 children with special health care needs; amending s.
63 409.915, F.S.; specifying criteria for determining a
64 county's eligible recipients; providing for payment of
65 billings that have been denied by the county from the
66 county's tax revenues; providing for refunds;
67 providing for the transfer of certain refunds to the
68 Lawton Chiles Endowment Fund; amending ss. 409.979 and
69 430.04, F.S.; deleting references to the Adult Day
70 Health Care Waiver in provisions relating to Medicaid
71 eligibility and duties and responsibilities of the
72 Department of Elderly Affairs; amending s. 31, chapter
73 2009-223, Laws of Florida, as amended, and
74 redesignating that section as s. 409.9132, F.S.;
75 expanding the home health agency monitoring pilot
76 project statewide; amending s. 32, chapter 2009-223,
77 Laws of Florida, and redesignating that section as s.
78 409.9133, F.S.; expanding the comprehensive care
79 management pilot project for home health services
80 statewide and including private-duty nursing and
81 personal care services; providing an additional site
82 in Broward County for the Program of All-Inclusive
83 Care for the Elderly; providing an effective date.
84
85 Be It Enacted by the Legislature of the State of Florida:
86
87 Section 1. Section 383.15, Florida Statutes, is amended to

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88 read:
89 383.15 Legislative intent; perinatal intensive care
90 services.—The Legislature finds ~~and declares~~ that many perinatal
91 diseases and disabilities have debilitating, costly, and often
92 fatal consequences if left untreated. Many of these debilitating
93 conditions could be prevented or ameliorated if services were
94 available to the public through a regional perinatal intensive
95 care centers program. Perinatal intensive care services are
96 critical to the well-being and development of a healthy society
97 and represent a constructive, cost-beneficial, and essential
98 investment in the future of our state. Therefore, it is the
99 intent of the Legislature to develop a regional perinatal
100 intensive care centers program. The Legislature further intends
101 that development of such ~~a regional perinatal intensive care~~
102 ~~centers~~ program ~~shall~~ not reduce or dilute the current financial
103 commitment of the state, as indicated through appropriation, to
104 the existing regional perinatal intensive care centers. It is
105 also the intent of the Legislature that any additional centers
106 ~~regional perinatal intensive care center~~ authorized under s.
107 383.19 after July 1, 1993, ~~shall~~ not receive payments under a
108 disproportionate share program for regional perinatal intensive
109 care centers authorized under chapter 409 ~~s. 409.9112~~ unless
110 specific appropriations are provided to expand such payments to
111 additional hospitals.
112 Section 2. Section 409.902, Florida Statutes, is amended to
113 read:
114 409.902 Designated single state agency; eligibility
115 determinations ~~payment requirements; program title; release of~~
116 ~~medical records~~.—

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117 (1) The Agency for Health Care Administration is designated
118 as the single state agency authorized to make payments for
119 medical assistance and related services under Title XIX of the
120 Social Security Act. These payments shall be made, subject to
121 any limitations or directions provided ~~for~~ in the General
122 Appropriations Act, only for services included in the program,
123 ~~shall be made~~ only on behalf of eligible individuals, and ~~shall~~
124 ~~be made~~ only to qualified providers in accordance with federal
125 requirements for Title XIX of the Social Security Act and ~~the~~
126 ~~provisions of~~ state law. This program of medical assistance is
127 designated the “Medicaid program.”
128 (2) The Department of Children and Family Services is
129 responsible for determining Medicaid eligibility ~~determinations~~,
130 including, but not limited to, policy, rules, and the agreement
131 with the Social Security Administration for Medicaid eligibility
132 ~~determinations~~ for Supplemental Security Income recipients, as
133 well as the actual determination of eligibility. As a condition
134 of Medicaid eligibility, subject to federal approval, the agency
135 ~~for Health Care Administration~~ and the department must ~~of~~
136 ~~Children and Family Services shall~~ ensure that each recipient of
137 Medicaid consents to the release of her or his medical records
138 to the agency ~~for Health Care Administration~~ and the Medicaid
139 Fraud Control Unit of the Department of Legal Affairs.
140 (3)~~(2)~~ Eligibility is restricted to United States citizens
141 and to lawfully admitted noncitizens who meet the criteria
142 provided in s. 414.095(3).
143 (a) Citizenship or immigration status must be verified. For
144 noncitizens, this includes verification of the validity of
145 documents with the United States Citizenship and Immigration

146 Services using the federal SAVE verification process.
147 (b) State funds may not be used to provide medical services
148 to individuals who do not meet the requirements of this
149 subsection unless the services are necessary to treat an
150 emergency medical condition or are for pregnant women. Such
151 services are authorized only to the extent provided under
152 federal law and in accordance with federal regulations as
153 provided in 42 C.F.R. s. 440.255.
154 (4) To the extent funds are appropriated, the department
155 shall collaborate with the agency to develop an Internet-based
156 system for determining eligibility for the Medicaid and Kidcare
157 programs which complies with all applicable federal and state
158 laws and requirements.
159 (a) The system must accomplish the following primary
160 business objectives:
161 1. Provide individuals and families with a single access
162 point to information that explains benefits, premiums, and cost-
163 sharing available through Medicaid, Kidcare, or any other state
164 or federal health insurance exchange.
165 2. Enable timely, accurate, and efficient enrollment of
166 eligible persons into available assistance programs.
167 3. Prevent eligibility fraud.
168 4. Allow for detailed financial analysis of eligibility-
169 based cost drivers.
170 (b) The system must include, but need not be limited to,
171 the following business and functional requirements:
172 1. Allowing for the completion and submission of an online
173 application for determining eligibility which accepts the use of
174 electronic signatures.

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175 2. Including a process that enables automatic enrollment of
176 qualified individuals into Medicaid, Kidcare, or any other state
177 or federal exchange that offers cost-sharing benefits for the
178 purchase of health insurance.
179 3. Allowing for the determination of Medicaid eligibility
180 based on modified adjusted gross income by using information
181 submitted in the application and information accessed and
182 verified through automated and secure interfaces with authorized
183 databases.
184 4. Including the ability to determine specific categories
185 of Medicaid eligibility and interface with the Florida Medicaid
186 Management Information System to support such determination,
187 using federally approved assessment methodologies, of state and
188 federal financial participation rates for persons in each
189 eligibility category.
190 5. Allowing for the accurate and timely processing of
191 eligibility claims and adjudications.
192 6. Aligning with and incorporating all applicable state and
193 federal laws, requirements, and standards, including the
194 information technology security requirements established under
195 s. 282.318 and the accessibility standards established under
196 part II of chapter 282.
197 7. Producing transaction data, reports, and performance
198 information that contributes to an evaluation of the program,
199 continuous improvement in business operations, and increased
200 transparency and accountability.
201 (c) The department shall develop the system subject to
202 approval by the Legislative Budget Commission and as required by
203 the General Appropriations Act for the 2012-2013 fiscal year.

204 (d) The system must be completed by October 1, 2013, and
205 ready for implementation by January 1, 2014.
206 (e) The department shall implement the following project-
207 governance structure until the system is implemented:
208 1. The director of the department’s Economic Self-
209 Sufficiency Services Program Office shall have overall
210 responsibility for the project.
211 2. The project shall be governed by an executive steering
212 committee composed of three department staff members appointed
213 by the Secretary of Children and Family Services; three agency
214 staff members, including at least two state Medicaid program
215 staff members, appointed by the Secretary of Health Care
216 Administration; and one staff member from Children’s Medical
217 Services within the Department of Health appointed by the
218 Surgeon General.
219 3. The executive steering committee shall have overall
220 responsibility for ensuring that the project meets its primary
221 business objectives and shall:
222 a. Provide management direction and support to the project
223 management team.
224 b. Review and approve any changes to the project’s scope,
225 schedule, and budget.
226 c. Review, approve, and determine whether to proceed with
227 any major deliverable project.
228 d. Recommend suspension or termination of the project to
229 the Governor, the President of the Senate, and the Speaker of
230 the House of Representatives if the committee determines that
231 the primary business objectives cannot be achieved.
232 4. A project management team shall be appointed by and work

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233 under the direction of the executive steering committee. The
234 project management team shall:
235 a. Provide planning, management, and oversight of the
236 project.
237 b. Submit an operational work plan and provide quarterly
238 updates to the plan to the executive steering committee. The
239 plan must specify project milestones, deliverables, and
240 expenditures.
241 c. Submit written monthly project status reports to the
242 executive steering committee.
243 Section 3. Subsections (5) of section 409.905, Florida
244 Statutes, is amended to read:
245 409.905 Mandatory Medicaid services.—The agency may make
246 payments for the following services, which are required of the
247 state by Title XIX of the Social Security Act, furnished by
248 Medicaid providers to recipients who are determined to be
249 eligible on the dates on which the services were provided. Any
250 service under this section shall be provided only when medically
251 necessary and in accordance with state and federal law.
252 Mandatory services rendered by providers in mobile units to
253 Medicaid recipients may be restricted by the agency. Nothing in
254 this section shall be construed to prevent or limit the agency
255 from adjusting fees, reimbursement rates, lengths of stay,
256 number of visits, number of services, or any other adjustments
257 necessary to comply with the availability of moneys and any
258 limitations or directions provided for in the General
259 Appropriations Act or chapter 216.
260 (5) HOSPITAL INPATIENT SERVICES.—The agency shall pay for
261 all covered services provided for the medical care and treatment

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262 of a Medicaid recipient who is admitted as an inpatient by a
263 licensed physician or dentist to a hospital licensed under part
264 I of chapter 395. However, the agency shall limit the payment
265 for inpatient hospital services for a nonpregnant ~~Medicaid~~
266 recipient 21 years of age or older to 45 days per fiscal year ~~or~~
267 ~~the number of days necessary to comply with the General~~
268 ~~Appropriations Act~~. Effective August 1, 2012, the agency shall
269 limit payment for hospital emergency department visits for a
270 nonpregnant recipient 21 years of age or older to six visits per
271 fiscal year.
272 (a) The agency may ~~is authorized to~~ implement reimbursement
273 and utilization management reforms in order to comply with any
274 limitations or directions in the General Appropriations Act,
275 which may include, but are not limited to: prior authorization
276 for inpatient psychiatric days; prior authorization for
277 nonemergency hospital inpatient admissions for individuals 21
278 years of age and older; authorization of emergency and urgent-
279 care admissions within 24 hours after admission; enhanced
280 utilization and concurrent review programs for highly utilized
281 services; reduction or elimination of covered days of service;
282 adjusting reimbursement ceilings for variable costs; adjusting
283 reimbursement ceilings for fixed and property costs; and
284 implementing target rates of increase. The agency may limit
285 prior authorization for hospital inpatient services to selected
286 diagnosis-related groups, based on an analysis of the cost and
287 potential for unnecessary hospitalizations represented by
288 certain diagnoses. Admissions for normal delivery and newborns
289 are exempt from ~~requirements for~~ prior authorization
290 requirements. In implementing ~~the provisions of~~ this section

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291 related to prior authorization, the agency must ~~shall~~ ensure
292 that the process for authorization is accessible 24 hours per
293 day, 7 days per week and authorization is automatically granted
294 if ~~when~~ not denied within 4 hours after the request.
295 Authorization procedures must include steps for the review of
296 denials. Upon implementing the prior authorization program for
297 hospital inpatient services, the agency shall discontinue its
298 hospital retrospective review program.
299 (b) A licensed hospital maintained primarily for the care
300 and treatment of patients having mental disorders or mental
301 diseases is not eligible to participate in the hospital
302 inpatient portion of the Medicaid program except as provided
303 under ~~in~~ federal law. However, the department shall apply for a
304 waiver, within 9 months after June 5, 1991, designed to provide
305 hospitalization services for mental health reasons to children
306 and adults in the most cost-effective and lowest cost setting
307 possible. Such waiver must ~~shall~~ include a request for the
308 opportunity to pay for care in hospitals known under federal law
309 as “institutions for mental disease” or “IMD’s.” The waiver
310 proposal may not ~~shall~~ propose ~~no~~ additional aggregate cost to
311 the state or Federal Government, and shall be conducted in
312 Hillsborough County, Highlands County, Hardee County, Manatee
313 County, and Polk County. The waiver proposal may incorporate
314 competitive bidding for hospital services, comprehensive
315 brokering, prepaid capitated arrangements, or other mechanisms
316 deemed by the department to show promise in reducing the cost of
317 acute care and increasing the effectiveness of preventive care.
318 When developing the waiver proposal, the department shall take
319 into account price, quality, accessibility, linkages of the

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

(c) The agency shall implement a methodology for establishing base reimbursement rates for each hospital based on allowable costs~~,~~ as defined by the agency. Rates shall be calculated annually and take effect July 1 of each year based on the most recent complete and accurate cost report submitted by each hospital. Adjustments may not be made to the rates after September 30 of the state fiscal year in which the rate takes effect, except that the agency may request that adjustments be approved by the Legislative Budget Commission when needed due to insufficient commitments or collections of intergovernmental transfers under s. 409.908(1) or s. 409.908(4). Errors in cost reporting or calculation of rates discovered after September 30 must be reconciled in a subsequent rate period. The agency may not make any adjustment to a hospital's reimbursement rate more than 5 years after a hospital is notified of an audited rate established by the agency. The prohibition against ~~requirement that~~ the agency making ~~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 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.

349 (d) The agency shall implement a comprehensive utilization
350 management program for hospital neonatal intensive care stays in
351 certain high-volume participating hospitals, select counties, or
352 statewide, and replace existing hospital inpatient utilization
353 management programs for neonatal intensive care admissions. The
354 program shall be designed to manage the lengths of stay for
355 children being treated in neonatal intensive care units and must
356 seek the earliest medically appropriate discharge to the child's
357 home or other less costly treatment setting. The agency may
358 competitively bid a contract for the selection of a qualified
359 organization to provide neonatal intensive care utilization
360 management services. The agency may seek federal waivers to
361 implement this initiative.
362 (e) The agency may develop and implement a program to
363 reduce the number of hospital readmissions among the non-
364 Medicare population eligible in areas 9, 10, and 11.
365 (f) The agency shall develop a plan to convert Medicaid
366 inpatient hospital rates to a prospective payment system that
367 categorizes each case into diagnosis-related groups (DRG) and
368 assigns a payment weight based on the average resources used to
369 treat Medicaid patients in that DRG. To the extent possible, the
370 agency shall propose an adaptation of an existing prospective
371 payment system, such as the one used by Medicare, and shall
372 propose such adjustments as are necessary for the Medicaid
373 population and to maintain budget neutrality for inpatient
374 hospital expenditures.
375 1. The plan must:
376 a. Define and describe DRGs for inpatient hospital care
377 specific to Medicaid in this state;

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378 b. Develop the use of resources needed for each DRG;
379 c. Apply current statewide levels of funding to DRGs based
380 on the associated resource value of DRGs. Current statewide
381 funding levels shall be calculated both with and without the use
382 of intergovernmental transfers;
383 d. Calculate the current number of services provided in the
384 Medicaid program based on DRGs defined under this subparagraph;
385 e. Estimate the number of cases in each DRG for future
386 years based on agency data and the official workload estimates
387 of the Social Services Estimating Conference;
388 f. Estimate potential funding for each hospital with a
389 Medicaid provider agreement, based on the DRGs and estimated
390 workload;
391 g. Propose supplemental DRG payments to augment hospital
392 reimbursements based on patient acuity and individual hospital
393 characteristics, including classification as a children's
394 hospital, rural hospital, trauma center, burn unit, and other
395 characteristics that could warrant higher reimbursements; and
396 h. Estimate potential funding for each hospital with a
397 Medicaid provider agreement for DRGs defined pursuant to this
398 subparagraph and supplemental DRG payments using current funding
399 levels, calculated both with and without the use of
400 intergovernmental transfers.
401 2. The agency, through a competitive procurement pursuant
402 to chapter 287, shall engage a consultant with expertise and
403 experience in the implementation of DRG systems for hospital
404 reimbursement to develop the DRG plan under subparagraph 1.
405 3. The agency shall submit the ~~Medicaid~~ DRG plan,
406 identifying all steps necessary for the transition and any costs

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407 associated with plan implementation, to the Governor, the
408 President of the Senate, and the Speaker of the House of
409 Representatives no later than December 1, 2012 ~~January 1, 2013~~.
410 Upon receiving legislative authorization, the agency shall begin
411 making the necessary changes to fiscal agent coding by June 1,
412 2013, with a target date of November 1, 2013, for full
413 implementation of the DRG system of hospital reimbursement. If,
414 during implementation of this paragraph, the agency determines
415 that these timeframes might not be achievable, the agency shall
416 report to the Legislative Budget Commission the status of its
417 implementation efforts, the reasons the timeframes might not be
418 achievable, and proposals for new timeframes.
419 Section 4. Paragraph (c) of subsection (1) of section
420 409.908, Florida Statutes, is amended, paragraph (e) is added to
421 that subsection, and subsections (4) and (21) of that section
422 are amended, to read:
423 409.908 Reimbursement of Medicaid providers.—Subject to
424 specific appropriations, the agency shall reimburse Medicaid
425 providers, in accordance with state and federal law, according
426 to methodologies set forth in the rules of the agency and in
427 policy manuals and handbooks incorporated by reference therein.
428 These methodologies may include fee schedules, reimbursement
429 methods based on cost reporting, negotiated fees, competitive
430 bidding pursuant to s. 287.057, and other mechanisms the agency
431 considers efficient and effective for purchasing services or
432 goods on behalf of recipients. If a provider is reimbursed based
433 on cost reporting and submits a cost report late and that cost
434 report would have been used to set a lower reimbursement rate
435 for a rate semester, then the provider’s rate for that semester

436 shall be retroactively calculated using the new cost report, and
437 full payment at the recalculated rate shall be effected
438 retroactively. Medicare-granted extensions for filing cost
439 reports, if applicable, shall also apply to Medicaid cost
440 reports. Payment for Medicaid compensable services made on
441 behalf of Medicaid eligible persons is subject to the
442 availability of moneys and any limitations or directions
443 provided for in the General Appropriations Act or chapter 216.
444 Further, nothing in this section shall be construed to prevent
445 or limit the agency from adjusting fees, reimbursement rates,
446 lengths of stay, number of visits, or number of services, or
447 making any other adjustments necessary to comply with the
448 availability of moneys and any limitations or directions
449 provided for in the General Appropriations Act, provided the
450 adjustment is consistent with legislative intent.
451 (1) Reimbursement to hospitals licensed under part I of
452 chapter 395 must be made prospectively or on the basis of
453 negotiation.
454 (c) Hospitals that provide services to a disproportionate
455 share of low-income Medicaid recipients, or that participate in
456 the regional perinatal intensive care center program under
457 chapter 383, or that participate in the statutory teaching
458 hospital disproportionate share program may receive additional
459 reimbursement. The total amount of payment for disproportionate
460 share hospitals shall be fixed by the General Appropriations
461 Act. The computation of these payments must be made in
462 compliance with all federal regulations and the methodologies
463 described in ss. 409.911~~, 409.9112,~~ and 409.9113.
464 (e) The agency may accept voluntary intergovernmental

465 transfers of local taxes and other qualified revenue from
466 counties, municipalities, or special taxing districts under
467 paragraphs (a) and (b) or the General Appropriations Act for the
468 purpose of funding the costs of special Medicaid payments to
469 hospitals, the costs of exempting hospitals from reimbursement
470 ceilings, or the costs of buying back hospital Medicaid trend
471 adjustments authorized under the General Appropriations Act,
472 except that the use of these intergovernmental transfers for
473 fee-for-service payments to hospitals is limited to the
474 proportionate use of such funds accepted by the agency under
475 subsection (4). As used in this paragraph, the term
476 "proportionate use" means that the use of intergovernmental
477 transfer funds under this subsection must be in the same
478 proportion to the use of such funds under subsection (4)
479 relative to the need for funding hospital costs under each
480 subsection.
481 (4) Subject to any limitations or directions provided ~~for~~
482 in the General Appropriations Act, ~~alternative health plans,~~
483 ~~health maintenance organizations, and~~ prepaid health plans,
484 including health maintenance organizations, prepaid provider
485 service networks, and other capitated managed care plans, shall
486 be reimbursed a fixed, prepaid amount negotiated, or
487 competitively bid pursuant to s. 287.057~~,~~ by the agency and
488 prospectively paid to the provider monthly for each Medicaid
489 recipient enrolled. The amount may not exceed the average amount
490 the agency determines it would have paid, based on claims
491 experience, for recipients in the same or similar category of
492 eligibility. The agency shall calculate capitation rates on a
493 regional basis and~~, beginning September 1, 1995,~~ shall include

494 age-band differentials in such calculations.
495 (a) Effective September 1, 2012:
496 1. The costs of special Medicaid payments to hospitals, the
497 costs of exempting hospitals from reimbursement ceilings, and
498 the costs of buying back hospital Medicaid trend adjustments
499 authorized under the General Appropriations Act, which are
500 funded through intergovernmental transfers, may not be included
501 as inpatient or outpatient costs in the calculation of prepaid
502 health plan capitations under this part. This provision must be
503 construed so that inpatient hospital costs included in the
504 calculation of prepaid health plan capitations are identical to
505 those represented by county billing rates under s. 409.915.
506 2. Prepaid health plans may not reimburse hospitals for the
507 costs described in subparagraph 1., except that plans may
508 contract with hospitals to pay inpatient per diems that are
509 between 95 percent and 105 percent of the county billing rate.
510 Hospitals and prepaid health plans may negotiate mutually
511 acceptable higher rates for medically complex care.
512 (b) Notwithstanding paragraph (a):
513 1. In order to fund the inclusion of costs described in
514 paragraph (a) in the calculation of capitations paid to prepaid
515 health plans, the agency may accept voluntary intergovernmental
516 transfers of local taxes and other qualified revenue from
517 counties, municipalities, or special taxing districts. After
518 securing commitments from counties, municipalities, or special
519 taxing districts to contribute intergovernmental transfers for
520 that purpose, the agency shall develop capitation payments for
521 prepaid health plans which include the costs described in
522 paragraph (a) if those components of the capitation are funded

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523 through intergovernmental transfers and not with general
524 revenue. The rate-setting methodology must preserve federal
525 matching funds for the intergovernmental transfers collected
526 under this paragraph and result in actuarially sound rates. The
527 agency has the discretion to perform this function using
528 supplemental capitation payments.
529 2. The amounts included in a prepaid health plan's
530 capitations or supplemental capitations under this paragraph for
531 funding the costs described in paragraph (a) must be used
532 exclusively by the prepaid health plan to enhance hospital
533 payments and be calculated by the agency as accurately as
534 possible to equal the costs described in paragraph (a) which the
535 prepaid health plan actually incurs and for which
536 intergovernmental transfers have been secured.
537 (21) The agency shall reimburse school districts that ~~which~~
538 certify the state match pursuant to ss. 409.9071 and 1011.70 for
539 the federal portion of the school district's allowable costs to
540 deliver the services, based on the reimbursement schedule. The
541 school district shall determine the costs for delivering
542 services as authorized in ss. 409.9071 and 1011.70 for which the
543 state match will be certified.
544 (a) School districts participating in the certified school
545 match program pursuant to this subsection and s. 1011.70 shall
546 be reimbursed by Medicaid, subject to the limitations of s.
547 1011.70(1), for a Medicaid-eligible child participating in the
548 services, as authorized under s. 1011.70 and as provided in s.
549 409.9071, regardless of whether the child is enrolled in
550 MediPass or a managed care plan. Managed care plans and school
551 districts shall make good faith efforts to execute agreements

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552 regarding the coordinated provision of services authorized under
553 s. 1011.70. County health departments delivering school-based
554 services pursuant to ss. 381.0056 and 381.0057 shall be
555 reimbursed by Medicaid for the federal share for a Medicaid-
556 eligible child who receives Medicaid-covered services in a
557 school setting, regardless of whether the child is enrolled in
558 MediPass or a managed care plan. Managed care plans and county
559 health departments shall make good faith efforts to execute
560 agreements regarding the coordinated provision of services to a
561 Medicaid-eligible child. To ensure continuity of care for
562 Medicaid patients, the agency, the Department of Health, and the
563 Department of Education shall develop procedures for ensuring
564 that a student's managed care plan or MediPass primary care
565 provider receives information relating to services provided in
566 accordance with ss. 381.0056, 381.0057, 409.9071, and 1011.70.
567 (b) Reimbursement of school-based providers is contingent
568 on such providers being enrolled as Medicaid providers and
569 meeting the qualifications contained in 42 C.F.R. s. 440.110,
570 unless otherwise waived by the federal Centers for Medicare and
571 Medicaid Services ~~Health Care Financing Administration~~. Speech
572 therapy providers who are certified through the Department of
573 Education pursuant to rule 6A-4.0176, Florida Administrative
574 Code, are eligible for reimbursement for services that are
575 provided on school premises. An ~~Any~~ employee of the school
576 district who has been fingerprinted and has received a criminal
577 background check in accordance with Department of Education
578 rules and guidelines is ~~shall be~~ exempt from any agency
579 requirements relating to criminal background checks.
580 Section 5. Subsection (1), paragraphs (a) and (b) of

581 subsection (2), and paragraph (d) of subsection (4) of section
582 409.911, Florida Statutes, are amended to read:
583 409.911 Disproportionate share program.—Subject to specific
584 allocations established within the General Appropriations Act
585 and any limitations established pursuant to chapter 216, the
586 agency shall distribute, pursuant to this section, moneys to
587 hospitals providing a disproportionate share of Medicaid or
588 charity care services by making quarterly Medicaid payments as
589 required. Notwithstanding the provisions of s. 409.915, counties
590 are exempt from contributing toward the cost of this special
591 reimbursement for hospitals serving a disproportionate share of
592 low-income patients.
593 (1) DEFINITIONS.—As used in this section~~, s. 409.9112,~~ and
594 the Florida Hospital Uniform Reporting System manual:
595 (a) "Adjusted patient days" means the sum of acute care
596 patient days and intensive care patient days as reported to the
597 agency ~~for Health Care Administration~~, divided by the ratio of
598 inpatient revenues generated from acute, intensive, ambulatory,
599 and ancillary patient services to gross revenues.
600 (b) "Actual audited data" or "actual audited experience"
601 means data reported to the agency ~~for Health Care Administration~~
602 which has been audited in accordance with generally accepted
603 auditing standards by the agency or representatives under
604 contract with the agency.
605 (c) "Charity care" or "uncompensated charity care" means
606 that portion of hospital charges reported to the agency ~~for~~
607 ~~Health Care Administration~~ for which there is no compensation,
608 other than restricted or unrestricted revenues provided to a
609 hospital by local governments or tax districts<u>,</u> regardless of

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610 the method of payment, for care provided to a patient whose
611 family income for the 12 months preceding the determination is
612 less than or equal to 200 percent of the federal poverty level,
613 unless the amount of hospital charges due from the patient
614 exceeds 25 percent of the annual family income. However, ~~in no~~
615 ~~case shall~~ the hospital charges for a patient whose family
616 income exceeds four times the federal poverty level for a family
617 of four may not be considered charity.
618 (d) "Charity care days" means the sum of the deductions
619 from revenues for charity care minus 50 percent of restricted
620 and unrestricted revenues provided to a hospital by local
621 governments or tax districts, divided by gross revenues per
622 adjusted patient day.
623 (e) "Hospital" means a health care institution licensed as
624 a hospital pursuant to chapter 395, but does not include
625 ambulatory surgical centers.
626 (f) "Medicaid days" means the number of actual days
627 attributable to Medicaid recipients ~~patients~~ as determined by
628 the agency ~~for Health Care Administration~~.
629 (2) The agency ~~for Health Care Administration~~ shall use the
630 following actual audited data to determine the Medicaid days and
631 charity care to be used in calculating the disproportionate
632 share payment:
633 (a) The average of the 2004, 2005, and 2006 audited
634 disproportionate share data to determine each hospital's
635 Medicaid days and charity care for the 2012-2013 ~~2011-2012~~ state
636 fiscal year.
637 (b) If the agency ~~for Health Care Administration~~ does not
638 have the prescribed 3 years of audited disproportionate share

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639 data as noted in paragraph (a) for a hospital, the agency shall
640 use the average of the years of the audited disproportionate
641 share data as noted in paragraph (a) which is available.
642 (4) The following formulas shall be used to pay
643 disproportionate share dollars to public hospitals:
644 (d) Any nonstate government owned or operated hospital
645 eligible for payments under this section on July 1, 2011,
646 remains eligible for payments during the 2012-2013 ~~2011-2012~~
647 state fiscal year.
648 Section 6. Section 409.9112, Florida Statutes, is repealed.
649 Section 7. Section 409.9113, Florida Statutes, is amended
650 to read:
651 409.9113 Disproportionate share program for teaching
652 hospitals.—In addition to the payments made under s. ~~ss.~~ 409.911
653 ~~and 409.9112~~, the agency shall make disproportionate share
654 payments to teaching hospitals, as defined in s. 408.07, for
655 their increased costs associated with medical education programs
656 and for tertiary health care services provided to the indigent.
657 This system of payments must conform to federal requirements and
658 distribute funds in each fiscal year for which an appropriation
659 is made by making quarterly Medicaid payments. Notwithstanding
660 s. 409.915, counties are exempt from contributing toward the
661 cost of this special reimbursement for hospitals serving a
662 disproportionate share of low-income patients. ~~For the 2011-2012~~
663 ~~state fiscal year,~~ The agency shall distribute the moneys
664 provided in the General Appropriations Act to statutorily
665 defined teaching hospitals and family practice teaching
666 hospitals, as defined in s. 395.805, pursuant to this section.
667 The funds provided for statutorily defined teaching hospitals

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668 shall be distributed as provided in the General Appropriations
669 Act. The funds provided for family practice teaching hospitals
670 shall be distributed equally among family practice teaching
671 hospitals.

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

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

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

695 1. The number of trainees enrolled in nationally accredited
696 graduate medical education programs, as defined in paragraph

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697 (a). Full-time equivalents are computed using the fraction of
698 the year during which each trainee is primarily assigned to the
699 given institution, over the state fiscal year preceding the date
700 on which the allocation fraction is calculated. The numerical
701 value of this factor is the fraction that the hospital
702 represents of the total number of full-time equivalent trainees
703 enrolled in accredited graduate programs, where the total is
704 computed for all statutory teaching hospitals.
705 2. The number of medical students enrolled in accredited
706 colleges of medicine and engaged in clinical activities,
707 including required clinical clerkships and clinical electives.
708 Full-time equivalents are computed using the fraction of the
709 year during which each trainee is primarily assigned to the
710 given institution, over the course of the state fiscal year
711 preceding the date on which the allocation fraction is
712 calculated. The numerical value of this factor is the fraction
713 that the given hospital represents of the total number of full-
714 time equivalent students enrolled in accredited colleges of
715 medicine, where the total is computed for all statutory teaching
716 hospitals.
717
718 The primary factor for full-time equivalent trainees is computed
719 as the sum of these two components, divided by two.
720 (c) A service index that comprises three components:
721 1. The Agency for Health Care Administration Service Index,
722 computed by applying the standard Service Inventory Scores
723 established by the agency to services offered by the given
724 hospital, as reported on Worksheet A-2 for the last fiscal year
725 reported to the agency before the date on which the allocation

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726 fraction is calculated. The numerical value of this factor is
727 the fraction that the given hospital represents of the total
728 index values, where the total is computed for all statutory
729 teaching hospitals.
730 2. A volume-weighted service index, computed by applying
731 the standard Service Inventory Scores established by the agency
732 to the volume of each service, expressed in terms of the
733 standard units of measure reported on Worksheet A-2 for the last
734 fiscal year reported to the agency before the date on which the
735 allocation factor is calculated. The numerical value of this
736 factor is the fraction that the given hospital represents of the
737 total volume-weighted service index values, where the total is
738 computed for all statutory teaching hospitals.
739 3. Total Medicaid payments to each hospital for direct
740 inpatient and outpatient services during the fiscal year
741 preceding the date on which the allocation factor is calculated.
742 This includes payments made to each hospital for such services
743 by Medicaid prepaid health plans, whether the plan was
744 administered by the hospital or not. The numerical value of this
745 factor is the fraction that each hospital represents of the
746 total of such Medicaid payments, where the total is computed for
747 all statutory teaching hospitals.
748
749 The primary factor for the service index is computed as the sum
750 of these three components, divided by three.
751 (2) By October 1 of each year, the agency shall use the
752 following formula to calculate the maximum additional
753 disproportionate share payment for statutory teaching hospitals:
754

755 TAP = THAF x A
756
757 Where:
758 TAP = total additional payment.
759 THAF = teaching hospital allocation factor.
760 A = amount appropriated for a teaching hospital
761 disproportionate share program.
762 Section 8. Section 409.9117, Florida Statutes, is repealed.
763 Section 9. Paragraphs (b) and (d) of subsection (4) of
764 section 409.912, Florida Statutes, are amended to read:
765 409.912 Cost-effective purchasing of health care.—The
766 agency shall purchase goods and services for Medicaid recipients
767 in the most cost-effective manner consistent with the delivery
768 of quality medical care. To ensure that medical services are
769 effectively utilized, the agency may, in any case, require a
770 confirmation or second physician's opinion of the correct
771 diagnosis for purposes of authorizing future services under the
772 Medicaid program. This section does not restrict access to
773 emergency services or poststabilization care services as defined
774 in 42 C.F.R. part 438.114. Such confirmation or second opinion
775 shall be rendered in a manner approved by the agency. The agency
776 shall maximize the use of prepaid per capita and prepaid
777 aggregate fixed-sum basis services when appropriate and other
778 alternative service delivery and reimbursement methodologies,
779 including competitive bidding pursuant to s. 287.057, designed
780 to facilitate the cost-effective purchase of a case-managed
781 continuum of care. The agency shall also require providers to
782 minimize the exposure of recipients to the need for acute
783 inpatient, custodial, and other institutional care and the

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784 inappropriate or unnecessary use of high-cost services. The
785 agency shall contract with a vendor to monitor and evaluate the
786 clinical practice patterns of providers in order to identify
787 trends that are outside the normal practice patterns of a
788 provider's professional peers or the national guidelines of a
789 provider's professional association. The vendor must be able to
790 provide information and counseling to a provider whose practice
791 patterns are outside the norms, in consultation with the agency,
792 to improve patient care and reduce inappropriate utilization.
793 The agency may mandate prior authorization, drug therapy
794 management, or disease management participation for certain
795 populations of Medicaid beneficiaries, certain drug classes, or
796 particular drugs to prevent fraud, abuse, overuse, and possible
797 dangerous drug interactions. The Pharmaceutical and Therapeutics
798 Committee shall make recommendations to the agency on drugs for
799 which prior authorization is required. The agency shall inform
800 the Pharmaceutical and Therapeutics Committee of its decisions
801 regarding drugs subject to prior authorization. The agency is
802 authorized to limit the entities it contracts with or enrolls as
803 Medicaid providers by developing a provider network through
804 provider credentialing. The agency may competitively bid single-
805 source-provider contracts if procurement of goods or services
806 results in demonstrated cost savings to the state without
807 limiting access to care. The agency may limit its network based
808 on the assessment of beneficiary access to care, provider
809 availability, provider quality standards, time and distance
810 standards for access to care, the cultural competence of the
811 provider network, demographic characteristics of Medicaid
812 beneficiaries, practice and provider-to-beneficiary standards,

813 appointment wait times, beneficiary use of services, provider
814 turnover, provider profiling, provider licensure history,
815 previous program integrity investigations and findings, peer
816 review, provider Medicaid policy and billing compliance records,
817 clinical and medical record audits, and other factors. Providers
818 are not entitled to enrollment in the Medicaid provider network.
819 The agency shall determine instances in which allowing Medicaid
820 beneficiaries to purchase durable medical equipment and other
821 goods is less expensive to the Medicaid program than long-term
822 rental of the equipment or goods. The agency may establish rules
823 to facilitate purchases in lieu of long-term rentals in order to
824 protect against fraud and abuse in the Medicaid program as
825 defined in s. 409.913. The agency may seek federal waivers
826 necessary to administer these policies.
827 (4) The agency may contract with:
828 (b) An entity that is providing comprehensive behavioral
829 health care services to certain Medicaid recipients through a
830 capitated, prepaid arrangement pursuant to the federal waiver
831 provided ~~for~~ by s. 409.905(5). Such entity must be licensed
832 under chapter 624, chapter 636, or chapter 641, or authorized
833 under paragraph (c) or paragraph (d), and must possess the
834 clinical systems and operational competence to manage risk and
835 provide comprehensive behavioral health care to Medicaid
836 recipients. As used in this paragraph, the term “comprehensive
837 behavioral health care services” means covered mental health and
838 substance abuse treatment services that are available to
839 Medicaid recipients. The secretary of the Department of Children
840 and Family Services shall approve provisions of procurements
841 related to children in the department’s care or custody before

842 enrolling such children in a prepaid behavioral health plan. Any
843 contract awarded under this paragraph must be competitively
844 procured. In developing the behavioral health care prepaid plan
845 procurement document, the agency must ~~shall~~ ensure that the
846 ~~procurement~~ document requires the contractor to develop and
847 implement a plan that ensures ~~to ensure~~ compliance with s.
848 394.4574 related to services provided to residents of licensed
849 assisted living facilities that hold a limited mental health
850 license. Except as provided in subparagraph 5., and except in
851 counties where the Medicaid managed care pilot program is
852 authorized pursuant to s. 409.91211, the agency shall seek
853 federal approval to contract with a single entity meeting these
854 requirements to provide comprehensive behavioral health care
855 services to all Medicaid recipients not enrolled in a Medicaid
856 managed care plan authorized under s. 409.91211, a provider
857 service network authorized under paragraph (d), or a Medicaid
858 health maintenance organization in an AHCA area. In an AHCA area
859 where the Medicaid managed care pilot program is authorized
860 pursuant to s. 409.91211 in one or more counties, the agency may
861 procure a contract with a single entity to serve the remaining
862 counties as an AHCA area or the remaining counties may be
863 included with an adjacent AHCA area and are subject to this
864 paragraph. Each entity must offer a sufficient choice of
865 providers in its network to ensure recipient access to care and
866 the opportunity to select a provider with whom they are
867 satisfied. The network must ~~shall~~ include all public mental
868 health hospitals. To ensure unimpaired access to behavioral
869 health care services by Medicaid recipients, all contracts
870 issued pursuant to this paragraph must require 80 percent of the

871 capitation paid to the managed care plan, including health
872 maintenance organizations and capitated provider service
873 networks, to be expended for the provision of behavioral health
874 care services. If the managed care plan expends less than 80
875 percent of the capitation paid for the provision of behavioral
876 health care services, the difference shall be returned to the
877 agency. The agency shall provide the plan with a certification
878 letter indicating the amount of capitation paid during each
879 calendar year for behavioral health care services pursuant to
880 this section. The agency may reimburse for substance abuse
881 treatment services on a fee-for-service basis until the agency
882 finds that adequate funds are available for capitated, prepaid
883 arrangements.
884 1. The agency shall modify the contracts with the entities
885 providing comprehensive inpatient and outpatient mental health
886 care services to Medicaid recipients in Hillsborough, Highlands,
887 Hardee, Manatee, and Polk Counties, to include substance abuse
888 treatment services.
889 2. Except as provided in subparagraph 5., the agency and
890 the Department of Children and Family Services shall contract
891 with managed care entities in each AHCA area except area 6 or
892 arrange to provide comprehensive inpatient and outpatient mental
893 health and substance abuse services through capitated prepaid
894 arrangements to all Medicaid recipients who are eligible to
895 participate in such plans under federal law and regulation. In
896 AHCA areas where eligible individuals number less than 150,000,
897 the agency shall contract with a single managed care plan to
898 provide comprehensive behavioral health services to all
899 recipients who are not enrolled in a Medicaid health maintenance

900 organization, a provider service network authorized under
901 paragraph (d), or a Medicaid capitated managed care plan
902 authorized under s. 409.91211. The agency may contract with more
903 than one comprehensive behavioral health provider to provide
904 care to recipients who are not enrolled in a Medicaid capitated
905 managed care plan authorized under s. 409.91211, a provider
906 service network authorized under paragraph (d), or a Medicaid
907 health maintenance organization in AHCA areas where the eligible
908 population exceeds 150,000. In an AHCA area where the Medicaid
909 managed care pilot program is authorized pursuant to s.
910 409.91211 in one or more counties, the agency may procure a
911 contract with a single entity to serve the remaining counties as
912 an AHCA area or the remaining counties may be included with an
913 adjacent AHCA area and shall be subject to this paragraph.
914 Contracts for comprehensive behavioral health providers awarded
915 pursuant to this section shall be competitively procured. Both
916 for-profit and not-for-profit corporations are eligible to
917 compete. Managed care plans contracting with the agency under
918 subsection (3) or paragraph (d) shall provide and receive
919 payment for the same comprehensive behavioral health benefits as
920 provided in AHCA rules, including handbooks incorporated by
921 reference. In AHCA area 11, prior to any fiscal year for which
922 the agency expects the number of MediPass enrollees in that area
923 to exceed 150,000, the agency shall seek to contract with at
924 least two comprehensive behavioral health care providers to
925 provide behavioral health care to recipients in that area who
926 are enrolled in, or assigned to, the MediPass program, and the
927 agency must offer one~~. One~~ of the behavioral health care
928 contracts to ~~must be with~~ the existing public hospital-operated

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929 provider service network ~~pilot project,~~ as described in
930 paragraph (d), for the purpose of demonstrating the cost-
931 effectiveness of the provision of quality mental health services
932 through a public hospital-operated managed care model. Payment
933 shall be ~~at an agreed-upon~~ capitated ~~rate~~ to ensure cost
934 savings. ~~Of the recipients in area 11 who are assigned to~~
935 ~~MediPass under s. 409.9122(2)(k), a minimum of 50,000 of those~~
936 ~~MediPass-enrolled recipients shall be assigned to the existing~~
937 ~~provider service network in area 11 for their behavioral care.~~
938 3. Children residing in a statewide inpatient psychiatric
939 program, or in a Department of Juvenile Justice or a Department
940 of Children and Family Services residential program approved as
941 a Medicaid behavioral health overlay services provider may not
942 be included in a behavioral health care prepaid health plan or
943 any other Medicaid managed care plan pursuant to this paragraph.
944 4. Traditional community mental health providers under
945 contract with the Department of Children and Family Services
946 pursuant to part IV of chapter 394, child welfare providers
947 under contract with the Department of Children and Family
948 Services in areas 1 and 6, and inpatient mental health providers
949 licensed pursuant to chapter 395 must be offered an opportunity
950 to accept or decline a contract to participate in <u>a</u> ~~any~~ provider
951 network for prepaid behavioral health services.
952 5. All Medicaid-eligible children, except children in area
953 1 and children in Highlands County, Hardee County, Polk County,
954 or Manatee County of area 6, <u>which</u> ~~that~~ are open for child
955 welfare services in the statewide automated child welfare
956 information system, shall receive their behavioral health care
957 services through a specialty prepaid plan operated by community-

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958 based lead agencies through a single agency or formal agreements
959 among several agencies. The agency shall work with the specialty
960 plan to develop clinically effective, evidence-based
961 alternatives as a downward substitution for the statewide
962 inpatient psychiatric program and similar residential care and
963 institutional services. The specialty prepaid plan must result
964 in savings to the state comparable to savings achieved in other
965 Medicaid managed care and prepaid programs. Such plan must
966 provide mechanisms to maximize state and local revenues. The
967 specialty prepaid plan shall be developed by the agency and the
968 Department of Children and Family Services. The agency may seek
969 federal waivers to implement this initiative. Medicaid-eligible
970 children whose cases are open for child welfare services in the
971 statewide automated child welfare information system and who
972 reside in AHCA area 10 shall be enrolled in a capitated provider
973 service network or other capitated managed care plan, which, in
974 coordination with available community-based care providers
975 specified in s. 409.1671, must ~~shall~~ provide sufficient medical,
976 developmental, and behavioral health services to meet the needs
977 of these children.
978
979 This paragraph expires October 1, 2014.
980 (d)1. A provider service network, which may be reimbursed
981 on a fee-for-service or prepaid basis. Prepaid provider service
982 networks shall receive per-member, per-month payments. A
983 provider service network that does not choose to be a prepaid
984 plan shall receive fee-for-service rates with a shared savings
985 settlement. The fee-for-service option shall be available to a
986 provider service network only for the first 2 years of the

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987 plan’s operation or until the contract year beginning September
988 1, 2014, whichever is later. The agency shall annually conduct
989 cost reconciliations to determine the amount of cost savings
990 achieved by fee-for-service provider service networks for the
991 dates of service in the period being reconciled. Only payments
992 for covered services for dates of service within the
993 reconciliation period and paid within 6 months after the last
994 date of service in the reconciliation period shall be included.
995 The agency shall perform the necessary adjustments for the
996 inclusion of claims incurred but not reported within the
997 reconciliation for claims that could be received and paid by the
998 agency after the 6-month claims processing time lag. The agency
999 shall provide the results of the reconciliations to the fee-for-
1000 service provider service networks within 45 days after the end
1001 of the reconciliation period. The fee-for-service provider
1002 service networks shall review and provide written comments or a
1003 letter of concurrence to the agency within 45 days after receipt
1004 of the reconciliation results. This reconciliation shall be
1005 considered final.
1006 2. A provider service network <u>that</u> ~~which~~ is reimbursed by
1007 the agency on a prepaid basis <u>is</u> ~~shall be~~ exempt from parts I
1008 and III of chapter 641, but must comply with the solvency
1009 requirements in s. 641.2261(2) and meet appropriate financial
1010 reserve, quality assurance, and patient rights requirements ~~as~~
1011 established by the agency.
1012 3. <u>The agency shall assign</u> Medicaid recipients ~~assigned~~ to
1013 a provider service network <u>in accordance with s. 409.9122 or s.</u>
1014 <u>409.91211, as applicable</u> ~~shall be chosen equally from those who~~
1015 ~~would otherwise have been assigned to prepaid plans and~~

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1016 ~~MediPass~~. The agency may ~~is authorized to~~ seek federal Medicaid
1017 waivers as necessary to implement ~~the provisions of~~ this
1018 section. This subparagraph expires October 1, 2014.
1019 4. A provider service network is a network established or
1020 organized and operated by a health care provider, or group of
1021 affiliated health care providers, including minority physician
1022 networks and emergency room diversion programs that meet the
1023 requirements of s. 409.91211, which provides a substantial
1024 proportion of the health care items and services under a
1025 contract directly through the provider or affiliated group of
1026 providers and may make arrangements with physicians or other
1027 health care professionals, health care institutions, or any
1028 combination of such individuals or institutions to assume all or
1029 part of the financial risk on a prospective basis for the
1030 provision of basic health services by the physicians, by other
1031 health professionals, or through the institutions. The health
1032 care providers must have a controlling interest in the governing
1033 body of the provider service network organization.
1034 Section 10. Section 409.9121, Florida Statutes, is amended
1035 to read:
1036 409.9121 Legislative findings and intent.—The Legislature
1037 ~~hereby~~ finds that the Medicaid program ~~has experienced an annual~~
1038 ~~growth rate of approximately 28 percent per year for the past 5~~
1039 ~~years, and is consuming more than half of all new general~~
1040 ~~revenue growth. The present Medicaid system~~ must be reoriented
1041 to emphasize, to the maximum extent possible, the delivery of
1042 health care through entities and mechanisms that ~~which~~ are
1043 designed to contain costs, to emphasize preventive and primary
1044 care, and to promote access and continuity of care. The

1045 Legislature further finds that the concept of “managed care”
1046 best encompasses these multiple goals. ~~The Legislature also~~
1047 ~~finds that, with the cooperation of the physician community,~~
1048 ~~MediPass, the Medicaid primary care case management program, is~~
1049 ~~responsible for ensuring that there is a sufficient supply of~~
1050 ~~primary care to provide access to preventive and primary care~~
1051 ~~services to Medicaid recipients.~~ Therefore, the Legislature
1052 declares its intent that the Medicaid program require, to the
1053 maximum extent practicable and permitted by federal law, that
1054 all Medicaid recipients be enrolled in a managed care program.
1055 Section 11. Subsections (1), (2), (4), (5), and (12) of
1056 section 409.9122, Florida Statutes, are amended to read:
1057 409.9122 Mandatory Medicaid managed care enrollment;
1058 programs and procedures.—
1059 (1) It is the intent of the Legislature that <u>Medicaid</u>
1060 <u>managed care</u> ~~the MediPass program~~ be cost-effective, provide
1061 quality health care, ~~and~~ improve access to health services, and
1062 ~~that the program~~ be <u>implemented</u> statewide. <u>Medicaid managed care</u>
1063 <u>shall consist of the enrollment of Medicaid recipients in the</u>
1064 <u>MediPass program or managed care plans for comprehensive medical</u>
1065 <u>services.</u> This subsection expires October 1, 2014.
1066 (2)~~(a)~~ The agency shall enroll <u>all Medicaid recipients</u> in a
1067 managed care plan or MediPass ~~all Medicaid recipients~~, except
1068 those ~~Medicaid~~ recipients who are~~:~~ in an institution<u>,</u>~~;~~ enrolled
1069 in the Medicaid medically needy program<u>,</u>~~;~~ or eligible for both
1070 Medicaid and Medicare. Upon enrollment, <u>recipients may</u>
1071 ~~individuals will be able to~~ change their managed care option
1072 during the 90-day opt out period required by federal Medicaid
1073 regulations. The agency <u>may</u> ~~is authorized to~~ seek the necessary

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1074 Medicaid state plan amendment to implement this policy. ~~However,~~
1075 (a) To the extent permitted by federal law, the agency may
1076 enroll a recipient in a managed care plan or MediPass ~~a Medicaid~~
1077 ~~recipient~~ who is exempt from mandatory managed care enrollment
1078 if~~, provided that~~:
1079 1. The recipient’s decision to enroll in a managed care
1080 plan or MediPass is voluntary;
1081 2. ~~If~~ The recipient chooses to enroll in a managed care
1082 plan and~~,~~ the agency has determined that the managed care plan
1083 provides specific programs and services that ~~which~~ address the
1084 special health needs of the recipient; and
1085 3. The agency receives any necessary waivers from the
1086 federal Centers for Medicare and Medicaid Services.
1087
1088 ~~School districts participating in the certified school match~~
1089 ~~program pursuant to ss. 409.908(21) and 1011.70 shall be~~
1090 ~~reimbursed by Medicaid, subject to the limitations of s.~~
1091 ~~1011.70(1), for a Medicaid-eligible child participating in the~~
1092 ~~services as authorized in s. 1011.70, as provided for in s.~~
1093 ~~409.9071, regardless of whether the child is enrolled in~~
1094 ~~MediPass or a managed care plan. Managed care plans shall make a~~
1095 ~~good faith effort to execute agreements with school districts~~
1096 ~~regarding the coordinated provision of services authorized under~~
1097 ~~s. 1011.70. County health departments delivering school-based~~
1098 ~~services pursuant to ss. 381.0056 and 381.0057 shall be~~
1099 ~~reimbursed by Medicaid for the federal share for a Medicaid-~~
1100 ~~eligible child who receives Medicaid-covered services in a~~
1101 ~~school setting, regardless of whether the child is enrolled in~~
1102 ~~MediPass or a managed care plan. Managed care plans shall make a~~

1103 ~~good faith effort to execute agreements with county health~~
1104 ~~departments regarding the coordinated provision of services to a~~
1105 ~~Medicaid-eligible child. To ensure continuity of care for~~
1106 ~~Medicaid patients, the agency, the Department of Health, and the~~
1107 ~~Department of Education shall develop procedures for ensuring~~
1108 ~~that a student's managed care plan or MediPass provider receives~~
1109 ~~information relating to services provided in accordance with ss.~~
1110 ~~381.0056, 381.0057, 409.9071, and 1011.70.~~
1111 (b) A Medicaid recipient may ~~shall~~ not be enrolled in or
1112 assigned to a managed care plan or MediPass unless the managed
1113 care plan or MediPass has complied with the quality-of-care
1114 standards specified in paragraphs (3)(a) and (b), respectively.
1115 (c) A Medicaid recipient eligible for managed care
1116 enrollment ~~recipients~~ shall have a choice of managed care
1117 options ~~plans or MediPass~~. The Agency for Health Care
1118 Administration, the Department of Health, the Department of
1119 Children and Family Services, and the Department of Elderly
1120 Affairs shall cooperate to ensure that each ~~Medicaid~~ recipient
1121 receives clear and easily understandable information that meets
1122 the following requirements:
1123 1. Explains the concept of managed care~~, including~~
1124 ~~MediPass~~.
1125 2. Provides information on the comparative performance of
1126 managed care options available to the recipient ~~plans and~~
1127 ~~MediPass~~ in the areas of quality, credentialing, preventive
1128 health programs, network size and availability, and patient
1129 satisfaction.
1130 3. Explains where additional information on each managed
1131 care option ~~plan and MediPass~~ in the recipient's area can be

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1132 obtained.
1133 4. Explains that recipients have the right to choose their
1134 managed care coverage at the time they first enroll in Medicaid
1135 and again at regular intervals set by the agency. However, if a
1136 recipient does not choose a managed care option ~~plan or~~
1137 ~~MediPass~~, the agency shall ~~will~~ assign the recipient ~~to a~~
1138 ~~managed care plan or MediPass~~ according to the criteria
1139 specified in this section.
1140 5. Explains the recipient’s right to complain, file a
1141 grievance, or change his or her managed care option as specified
1142 in this section ~~plans or MediPass providers if the recipient is~~
1143 ~~not satisfied with the managed care plan or MediPass~~.
1144 (d) The agency shall develop a mechanism for providing
1145 information to Medicaid recipients for the purpose of choosing
1146 ~~making~~ a managed care option ~~plan or MediPass selection~~.
1147 Examples of such mechanisms ~~may~~ include, but are not ~~be~~ limited
1148 to, interactive information systems, mailings, and mass
1149 marketing materials. Managed care plans and MediPass providers
1150 may not provide ~~are prohibited from providing~~ inducements to
1151 ~~Medicaid~~ recipients to select their plans or prejudice ~~from~~
1152 ~~prejudicing Medicaid~~ recipients against other managed care plans
1153 or MediPass providers.
1154 (e) Medicaid recipients who are already enrolled in a
1155 managed care plan or MediPass shall be offered the opportunity
1156 to change managed care plans or MediPass providers, as
1157 applicable, on a staggered basis, as defined by the agency. All
1158 ~~Medicaid~~ recipients shall have 30 days in which to choose a
1159 managed care option ~~make a choice of managed care plans or~~
1160 ~~MediPass providers~~. Those ~~Medicaid~~ recipients who do not make a

1161 choice shall be assigned in accordance with paragraph (f). ~~To~~
1162 ~~facilitate continuity of care, for a Medicaid recipient who is~~
1163 ~~also a recipient of Supplemental Security Income (SSI), prior to~~
1164 ~~assigning the SSI recipient to a managed care plan or MediPass,~~
1165 ~~the agency shall determine whether the SSI recipient has an~~
1166 ~~ongoing relationship with a MediPass provider or managed care~~
1167 ~~plan, and if so, the agency shall assign the SSI recipient to~~
1168 ~~that MediPass provider or managed care plan. Those SSI~~
1169 ~~recipients who do not have such a provider relationship shall be~~
1170 ~~assigned to a managed care plan or MediPass provider in~~
1171 ~~accordance with paragraph (f).~~
1172 1. During the 30-day choice period:
1173 a. A recipient residing in a county in which two or more
1174 managed care plans are eligible to accept Medicaid enrollees,
1175 including a recipient who was enrolled in MediPass at the
1176 commencement of his or her 30-day choice period, shall choose
1177 from those managed care plans. A recipient may opt out of his or
1178 her choice and choose a different managed care plan during the
1179 90-day opt out period.
1180 b. A recipient residing in a county in which only one
1181 managed care plan is eligible to accept Medicaid enrollees shall
1182 choose the managed care plan or a MediPass provider. A recipient
1183 who chooses the managed care plan may opt out of the plan and
1184 choose a MediPass provider during the 90-day opt out period.
1185 c. A recipient residing in a county in which no managed
1186 care plan is accepting Medicaid enrollees shall choose a
1187 MediPass provider.
1188 2. For the purposes of recipient choice, if a managed care
1189 plan reaches its enrollment capacity, as determined by the

1190 agency, the plan may not accept additional Medicaid enrollees
1191 until the agency determines that the plan's enrollment is
1192 sufficiently less than its enrollment capacity, due to a decline
1193 in enrollment or by an increase in enrollment capacity. If a
1194 managed care plan notifies the agency of its intent to exit a
1195 county, the plan may not accept additional Medicaid enrollees in
1196 that county before the exit date.
1197 3. As used in this paragraph, when referring to recipient
1198 choice, the term "managed care plans" includes health
1199 maintenance organizations, exclusive provider organizations,
1200 provider service networks, minority physician networks,
1201 Children's Medical Services Networks, and pediatric emergency
1202 department diversion programs authorized by this chapter or the
1203 General Appropriations Act.
1204 4. The agency shall seek federal waiver authority or a
1205 state plan amendment consistent with 42 U.S.C. 1396u-2(a)(1), as
1206 needed, to implement this paragraph.
1207 (f) If a Medicaid recipient does not choose a managed care
1208 option:
1209 1. If the recipient resides in a county in which two or
1210 more managed care plans are accepting Medicaid enrollees, the
1211 agency shall assign the recipient, including a recipient who was
1212 enrolled in MediPass at the commencement of his or her 30-day
1213 choice period, to one of those managed care plans. A recipient
1214 assigned to a managed care plan under this subparagraph may opt
1215 out of the managed care plan and enroll in a different managed
1216 care plan during the 90-day opt out period. The agency shall
1217 seek to make assignments among the managed care plans on an even
1218 basis under the criteria in subparagraph 6.

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1219 2. If the recipient resides in a county in which only one
1220 managed care plan is accepting Medicaid enrollees, the agency
1221 shall assign the recipient, including a recipient who was
1222 enrolled in MediPass at the commencement of his or her 30-day
1223 choice period, to the managed care plan. A recipient assigned to
1224 a managed care plan under this subparagraph may opt out of the
1225 managed care plan and choose a MediPass provider during the 90-
1226 day opt out period.
1227 3. If the recipient resides in a county in which no managed
1228 care plan is accepting Medicaid enrollees, the agency shall
1229 assign the recipient to a MediPass provider.
1230 4. For the purpose of assignment, if a managed care plan
1231 reaches its enrollment capacity, as determined by the agency,
1232 the plan may not accept additional Medicaid enrollees until the
1233 agency determines that the plan's enrollment is sufficiently
1234 less than its enrollment capacity, due to a decline in
1235 enrollment or by an increase in enrollment capacity. If a
1236 managed care plan notifies the agency of its intent to exit a
1237 county, the agency may not assign additional Medicaid enrollees
1238 to the plan in that county before the exit date. plan or
1239 MediPass provider, the agency shall assign the Medicaid
1240 recipient to a managed care plan or MediPass provider. Medicaid
1241 recipients eligible for managed care plan enrollment who are
1242 subject to mandatory assignment but who fail to make a choice
1243 shall be assigned to managed care plans until an enrollment of
1244 35 percent in MediPass and 65 percent in managed care plans, of
1245 all those eligible to choose managed care, is achieved. Once
1246 this enrollment is achieved, the assignments shall be divided in
1247 order to maintain an enrollment in MediPass and managed care

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1248 ~~plans which is in a 35 percent and 65 percent proportion,~~
1249 ~~respectively. Thereafter, assignment of Medicaid recipients who~~
1250 ~~fail to make a choice shall be based proportionally on the~~
1251 ~~preferences of recipients who have made a choice in the previous~~
1252 ~~period. Such proportions shall be revised at least quarterly to~~
1253 ~~reflect an update of the preferences of Medicaid recipients. The~~
1254 ~~agency shall disproportionately assign Medicaid-eligible~~
1255 ~~recipients who are required to but have failed to make a choice~~
1256 ~~of managed care plan or MediPass to the Children's Medical~~
1257 ~~Services Network as defined in s. 391.021, exclusive provider~~
1258 ~~organizations, provider service networks, minority physician~~
1259 ~~networks, and pediatric emergency department diversion programs~~
1260 ~~authorized by this chapter or the General Appropriations Act, in~~
1261 ~~such manner as the agency deems appropriate, until the agency~~
1262 ~~has determined that the networks and programs have sufficient~~
1263 ~~numbers to be operated economically.~~
1264 5. As used in ~~For purposes of~~ this paragraph, when
1265 referring to assignment, the term "managed care plans" includes
1266 health maintenance organizations, exclusive provider
1267 organizations, provider service networks, minority physician
1268 networks, Children's Medical Services Network, and pediatric
1269 emergency department diversion programs authorized by this
1270 chapter or the General Appropriations Act.
1271 6. When making assignments, the agency shall consider ~~take~~
1272 ~~into account~~ the following criteria, as applicable:
1273 a.~~1.~~ Whether a managed care plan has sufficient network
1274 capacity to meet the need of members.
1275 b.~~2.~~ Whether the managed care plan ~~or MediPass~~ has
1276 previously enrolled the recipient as a member, or one of the

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1277 managed care plan's primary care providers or a MediPass primary
1278 care provider ~~providers~~ has previously provided health care to
1279 the recipient.
1280 c.~~3.~~ Whether the agency has knowledge that the recipient
1281 ~~member~~ has previously expressed a preference for a particular
1282 managed care plan or MediPass primary care provider ~~as indicated~~
1283 ~~by Medicaid fee-for-service claims data,~~ but has failed to make
1284 a choice.
1285 d.~~4.~~ Whether the managed care plan's or MediPass primary
1286 care providers are geographically accessible to the recipient's
1287 residence.
1288 e. If the recipient was already enrolled in a managed care
1289 plan at the commencement of his or her 30-day choice period and
1290 fails to choose a different option, the recipient must remain
1291 enrolled in that same managed care plan.
1292 f. To facilitate continuity of care for a Medicaid
1293 recipient who is also a recipient of Supplemental Security
1294 Income (SSI), before assigning the SSI recipient, the agency
1295 shall determine whether the SSI recipient has an ongoing
1296 relationship with a managed care plan or a MediPass primary care
1297 provider, and if so, the agency shall assign the SSI recipient
1298 to that managed care plan or MediPass provider, as applicable.
1299 However, if the recipient has an ongoing relationship with a
1300 MediPass primary care provider who is included in the provider
1301 network of one or more managed care plans, the agency shall
1302 assign the recipient to one of those managed care plans.
1303 g. If the recipient is diagnosed with HIV/AIDS and resides
1304 in Broward County, Miami-Dade County, or Palm Beach County, the
1305 agency shall assign the Medicaid recipient to a managed care

1306 plan that is a health maintenance organization authorized under
1307 chapter 641, that was under contract with the agency on July 1,
1308 2011, and that offers a delivery system in partnership with a
1309 university-based teaching and research-oriented organization
1310 specializing in providing health care services and treatment for
1311 individuals diagnosed with HIV/AIDS. Recipients not diagnosed
1312 with HIV/AIDS may not be assigned under this paragraph to a
1313 managed care plan that specializes in HIV/AIDS.
1314 7. The agency shall seek federal waiver authority or a
1315 state plan amendment consistent with 42 U.S.C. 1396u-2(a)(4)(D),
1316 as needed, to implement this paragraph.
1317 (g) When more than one managed care plan or MediPass
1318 provider meets the criteria specified in paragraph (f), the
1319 agency shall make recipient assignments consecutively by family
1320 unit.
1321 (h) The agency may not engage in practices that are
1322 designed to favor one managed care plan over another or that are
1323 designed to influence Medicaid recipients to enroll in MediPass
1324 rather than in a managed care plan or to enroll in a managed
1325 care plan rather than in MediPass, as applicable. This
1326 subsection does not prohibit the agency from reporting on the
1327 performance of MediPass or any managed care plan, as measured by
1328 performance criteria developed by the agency.
1329 (i) After a recipient has made his or her selection or has
1330 been enrolled in a managed care plan or MediPass, the recipient
1331 shall have 90 days to exercise the opportunity to voluntarily
1332 disenroll and select another managed care option plan or
1333 MediPass. After 90 days, no further changes may be made except
1334 for good cause. Good cause includes, but is not limited to, poor

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1335 quality of care, lack of access to necessary specialty services,
1336 an unreasonable delay or denial of service, or fraudulent
1337 enrollment. The agency shall develop criteria for good cause
1338 disenrollment for chronically ill and disabled populations who
1339 are assigned to managed care plans if more appropriate care is
1340 available through the MediPass program. The agency must make a
1341 determination as to whether good cause exists. However, the
1342 agency may require a recipient to use the managed care plan's or
1343 MediPass grievance process prior to the agency's determination
1344 of good cause, except in cases in which immediate risk of
1345 permanent damage to the recipient's health is alleged. The
1346 grievance process, if used ~~when utilized~~, must be completed in
1347 time to permit the recipient to disenroll by the first day of
1348 the second month after the month the disenrollment request was
1349 made. If the managed care plan or MediPass, as a result of the
1350 grievance process, approves an enrollee's request to disenroll,
1351 the agency is not required to make a determination in the case.
1352 The agency must make a determination and take final action on a
1353 recipient's request so that disenrollment occurs by ~~no later~~
1354 ~~than~~ the first day of the second month after the month the
1355 request was made. If the agency fails to act within the
1356 specified timeframe, the recipient's request to disenroll is
1357 deemed to be approved as of the date agency action was required.
1358 Recipients who disagree with the agency's finding that good
1359 cause does not exist for disenrollment shall be advised of their
1360 right to pursue a Medicaid fair hearing to dispute the agency's
1361 finding.
1362 (j) Consistent with 42 U.S.C. 1396u-2(a)(4)(A) or under
1363 federal waiver authority, as needed, the agency shall ~~apply for~~

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1364 ~~a federal waiver from the Centers for Medicare and Medicaid~~
1365 ~~Services to~~ lock eligible Medicaid recipients into a managed
1366 care plan or MediPass for 12 months after an ~~open~~ enrollment
1367 period, except for the 90-day opt out period and good cause
1368 disenrollment. After 12 months' enrollment, a recipient may
1369 select another managed care ~~plan or MediPass provider~~. However,
1370 ~~nothing shall prevent~~ a Medicaid recipient may not be prevented
1371 from changing primary care providers within the managed care
1372 plan or MediPass program, as applicable, during the 12-month
1373 period.
1374 (k) The agency shall maintain MediPass provider networks in
1375 all counties, including those counties in which two or more
1376 managed care plans are accepting Medicaid enrollees. ~~When a~~
1377 ~~Medicaid recipient does not choose a managed care plan or~~
1378 ~~MediPass provider, the agency shall assign the Medicaid~~
1379 ~~recipient to a managed care plan, except in those counties in~~
1380 ~~which there are fewer than two managed care plans accepting~~
1381 ~~Medicaid enrollees, in which case assignment shall be to a~~
1382 ~~managed care plan or a MediPass provider. Medicaid recipients in~~
1383 ~~counties with fewer than two managed care plans accepting~~
1384 ~~Medicaid enrollees who are subject to mandatory assignment but~~
1385 ~~who fail to make a choice shall be assigned to managed care~~
1386 ~~plans until an enrollment of 35 percent in MediPass and 65~~
1387 ~~percent in managed care plans, of all those eligible to choose~~
1388 ~~managed care, is achieved. Once that enrollment is achieved, the~~
1389 ~~assignments shall be divided in order to maintain an enrollment~~
1390 ~~in MediPass and managed care plans which is in a 35 percent and~~
1391 ~~65 percent proportion, respectively. For purposes of this~~
1392 ~~paragraph, when referring to assignment, the term "managed care~~

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1393 ~~plans” includes exclusive provider organizations, provider~~
1394 ~~service networks, Children’s Medical Services Network, minority~~
1395 ~~physician networks, and pediatric emergency department diversion~~
1396 ~~programs authorized by this chapter or the General~~
1397 ~~Appropriations Act. When making assignments, the agency shall~~
1398 ~~take into account the following criteria:~~
1399 ~~1. A managed care plan has sufficient network capacity to~~
1400 ~~meet the need of members.~~
1401 ~~2. The managed care plan or MediPass has previously~~
1402 ~~enrolled the recipient as a member, or one of the managed care~~
1403 ~~plan’s primary care providers or MediPass providers has~~
1404 ~~previously provided health care to the recipient.~~
1405 ~~3. The agency has knowledge that the member has previously~~
1406 ~~expressed a preference for a particular managed care plan or~~
1407 ~~MediPass provider as indicated by Medicaid fee-for-service~~
1408 ~~claims data, but has failed to make a choice.~~
1409 ~~4. The managed care plan’s or MediPass primary care~~
1410 ~~providers are geographically accessible to the recipient’s~~
1411 ~~residence.~~
1412 ~~5. The agency has authority to make mandatory assignments~~
1413 ~~based on quality of service and performance of managed care~~
1414 ~~plans.~~
1415 ~~(l) If the Medicaid recipient is diagnosed with HIV/AIDS~~
1416 ~~and resides in Broward County, Miami-Dade County, or Palm Beach~~
1417 ~~County, the agency shall assign the Medicaid recipient to a~~
1418 ~~managed care plan that is a health maintenance organization~~
1419 ~~authorized under chapter 641, is under contract with the agency~~
1420 ~~on July 1, 2011, and which offers a delivery system through a~~
1421 ~~university-based teaching and research-oriented organization~~

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1422 ~~that specializes in providing health care services and treatment~~
1423 ~~for individuals diagnosed with HIV/AIDS.~~
1424 (l)~~(m)~~ Notwithstanding ~~the provisions of~~ chapter 287, the
1425 agency may~~, at its discretion,~~ renew cost-effective contracts
1426 for choice counseling services once or more for such periods as
1427 the agency may decide. However, all such renewals may not
1428 combine to exceed a total period longer than the term of the
1429 original contract.
1430
1431 This subsection expires October 1, 2014.
1432 (4)(a) Each female recipient may select as her primary care
1433 provider an obstetrician/gynecologist who has agreed to
1434 participate within a managed care plan’s provider network or as
1435 a MediPass primary care case manager, as applicable.
1436 (b) The agency shall establish a complaints and grievance
1437 process to assist Medicaid recipients enrolled in the MediPass
1438 program to resolve complaints and grievances. The agency shall
1439 investigate reports of quality-of-care grievances which remain
1440 unresolved to the satisfaction of the enrollee.
1441
1442 This subsection expires October 1, 2014.
1443 (5)(a) The agency shall work cooperatively with the Social
1444 Security Administration to identify recipients ~~beneficiaries~~ who
1445 are jointly eligible for Medicare and Medicaid and shall develop
1446 cooperative programs to encourage these recipients ~~beneficiaries~~
1447 to enroll in a Medicare participating health maintenance
1448 organization or prepaid health plans.
1449 (b) The agency shall work cooperatively with the Department
1450 of Elderly Affairs to assess the potential cost-effectiveness of

1451 providing managed care enrollment ~~MediPass~~ to recipients
1452 ~~beneficiaries~~ who are jointly eligible for Medicare and Medicaid
1453 on a voluntary choice basis. If the agency determines that
1454 enrollment of these recipients ~~beneficiaries~~ in managed care
1455 ~~MediPass~~ has the potential for being cost-effective for the
1456 state, the agency shall offer managed care enrollment ~~MediPass~~
1457 to these recipients ~~beneficiaries~~ on a voluntary choice basis in
1458 the counties where managed care is available ~~MediPass operates~~.
1459
1460 This subsection expires October 1, 2014.
1461 (12) The agency shall include in its calculation of the
1462 hospital inpatient component of a Medicaid health maintenance
1463 organization’s capitation rate any special payments, including,
1464 but not limited to, upper payment limit or disproportionate
1465 share hospital payments, made to qualifying hospitals through
1466 the fee-for-service program. The agency may seek federal waiver
1467 approval or state plan amendment as needed to implement this
1468 adjustment. This subsection expires September 1, 2012.
1469 Section 12. Section 409.9123, Florida Statutes, is amended
1470 to read:
1471 409.9123 Quality-of-care reporting.~~—In order to promote~~
1472 ~~competition between Medicaid managed care plans and MediPass~~
1473 ~~based on quality-of-care indicators,~~ The agency shall annually
1474 develop and publish a set of measures of managed care plan
1475 performance based on quality-of-care indicators. This
1476 information shall be made available to each Medicaid recipient
1477 who makes a choice of a managed care plan in her or his area.
1478 This information must ~~shall~~ be easily understandable to the
1479 ~~Medicaid~~ recipient and ~~shall~~ use nationally recognized standards

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1480 wherever possible. In formulating this information, the agency
1481 shall, at a minimum, consider ~~take into account at least~~ the
1482 following:
1483 (1) The recommendations of the National Committee for
1484 Quality Assurance Medicaid HEDIS Task Force.
1485 (2) Requirements and recommendations of the Centers for
1486 Medicare and Medicaid Services ~~Health Care Financing~~
1487 ~~Administration~~.
1488 (3) Recommendations of the managed care industry.
1489 Section 13. For the purpose of incorporating the amendment
1490 made by this act to section 409.9122, Florida Statutes, in a
1491 reference thereto, subsection (1) of section 409.9126, Florida
1492 Statutes, is reenacted to read:
1493 409.9126 Children with special health care needs.—
1494 (1) Except as provided in subsection (4), children eligible
1495 for Children’s Medical Services who receive Medicaid benefits,
1496 and other Medicaid-eligible children with special health care
1497 needs, shall be exempt from the provisions of s. 409.9122 and
1498 shall be served through the Children’s Medical Services network
1499 established in chapter 391.
1500 Section 14. Effective upon this act becoming a law,
1501 subsections (4) through (6) of section 409.915, Florida
1502 Statutes, are amended, and subsections (7) through (11) are
1503 added to that section, to read:
1504 409.915 County contributions to Medicaid.—Although the
1505 state is responsible for the full portion of the state share of
1506 the matching funds required for the Medicaid program, in order
1507 to acquire a certain portion of these funds, the state shall
1508 charge the counties for certain items of care and service as

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1509 provided in this section.
1510 (4) Each county shall contribute ~~pay into the General~~
1511 ~~Revenue Fund, unallocated,~~ its pro rata share of the total
1512 county participation based upon statements rendered by the
1513 agency ~~in consultation with the counties~~. The agency shall
1514 render such statements monthly based on each county’s eligible
1515 recipients. For purposes of this section, each county’s eligible
1516 recipients shall be determined by the recipients’ address
1517 information contained in the federally approved Medicaid
1518 eligibility system within the Department of Children and Family
1519 Services. The process developed under subsection (10) may be
1520 used for cases in which the Medicaid eligibility system’s
1521 address information may indicate a need for revision.
1522 ~~(5) The Department of Financial Services shall withhold~~
1523 ~~from the cigarette tax receipts or any other funds to be~~
1524 ~~distributed to the counties the individual county share that has~~
1525 ~~not been remitted within 60 days after billing.~~
1526 (5)~~(6)~~ In any county in which a special taxing district or
1527 authority is located which will benefit from the medical
1528 assistance programs covered by this section, the board of county
1529 commissioners may divide the county’s financial responsibility
1530 for this purpose proportionately, and each such district or
1531 authority must furnish its share to the board of county
1532 commissioners in time for the board to comply with ~~the~~
1533 ~~provisions of~~ subsection (3). Any appeal of the proration made
1534 by the board of county commissioners must be made to the
1535 Department of Financial Services, which shall then set the
1536 proportionate share of each party.
1537 (6)~~(7)~~ Counties are exempt from contributing toward the

1538 cost of new exemptions on inpatient ceilings for statutory
1539 teaching hospitals, specialty hospitals, and community hospital
1540 education program hospitals that came into effect July 1, 2000,
1541 and for special Medicaid payments that came into effect on or
1542 after July 1, 2000.
1543 (7) By September 1, 2012, the agency shall certify to the
1544 Department of Revenue, for each county, an amount equal to 85
1545 percent of each county's billings through April 30, 2012, which
1546 remain unpaid.
1547 (8)(a) Beginning with the October 2012 distribution, the
1548 Department of Revenue shall reduce each county's distributions
1549 pursuant to s. 218.26 by one thirty-sixth of the amount
1550 certified by the agency under subsection (7) for that county.
1551 However, the amount of the reduction may not exceed 50 percent
1552 of each county's distribution. If, after 36 months, the
1553 reductions for each county do not equal the total amount
1554 initially certified by the agency, the Department of Revenue
1555 shall continue to reduce each distribution by up to 50 percent
1556 until the total amount certified is reached. The amounts by
1557 which the distributions are reduced shall be transferred to the
1558 General Revenue Fund.
1559 (b) As an assurance to holders of bonds issued before the
1560 effective date of this act to which distributions made pursuant
1561 to s. 218.26 are pledged, or bonds issued to refund such bonds
1562 which mature no later than the bonds they refunded and which
1563 result in a reduction of debt service payable in each fiscal
1564 year, the amount available for distribution to a county shall
1565 remain as provided by law and continue to be subject to any lien
1566 or claim on behalf of the bondholders. The Department of Revenue

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1567 must ensure that any reduction in amounts distributed pursuant
1568 to paragraph (a) does not reduce the amount of distribution to a
1569 county below the amount necessary for the payment of principal
1570 and interest on the bonds and the amount necessary to comply
1571 with any covenant under the bond resolution or other documents
1572 relating to the issuance of the bonds.
1573 (9)(a) Beginning May 1, 2012, and each month thereafter,
1574 the agency shall certify to the Department of Revenue the amount
1575 of the monthly statement rendered to each county pursuant to
1576 subsection (4). The department shall reduce each county's
1577 monthly distribution pursuant to s. 218.61 by the amount
1578 certified. The amounts by which the distributions are reduced
1579 shall be transferred to the General Revenue Fund.
1580 (b) As an assurance to holders of bonds issued before the
1581 effective date of this act to which distributions made pursuant
1582 to s. 218.61 are pledged, or bonds issued to refund such bonds
1583 which mature no later than the bonds they refunded and which
1584 result in a reduction of debt service payable in each fiscal
1585 year, the amount available for distribution to a county shall
1586 remain as provided by law and continue to be subject to any lien
1587 or claim on behalf of the bondholders. The Department of Revenue
1588 must ensure that any reductions in amounts distributed pursuant
1589 to paragraph (a) does not reduce the amount of distribution to a
1590 county below the amount necessary for the payment of principal
1591 and interest on the bonds and the amount necessary to comply
1592 with any covenant under the bond resolution or other documents
1593 relating to the issuance of the bonds.
1594 (10) The Department of Revenue shall pay certified refund
1595 requests in accordance with a process developed by the agency

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1596 and the department which:
1597 (a) Allows counties to submit to the agency written
1598 requests for refunds of any amounts by which the distributions
1599 were reduced as provided in subsection (9) and which set forth
1600 the reasons for the refund requests.
1601 (b) Requires the agency to make a determination as to
1602 whether a refund request is appropriate and should be approved,
1603 in which case the agency shall certify the amount of the refund
1604 to the department.
1605 (c) Requires the department to issue the refund for the
1606 certified amount to the county from the General Revenue Fund.
1607 (11) Beginning in the 2013-2014 fiscal year and each year
1608 thereafter until the 2020-2021 fiscal year, the Chief Financial
1609 Officer shall transfer from the General Revenue Fund to the
1610 Lawton Chiles Endowment Fund an amount equal to the amounts
1611 transferred to the General Revenue Fund in the previous fiscal
1612 year pursuant to subsections (8) and (9), reduced by the amount
1613 of refunds paid pursuant to subsection (10), which are in excess
1614 of the official estimate for medical hospital fees for such
1615 previous fiscal year adopted by the Revenue Estimating
1616 Conference on January 12, 2012, as reflected in the conference's
1617 workpapers. By July 20 of each year, the Office of Economic and
1618 Demographic Research shall certify the amount to be transferred
1619 to the Chief Financial Officer. Such transfers must be made
1620 before July 31 of each year until the total transfers for all
1621 years equal $265 million. The Office of Economic and Demographic
1622 Research shall publish the official estimates reflected in the
1623 conference's workpapers on its website.
1624 Section 15. Subsection (2) of section 409.979, Florida

1625 Statutes, is amended to read:
1626 409.979 Eligibility.—
1627 (2) Medicaid recipients who, on the date long-term care
1628 managed care plans become available in their region, reside in a
1629 nursing home facility or are enrolled in one of the following
1630 long-term care Medicaid waiver programs are eligible to
1631 participate in the long-term care managed care program for up to
1632 12 months without being reevaluated for their need for nursing
1633 facility care as defined in s. 409.985(3):
1634 (a) The Assisted Living for the Frail Elderly Waiver.
1635 (b) The Aged and Disabled Adult Waiver.
1636 ~~(c) The Adult Day Health Care Waiver.~~
1637 (c)~~(d)~~ The Consumer-Directed Care Plus Program as described
1638 in s. 409.221.
1639 (d)~~(e)~~ The Program of All-inclusive Care for the Elderly.
1640 (e)~~(f)~~ The long-term care community-based diversion pilot
1641 project as described in s. 430.705.
1642 (f)~~(g)~~ The Channeling Services Waiver for Frail Elders.
1643 Section 16. Subsection (15) of section 430.04, Florida
1644 Statutes, is amended to read:
1645 430.04 Duties and responsibilities of the Department of
1646 Elderly Affairs.—The Department of Elderly Affairs shall:
1647 (15) Administer all Medicaid waivers and programs relating
1648 to elders and their appropriations. The waivers include, but are
1649 not limited to:
1650 (a) The Assisted Living for the Frail Elderly Waiver.
1651 (b) The Aged and Disabled Adult Waiver.
1652 ~~(c) The Adult Day Health Care Waiver.~~
1653 (c)~~(d)~~ The Consumer-Directed Care Plus Program as defined

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

1654 in s. 409.221.

1655 (d) ~~(e)~~ The Program of All-inclusive Care for the Elderly.

1656 (e) ~~(f)~~ The Long-Term Care Community-Based Diversion Pilot

1657 Project as described in s. 430.705.

1658 (f) ~~(g)~~ The Channeling Services Waiver for Frail Elders.

1659

1660 The department shall develop a transition plan for recipients

1661 receiving services in long-term care Medicaid waivers for elders

1662 or disabled adults on the date eligible plans become available

1663 in each recipient's region defined in s. 409.981(2) to enroll

1664 those recipients in eligible plans. This subsection expires

1665 October 1, 2014.

1666 Section 17. Section 31 of chapter 2009-223, Laws of

1667 Florida, as amended by section 44 of chapter 2010-151, Laws of

1668 Florida, is redesignated as section 409.9132, Florida Statutes,

1669 and amended to read:

1670 409.9132 ~~Section 31.~~ Pilot project to monitor home health

1671 services.—The agency ~~for Health Care Administration~~ shall expand

1672 the ~~develop and implement a~~ home health agency monitoring pilot

1673 project in Miami-Dade County on a statewide basis effective July

1674 1, 2012, except in counties in which the program will not be

1675 cost-effective, as determined by the agency ~~by January 1, 2010~~.

1676 The agency shall contract with a vendor to verify the

1677 utilization and delivery of home health services and provide an

1678 electronic billing interface for home health services. The

1679 contract must require the creation of a program to submit claims

1680 electronically for the delivery of home health services. The

1681 program must verify telephonically visits for the delivery of

1682 home health services using voice biometrics. The agency may seek

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1683 amendments to the Medicaid state plan and waivers of federal
1684 laws, as necessary, to implement or expand the pilot project.
1685 Notwithstanding s. 287.057(3)(f), ~~Florida Statutes,~~ the agency
1686 must award the contract through the competitive solicitation
1687 process and may use the current contract to expand the home
1688 health agency monitoring pilot project to include additional
1689 counties as authorized under this section. ~~The agency shall~~
1690 ~~submit a report to the Governor, the President of the Senate,~~
1691 ~~and the Speaker of the House of Representatives evaluating the~~
1692 ~~pilot project by February 1, 2011.~~
1693 Section 18. Section 32 of chapter 2009-223, Laws of
1694 Florida, is redesignated as section 409.9133, Florida Statutes,
1695 and amended to read:
1696 409.9133 ~~Section 32.~~ Pilot project for home health care
1697 management.—The agency ~~for Health Care Administration~~ shall
1698 expand the ~~implement a~~ comprehensive care management pilot
1699 project for home health services statewide and include private-
1700 duty nursing and personal care services effective July 1, 2012,
1701 except in counties in which the program will not be cost-
1702 effective, as determined by the agency ~~by January 1, 2010~~. The
1703 program must include~~, which includes~~ face-to-face assessments by
1704 a nurse licensed pursuant to chapter 464, ~~Florida Statutes,~~
1705 consultation with physicians ordering services to substantiate
1706 the medical necessity for services, and on-site or desk reviews
1707 of recipients’ medical records ~~in Miami-Dade County~~. The agency
1708 may ~~enter into a~~ contract with a qualified organization to
1709 implement or expand the pilot project. The agency may use the
1710 current contract to expand the comprehensive care management
1711 pilot project to include the additional services and counties

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1712 authorized under this section. The agency may seek amendments to
1713 the Medicaid state plan and waivers of federal laws, as
1714 necessary, to implement or expand the pilot project.
1715 Section 19. Notwithstanding s. 430.707, Florida Statutes,
1716 and subject to federal approval of an additional site for the
1717 Program of All-Inclusive Care for the Elderly (PACE), the Agency
1718 for Health Care Administration shall contract with a current
1719 PACE organization authorized to provide PACE services in
1720 Southeast Florida to develop and operate a PACE program in
1721 Broward County to serve frail elders who reside in Broward
1722 County. The organization shall be exempt from chapter 641,
1723 Florida Statutes. The agency, in consultation with the
1724 Department of Elderly Affairs and subject to an appropriation,
1725 shall approve up to 150 initial enrollee slots in the Broward
1726 program established by the organization.
1727 Section 20. Except as otherwise expressly provided in this
1728 act and except for this section, which shall take effect upon
1729 this act becoming a law, this act shall take effect July 1.
1730 2012.