1 A bill to be entitled
2 An act relating to health care; amending s. 409.814, F.S.;
3 providing Florida Kidcare eligibility determination
4 requirements; amending s. 409.815, F.S.; revising
5 mandatory benefit requirements for behavioral health and
6 dental services; providing reimbursement requirements for
7 federally qualified health centers and rural health
8 clinics; amending s. 409.818, F.S.; requiring the Agency
9 for Health Care Administration to monitor the compliance
10 and quality of health insurance plans in the Florida
11 Kidcare program as required by federal law; amending s.
12 409.904, F.S.; revising the date provisions authorizing
13 the Medically Aged and Disabled waiver expire; revising
14 the date that the provisions authorizing a specified
15 medically needy program expire; amending s. 409.905, F.S.,
16 relating to mandatory Medicaid services; requiring prior
17 authorization for certain home health services; requiring
18 home health agencies to submit certain supporting
19 documentation when requesting prior authorization;
20 establishing reimbursement requirements for home health
21 services; amending s. 409.906, F.S., relating to optional
22 Medicaid services; providing limitations on the provision
23 of adult vision services; amending s. 409.9082, F.S.;
24 modifying circumstances requiring discontinuance of the
25 quality assessment on nursing home facility providers;
26 creating s. 409.9083, F.S.; providing for a quality
27 assessment to be imposed upon intermediate care facility
28 providers; providing definitions; requiring the agency to

29 calculate the quality assessment rate annually; providing
30 requirements for reporting and collecting the assessment;
31 specifying the purposes of the assessment and an order of
32 priority; requiring that the agency seek federal
33 authorization to implement the act; specifying
34 circumstances requiring discontinuance of the quality
35 assessment; authorizing the agency to impose certain
36 penalties against providers that fail to pay the
37 assessment; requiring the agency to adopt rules; providing
38 for future repeal of provisions; amending s. 409.911,
39 F.S.; revising the share data used to calculate
40 disproportionate share payments to hospitals; amending s.
41 409.9112, F.S.; revising the time period during which the
42 agency is prohibited from distributing disproportionate
43 share payments to regional perinatal intensive care
44 centers; amending s. 409.9113, F.S.; requiring the agency
45 to distribute moneys provided in the General
46 Appropriations Act to statutorily defined teaching
47 hospitals and family practice teaching hospitals under the
48 teaching hospital disproportionate share program for the
49 2009-2010 fiscal year; amending s. 409.9117, F.S.;
50 prohibiting the agency from distributing moneys under the
51 primary care disproportionate share program for the 2009-
52 2010 fiscal year; amending s. 409.912, F.S.; deleting
53 provisions relating to a integrated fixed-payment delivery
54 program for certain elderly or dually eligible recipients;
55 conforming cross-references to changes made by the act;
56 creating a pilot project in Miami-Dade County to monitor

57 the delivery of home health services and provide for
58 electronic claims for home health services; creating a
59 comprehensive care management pilot project in Miami-Dade
60 County for home health services; amending s. 409.91211,
61 F.S.; conforming cross-references to changes made by the
62 act; revising the date that the provider service networks
63 convert from fee-for-service to capitation rates; amending
64 s. 430.04, F.S.; requiring the Department of Elderly
65 Affairs to administer all Medicaid waivers and programs
66 relating to elders and their appropriations; amending s.
67 430.707, F.S.; requiring the agency, in consultation with
68 the Department of Elderly Affairs, to accept and forward
69 to the Centers for Medicare and Medicaid Services an
70 application for expansion of a pilot project from an
71 entity that provides certain benefits under a federal
72 program; amending ss. 408.040, 409.91195, 409.91196, and
73 641.386, F.S.; conforming cross-references to changes made
74 by the act; providing an effective date.
75
76 Be It Enacted by the Legislature of the State of Florida:
77
78 Section 1. Paragraph (c) is added to subsection (8) of
79 section 409.814, Florida Statutes, is to read:
80 409.814 Eligibility.--A child who has not reached 19 years
81 of age whose family income is equal to or below 200 percent of
82 the federal poverty level is eligible for the Florida Kidcare
83 program as provided in this section. For enrollment in the
84 Children's Medical Services Network, a complete application

85 includes the medical or behavioral health screening. If,
86 subsequently, an individual is determined to be ineligible for
87 coverage, he or she must immediately be disenrolled from the
88 respective Florida Kidcare program component.
89 (8) In determining the eligibility of a child, an assets
90 test is not required. Each applicant shall provide written
91 documentation during the application process and the
92 redetermination process, including, but not limited to, the
93 following:
94 (a) Proof of family income, which must include a copy of
95 the applicant's most recent federal income tax return. In the
96 absence of a federal income tax return, an applicant may submit
97 wages and earnings statements (pay stubs), W-2 forms, or other
98 appropriate documents.
99 (b) A statement from all family members that:
100 1. Their employer does not sponsor a health benefit plan
101 for employees; or
102 2. The potential enrollee is not covered by the employer-
103 sponsored health benefit plan because the potential enrollee is
104 not eligible for coverage, or, if the potential enrollee is
105 eligible but not covered, a statement of the cost to enroll the
106 potential enrollee in the employer-sponsored health benefit
107 plan.
108 (c) Effective no later than January 1, 2010, verification
109 of the potential enrollee's or enrollee's citizenship status to
110 the extent required under Title XXI of the Social Security Act.

111 Section 2. Paragraphs (g) and (q) of subsection (2) of
112 section 409.815, Florida Statutes, are amended, and paragraph
113 (w) is added to that subsection, to read:
114 409.815 Health benefits coverage; limitations.--
115 (2) BENCHMARK BENEFITS.--In order for health benefits
116 coverage to qualify for premium assistance payments for an
117 eligible child under ss. 409.810-409.820, the health benefits
118 coverage, except for coverage under Medicaid and Medikids, must
119 include the following minimum benefits, as medically necessary.
120 (g) Behavioral health services.--
121 1. Mental health benefits include:
122 a. Inpatient services, limited to not more than 30
123 inpatient days per contract year for psychiatric admissions, or
124 residential services in facilities licensed under s. 394.875(6)
125 or s. 395.003 in lieu of inpatient psychiatric admissions;
126 however, a minimum of 10 of the 30 days shall be available only
127 for inpatient psychiatric services when authorized by a
128 physician; and
129 b. Outpatient services, including outpatient visits for
130 psychological or psychiatric evaluation, diagnosis, and
131 treatment by a licensed mental health professional, limited to a
132 maximum of 40 outpatient visits each contract year.
133 2. Substance abuse services include:
134 a. Inpatient services, limited to not more than 7
135 inpatient days per contract year for medical detoxification only
136 and 30 days of residential services; and

137 b. Outpatient services, including evaluation, diagnosis,
138 and treatment by a licensed practitioner, limited to a maximum
139 of 40 outpatient visits per contract year.
140 3. Effective October 1, 2009, covered services include
141 inpatient and outpatient services for mental and nervous
142 disorders as defined in the most recent edition of the
143 Diagnostic and Statistical Manual of Mental Disorders published
144 by the American Psychiatric Association. Such benefits include
145 psychological or psychiatric evaluation, diagnosis, and
146 treatment by a licensed mental health professional and
147 inpatient, outpatient, and residential treatment services for
148 the diagnosis and treatment of substance abuse disorders. Any
149 benefit limitations, including duration of services, number of
150 visits, or number of days for hospitalization or residential
151 services may not be any less favorable than those for physical
152 illnesses generally for the care and treatment of schizophrenia
153 and psychotic disorders, mood disorders, anxiety disorders,
154 substance abuse disorders, eating disorders, and childhood
155 attention deficit disorders. The program may also implement
156 appropriate financial incentives, peer review, utilization
157 requirements, and other methods used for the management of
158 benefits provided for other medical conditions in order to
159 reduce service costs and utilization without compromising
160 quality of care.
161 (q) Dental services.--Effective October 1, 2009, dental
162 services shall be covered as required under federal law and may
163 also include those dental benefits provided to children by the
164 Florida Medicaid program under s. 409.906(6). Changes to the

165 dental benefit in order to comply with federal law are effective
166 October 1, 2009.
167 (w) Reimbursement of federally qualified health centers
168 and rural health clinics.--Effective October 1, 2009, payments
169 for services provided to enrollees by federally qualified health
170 centers and rural health clinics under this section shall be
171 reimbursed using the Medicaid Prospective Payment System as
172 provided for under s. 2107(e)(1)(D) of the Social Security Act,
173 42 U.S.C. s. 1397gg(e)(1)(D), as added by Pub. L. No 105-33,
174 Title IV, s. 4901(a). If such services are paid for by health
175 insurers or health care providers under contract with the
176 Florida Healthy Kids Corporation, such entities are responsible
177 for this payment. The agency may seek any available federal
178 grants to assist with this transition.
179 Section 3. Paragraph (c) of subsection (3) of section
180 409.818, Florida Statutes, is amended to read:
181 409.818 Administration.--In order to implement ss.
182 409.810-409.820, the following agencies shall have the following
183 duties:
184 (3) The Agency for Health Care Administration, under the
185 authority granted in s. 409.914(1), shall:
186 (c) Monitor compliance with quality assurance and access
187 standards developed under s. 409.820 and in accordance with s.
188 2103(f) of the Social Security Act, 42 U.S.C. s. 1397cc(f).
189
190 The agency is designated the lead state agency for Title XXI of
191 the Social Security Act for purposes of receipt of federal

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

V

192 funds, for reporting purposes, and for ensuring compliance with
193 federal and state regulations and rules.
194 Section 4. Subsections (1) and (2) of section 409.904,
195 Florida Statutes, are amended to read:
196 409.904 Optional payments for eligible persons.--The
197 agency may make payments for medical assistance and related
198 services on behalf of the following persons who are determined
199 to be eligible subject to the income, assets, and categorical
200 eligibility tests set forth in federal and state law. Payment on
201 behalf of these Medicaid eligible persons is subject to the
202 availability of moneys and any limitations established by the
203 General Appropriations Act or chapter 216.
204 (1) Effective January 1, 2006, and subject to federal
205 waiver approval, a person who is age 65 or older or is
206 determined to be disabled, whose income is at or below 88
207 percent of the federal poverty level, whose assets do not exceed
208 established limitations, and who is not eligible for Medicare
209 or, if eligible for Medicare, is also eligible for and receiving
210 Medicaid-covered institutional care services, hospice services,
211 or home and community-based services. The agency shall seek
212 federal authorization through a waiver to provide this coverage.
213 This subsection expires June 30, 2010 ~~2009~~.
214 (2)(a) A family, a pregnant woman, a child under age 21, a
215 person age 65 or over, or a blind or disabled person, who would
216 be eligible under any group listed in s. 409.903(1), (2), or
217 (3), except that the income or assets of such family or person
218 exceed established limitations. For a family or person in one of
219 these coverage groups, medical expenses are deductible from

220 income in accordance with federal requirements in order to make
221 a determination of eligibility. A family or person eligible
222 under the coverage known as the "medically needy," is eligible
223 to receive the same services as other Medicaid recipients, with
224 the exception of services in skilled nursing facilities and
225 intermediate care facilities for the developmentally disabled.
226 This subsection expires June 30, 2010 ~~2009~~.
227 (b) Effective July 1, 2009, a pregnant woman or a child
228 younger than 21 years of age who would be eligible under any
229 group listed in s. 409.903, except that the income or assets of
230 such group exceed established limitations. For a person in one
231 of these coverage groups, medical expenses are deductible from
232 income in accordance with federal requirements in order to make
233 a determination of eligibility. A person eligible under the
234 coverage known as the "medically needy" is eligible to receive
235 the same services as other Medicaid recipients, with the
236 exception of services in skilled nursing facilities and
237 intermediate care facilities for the developmentally disabled.
238 Section 5. Subsection (4) of section 409.905, Florida
239 Statutes, is amended to read:
240 409.905 Mandatory Medicaid services.--The agency may make
241 payments for the following services, which are required of the
242 state by Title XIX of the Social Security Act, furnished by
243 Medicaid providers to recipients who are determined to be
244 eligible on the dates on which the services were provided. Any
245 service under this section shall be provided only when medically
246 necessary and in accordance with state and federal law.
247 Mandatory services rendered by providers in mobile units to

248 Medicaid recipients may be restricted by the agency. Nothing in
249 this section shall be construed to prevent or limit the agency
250 from adjusting fees, reimbursement rates, lengths of stay,
251 number of visits, number of services, or any other adjustments
252 necessary to comply with the availability of moneys and any
253 limitations or directions provided for in the General
254 Appropriations Act or chapter 216.
255 (4) HOME HEALTH CARE SERVICES.--The agency shall pay for
256 nursing and home health aide services, supplies, appliances, and
257 durable medical equipment, necessary to assist a recipient
258 living at home. An entity that provides services pursuant to
259 this subsection shall be licensed under part III of chapter 400.
260 These services, equipment, and supplies, or reimbursement
261 therefore, may be limited as provided in the General
262 Appropriations Act and do not include services, equipment, or
263 supplies provided to a person residing in a hospital or nursing
264 facility.
265 (a) In providing home health care services, the agency may
266 require prior authorization of care based on diagnosis or
267 utilization rates. Prior authorization is required for home
268 health services visits not associated with a skilled nursing
269 visit if the home health agency's utilization rates exceed the
270 state average by 50 percent or more. The home health agency must
271 submit documentation that supports the recipient's diagnosis and
272 the recipient's plan of care to the agency when requesting prior
273 authorization.
274 (b) The agency shall implement a comprehensive utilization
275 management program that requires prior authorization of all

276 private duty nursing services, an individualized treatment plan
277 that includes information about medication and treatment orders,
278 treatment goals, methods of care to be used, and plans for care
279 coordination by nurses and other health professionals. The
280 ~~utilization management~~ program shall also include a process for
281 periodically reviewing the ongoing use of private duty nursing
282 services. For a child, the assessment of need shall be based on
283 a child's condition, family support and care supplements, a
284 family's ability to provide care, and a family's and child's
285 schedule regarding work, school, sleep, and care for other
286 family dependents. When implemented, the private duty nursing
287 utilization management program shall replace the current
288 authorization program used by the Agency for Health Care
289 Administration and the Children's Medical Services program of
290 the Department of Health. The agency may competitively bid on a
291 contract to select a qualified organization to provide
292 utilization management of private duty nursing services. The
293 agency is authorized to seek federal waivers to implement this
294 initiative.
295 (c) The agency may provide reimbursement only for those
296 home health services that are medically necessary and if:
297 1. The services are ordered by a physician.
298 2. The written prescription for services is signed and
299 dated by the recipient's physician before the development of a
300 plan of care and before any required request for prior
301 authorization.
302 3. The physician ordering the services is not employed,
303 under contract with, or otherwise affiliated with the home

304 health agency rendering the services.
305 4. The physician ordering the services has examined the
306 recipient within 30 days before the initial request for services
307 and biannually thereafter.
308 5. The written prescription for the services includes the
309 recipient's acute or chronic medical condition or diagnosis; the
310 home health service required, including the minimum skill level
311 required to perform the service; and the frequency and duration
312 of the services.
313 6. The national provider identifier, Medicaid
314 identification number, or professional license number of the
315 physician ordering the services is listed on the written
316 prescription for the services, the claim for home health
317 reimbursement, and the prior authorization request.
318 Section 6. Subsection (23) of section 409.906, Florida
319 Statutes, is amended to read:
320 409.906 Optional Medicaid services.--Subject to specific
321 appropriations, the agency may make payments for services which
322 are optional to the state under Title XIX of the Social Security
323 Act and are furnished by Medicaid providers to recipients who
324 are determined to be eligible on the dates on which the services
325 were provided. Any optional service that is provided shall be
326 provided only when medically necessary and in accordance with
327 state and federal law. Optional services rendered by providers
328 in mobile units to Medicaid recipients may be restricted or
329 prohibited by the agency. Nothing in this section shall be
330 construed to prevent or limit the agency from adjusting fees,
331 reimbursement rates, lengths of stay, number of visits, or

332 number of services, or making any other adjustments necessary to
333 comply with the availability of moneys and any limitations or
334 directions provided for in the General Appropriations Act or
335 chapter 216. If necessary to safeguard the state's systems of
336 providing services to elderly and disabled persons and subject
337 to the notice and review provisions of s. 216.177, the Governor
338 may direct the Agency for Health Care Administration to amend
339 the Medicaid state plan to delete the optional Medicaid service
340 known as "Intermediate Care Facilities for the Developmentally
341 Disabled." Optional services may include:
342 (23) VISUAL SERVICES.--The agency may pay for visual
343 examinations, eyeglasses, and eyeglass repairs for a recipient
344 if they are prescribed by a licensed physician specializing in
345 diseases of the eye or by a licensed optometrist. Eyeglasses
346 frames for adult recipients shall be limited to one pair ~~two~~
347 ~~pairs per year~~ per recipient every 2 years, except a second
348 ~~third~~ pair may be provided during that period after prior
349 authorization. Eyeglass lenses for adult recipients shall be
350 limited to one pair per year and may only be provided after
351 prior authorization.
352 Section 7. Subsection (6) of section 409.9082, Florida
353 Statutes, as created by chapter 2009-4, Laws of Florida, is
354 amended to read:
355 409.9082 Quality assessment on nursing home facility
356 providers; exemptions; purpose; federal approval required;
357 remedies.--
358 (6) The quality assessment shall terminate and the agency
359 shall discontinue the imposition, assessment, and collection of

360 the nursing facility quality assessment if ~~any of the following~~
361 ~~occur:~~
362 ~~(a)~~ the agency does not obtain necessary federal approval
363 for the nursing home facility quality assessment or the payment
364 rates required by subsection (4)~~; or~~
365 ~~(b) The weighted average Medicaid rate paid to nursing~~
366 ~~home facilities is reduced below the weighted average Medicaid~~
367 ~~rate to nursing home facilities in effect on December 31, 2008,~~
368 ~~plus any future annual amount of the quality assessment and the~~
369 ~~applicable matching federal funds~~.
370
371 Upon termination of the quality assessment, all collected
372 assessment revenues, less any amounts expended by the agency,
373 shall be returned on a pro rata basis to the nursing facilities
374 that paid them.
375 Section 8. Section 409.9083, Florida Statutes, is created
376 to read:
377 409.9083 Quality assessment on privately operated
378 intermediate care facilities for the developmentally disabled;
379 exemptions; purpose; federal approval required; remedies.--
380 (1) As used in this section, the term:
381 (a) "Intermediate care facility for the developmentally
382 disabled" or "ICF/DD" means a privately operated intermediate
383 care facility for the developmentally disabled licensed under
384 part VIII of chapter 400.
385 (b) "Net patient service revenue" means gross revenues
386 from services provided to ICF/DD facility residents less
387 reductions from gross revenue resulting from an inability to

388 collect payment of charges. Patient service revenue excludes
389 nonresident care revenues such as gain or loss on asset
390 disposal, prior year revenue, donations and physician billings,
391 and all outpatient revenues. Reductions from gross revenue
392 include bad debts; contractual adjustments; uncompensated care;
393 administrative, courtesy, and policy discounts and adjustments;
394 and other such revenue deductions.
395 (c) "Resident day" means a calendar day of care provided
396 to an ICF/DD facility resident, including the day of admission
397 and excluding the day of discharge, except that, when admission
398 and discharge occur on the same day, 1 day of care exists.
399 (2) Effective October 1, 2009, there is imposed upon each
400 intermediate care facility for the developmentally disabled a
401 quality assessment. The aggregated amount of assessments for all
402 ICF/DDs in a given year shall be an amount not exceeding the
403 maximum percentage allowed under federal law of the total
404 aggregate net patient service revenue of assessed facilities.
405 The agency shall calculate the quality assessment rate annually
406 on a per-resident-day basis as reported by the facilities. The
407 per-resident-day assessment rate shall be uniform. Each facility
408 shall report monthly to the agency its total number of resident
409 days and shall remit an amount equal to the assessment rate
410 times the reported number of days. The agency shall collect, and
411 each facility shall pay, the quality assessment each month. The
412 agency shall collect the assessment from facility providers no
413 later than the 15th of the next succeeding calendar month. The
414 agency shall notify providers of the quality assessment rate and
415 provide a standardized form to complete and submit with

416 payments. The collection of the quality assessment shall
417 commence no sooner than 15 days after payment to the facilities
418 that implement the increased Medicaid rates containing the
419 elements prescribed in subsection (3) and monthly thereafter.
420 Intermediate care facilities for the developmentally disabled
421 may increase their rates to incorporate the assessment but may
422 not create a separate line-item charge for the purpose of
423 passing through the assessment to residents.
424 (3) The purpose of the facility quality assessment is to
425 ensure continued quality of care. Collected assessment funds
426 shall be used to obtain federal financial participation through
427 the Medicaid program to make Medicaid payments for such ICF/DD
428 services up to the amount of the Medicaid rates for such
429 facilities as calculated in accordance with the approved state
430 Medicaid plan in effect on April 1, 2008. The quality assessment
431 and federal matching funds shall be used exclusively for the
432 following purposes and in the following order of priority:
433 (a) To reimburse the Medicaid share of the quality
434 assessment as a pass-through, Medicaid-allowable cost.
435 (b) To increase each privately operated ICF/DD Medicaid
436 rate, as needed, by an amount that restores the rate reductions
437 implemented on October 1, 2008.
438 (c) To increase each ICF/DD Medicaid rate, as needed, by
439 an amount that restores any rate reductions for the 2008-2009
440 fiscal year.
441 (d) To increase payments to such facilities to fund
442 covered services to Medicaid beneficiaries.
443 (4) The agency shall seek necessary federal approval in

444 the form of state plan amendments in order to implement the
445 provisions of this section.
446 (5)(a) The quality assessment shall terminate and the
447 agency shall discontinue the imposition, assessment, and
448 collection of the quality assessment if the agency does not
449 obtain necessary federal approval for the facility quality
450 assessment or the payment rates required by subsection (3).
451 (b) Upon termination of the quality assessment, all
452 collected assessment revenues, less any amounts expended by the
453 agency, shall be returned on a pro rata basis to the facilities
454 that paid such assessments.
455 (6) The agency may seek any of the following remedies for
456 failure of any such facility provider to timely pay its
457 assessment:
458 (a) Withholding any medical assistance reimbursement
459 payments until the assessment amount is recovered.
460 (b) Suspending or revoking the facility's license.
461 (c) Imposing a fine of up to $1,000 per day for each
462 delinquent payment, not to exceed the amount of the assessment.
463 (7) The agency shall adopt rules necessary to administer
464 this section.
465 (8) This section is repealed October 1, 2011.
466 Section 9. Paragraph (a) of subsection (2) of section
467 409.911, Florida Statutes, is amended to read:
468 409.911 Disproportionate share program.--Subject to
469 specific allocations established within the General
470 Appropriations Act and any limitations established pursuant to
471 chapter 216, the agency shall distribute, pursuant to this

472 section, moneys to hospitals providing a disproportionate share
473 of Medicaid or charity care services by making quarterly
474 Medicaid payments as required. Notwithstanding the provisions of
475 s. 409.915, counties are exempt from contributing toward the
476 cost of this special reimbursement for hospitals serving a
477 disproportionate share of low-income patients.
478 (2) The Agency for Health Care Administration shall use
479 the following actual audited data to determine the Medicaid days
480 and charity care to be used in calculating the disproportionate
481 share payment:
482 (a) The average of the <u>2003, 2004, and 2005</u> ~~2002, 2003,~~
483 ~~and 2004~~ audited disproportionate share data to determine each
484 hospital's Medicaid days and charity care for the <u>2009-2010</u>
485 ~~2008-2009~~ state fiscal year.
486 Section 10. Section 409.9112, Florida Statutes, is amended
487 to read:
488 409.9112 Disproportionate share program for regional
489 perinatal intensive care centers.--
490 <u>(1)</u> In addition to the payments made under s. 409.911, the
491 Agency for Health Care Administration shall design and implement
492 a system of making disproportionate share payments to those
493 hospitals that participate in the regional perinatal intensive
494 care center program established pursuant to chapter 383. This
495 system of payments shall conform with federal requirements and
496 shall distribute funds in each fiscal year for which an
497 appropriation is made by making quarterly Medicaid payments.
498 Notwithstanding the provisions of s. 409.915, counties are
499 exempt from contributing toward the cost of this special

500 reimbursement for hospitals serving a disproportionate share of
501 low-income patients. For the state fiscal year 2009-2010 ~~2008-~~
502 ~~2009~~, the agency shall not distribute moneys under the regional
503 perinatal intensive care centers disproportionate share program.
504 (2) ~~(1)~~ The following formula shall be used by the agency
505 to calculate the total amount earned for hospitals that
506 participate in the regional perinatal intensive care center
507 program:
508
509 TAE = HDSP/THDSP
510
511 Where:
512 TAE = total amount earned by a regional perinatal intensive
513 care center.
514 HDSP = the prior state fiscal year regional perinatal
515 intensive care center disproportionate share payment to the
516 individual hospital.
517 THDSP = the prior state fiscal year total regional
518 perinatal intensive care center disproportionate share payments
519 to all hospitals.
520 (3) ~~(2)~~ The total additional payment for hospitals that
521 participate in the regional perinatal intensive care center
522 program shall be calculated by the agency as follows:
523
524 TAP = TAE x TA
525
526 Where:

527 TAP = total additional payment for a regional perinatal
528 intensive care center.
529 TAE = total amount earned by a regional perinatal intensive
530 care center.
531 TA = total appropriation for the regional perinatal
532 intensive care center disproportionate share program.
533 (4) ~~(3)~~ In order to receive payments under this section, a
534 hospital must be participating in the regional perinatal
535 intensive care center program pursuant to chapter 383 and must
536 meet the following additional requirements:
537 (a) Agree to conform to all departmental and agency
538 requirements to ensure high quality in the provision of
539 services, including criteria adopted by departmental and agency
540 rule concerning staffing ratios, medical records, standards of
541 care, equipment, space, and such other standards and criteria as
542 the department and agency deem appropriate as specified by rule.
543 (b) Agree to provide information to the department and
544 agency, in a form and manner to be prescribed by rule of the
545 department and agency, concerning the care provided to all
546 patients in neonatal intensive care centers and high-risk
547 maternity care.
548 (c) Agree to accept all patients for neonatal intensive
549 care and high-risk maternity care, regardless of ability to pay,
550 on a functional space-available basis.
551 (d) Agree to develop arrangements with other maternity and
552 neonatal care providers in the hospital's region for the
553 appropriate receipt and transfer of patients in need of
554 specialized maternity and neonatal intensive care services.

555 (e) Agree to establish and provide a developmental
556 evaluation and services program for certain high-risk neonates,
557 as prescribed and defined by rule of the department.
558 (f) Agree to sponsor a program of continuing education in
559 perinatal care for health care professionals within the region
560 of the hospital, as specified by rule.
561 (g) Agree to provide backup and referral services to the
562 department's county health departments and other low-income
563 perinatal providers within the hospital's region, including the
564 development of written agreements between these organizations
565 and the hospital.
566 (h) Agree to arrange for transportation for high-risk
567 obstetrical patients and neonates in need of transfer from the
568 community to the hospital or from the hospital to another more
569 appropriate facility.
570 (5) ~~(4)~~ Hospitals which fail to comply with any of the
571 conditions in subsection (4) ~~(3)~~ or the applicable rules of the
572 department and agency shall not receive any payments under this
573 section until full compliance is achieved. A hospital which is
574 not in compliance in two or more consecutive quarters shall not
575 receive its share of the funds. Any forfeited funds shall be
576 distributed by the remaining participating regional perinatal
577 intensive care center program hospitals.
578 Section 11. Section 409.9113, Florida Statutes, is amended
579 to read:
580 409.9113 Disproportionate share program for teaching
581 hospitals.--

582 (1) In addition to the payments made under ss. 409.911 and
583 409.9112, the Agency for Health Care Administration shall make
584 disproportionate share payments to statutorily defined teaching
585 hospitals for their increased costs associated with medical
586 education programs and for tertiary health care services
587 provided to the indigent. This system of payments shall conform
588 with federal requirements and shall distribute funds in each
589 fiscal year for which an appropriation is made by making
590 quarterly Medicaid payments. Notwithstanding s. 409.915,
591 counties are exempt from contributing toward the cost of this
592 special reimbursement for hospitals serving a disproportionate
593 share of low-income patients. For the state fiscal year 2009-
594 2010 ~~2008-2009~~, the agency shall distribute the moneys provided
595 in the General Appropriations Act to statutorily defined
596 teaching hospitals and family practice teaching hospitals under
597 the teaching hospital disproportionate share program. The funds
598 provided for statutorily defined teaching hospitals shall be
599 distributed in the same proportion as the state fiscal year
600 2003-2004 teaching hospital disproportionate share funds were
601 distributed or as otherwise provided in the General
602 Appropriations Act. The funds provided for family practice
603 teaching hospitals shall be distributed equally among family
604 practice teaching hospitals.
605 (2) ~~(1)~~ On or before September 15 of each year, the Agency
606 for Health Care Administration shall calculate an allocation
607 fraction to be used for distributing funds to state statutory
608 teaching hospitals. Subsequent to the end of each quarter of the
609 state fiscal year, the agency shall distribute to each statutory

610 teaching hospital, as defined in s. 408.07, an amount determined
611 by multiplying one-fourth of the funds appropriated for this
612 purpose by the Legislature times such hospital's allocation
613 fraction. The allocation fraction for each such hospital shall
614 be determined by the sum of three primary factors, divided by
615 three. The primary factors are:
616 (a) The number of nationally accredited graduate medical
617 education programs offered by the hospital, including programs
618 accredited by the Accreditation Council for Graduate Medical
619 Education and the combined Internal Medicine and Pediatrics
620 programs acceptable to both the American Board of Internal
621 Medicine and the American Board of Pediatrics at the beginning
622 of the state fiscal year preceding the date on which the
623 allocation fraction is calculated. The numerical value of this
624 factor is the fraction that the hospital represents of the total
625 number of programs, where the total is computed for all state
626 statutory teaching hospitals.
627 (b) The number of full-time equivalent trainees in the
628 hospital, which comprises two components:
629 1. The number of trainees enrolled in nationally
630 accredited graduate medical education programs, as defined in
631 paragraph (a). Full-time equivalents are computed using the
632 fraction of the year during which each trainee is primarily
633 assigned to the given institution, over the state fiscal year
634 preceding the date on which the allocation fraction is
635 calculated. The numerical value of this factor is the fraction
636 that the hospital represents of the total number of full-time
637 equivalent trainees enrolled in accredited graduate programs,

638 where the total is computed for all state statutory teaching
639 hospitals.
640 2. The number of medical students enrolled in accredited
641 colleges of medicine and engaged in clinical activities,
642 including required clinical clerkships and clinical electives.
643 Full-time equivalents are computed using the fraction of the
644 year during which each trainee is primarily assigned to the
645 given institution, over the course of the state fiscal year
646 preceding the date on which the allocation fraction is
647 calculated. The numerical value of this factor is the fraction
648 that the given hospital represents of the total number of full-
649 time equivalent students enrolled in accredited colleges of
650 medicine, where the total is computed for all state statutory
651 teaching hospitals.
652
653 The primary factor for full-time equivalent trainees is computed
654 as the sum of these two components, divided by two.
655 (c) A service index that comprises three components:
656 1. The Agency for Health Care Administration Service
657 Index, computed by applying the standard Service Inventory
658 Scores established by the Agency for Health Care Administration
659 to services offered by the given hospital, as reported on
660 Worksheet A-2 for the last fiscal year reported to the agency
661 before the date on which the allocation fraction is calculated.
662 The numerical value of this factor is the fraction that the
663 given hospital represents of the total Agency for Health Care
664 Administration Service Index values, where the total is computed
665 for all state statutory teaching hospitals.

666 2. A volume-weighted service index, computed by applying
667 the standard Service Inventory Scores established by the Agency
668 for Health Care Administration to the volume of each service,
669 expressed in terms of the standard units of measure reported on
670 Worksheet A-2 for the last fiscal year reported to the agency
671 before the date on which the allocation factor is calculated.
672 The numerical value of this factor is the fraction that the
673 given hospital represents of the total volume-weighted service
674 index values, where the total is computed for all state
675 statutory teaching hospitals.
676 3. Total Medicaid payments to each hospital for direct
677 inpatient and outpatient services during the fiscal year
678 preceding the date on which the allocation factor is calculated.
679 This includes payments made to each hospital for such services
680 by Medicaid prepaid health plans, whether the plan was
681 administered by the hospital or not. The numerical value of this
682 factor is the fraction that each hospital represents of the
683 total of such Medicaid payments, where the total is computed for
684 all state statutory teaching hospitals.
685
686 The primary factor for the service index is computed as the sum
687 of these three components, divided by three.
688 (3) ~~(2)~~ By October 1 of each year, the agency shall use the
689 following formula to calculate the maximum additional
690 disproportionate share payment for statutorily defined teaching
691 hospitals:
692
693 TAP = THAF x A

694
695 Where:
696 TAP = total additional payment.
697 THAF = teaching hospital allocation factor.
698 A = amount appropriated for a teaching hospital
699 disproportionate share program.
700 Section 12. Section 409.9117, Florida Statutes, is amended
701 to read:
702 409.9117 Primary care disproportionate share program.--
703 (1) For the state fiscal year 2009-2010 ~~2008-2009~~, the
704 agency shall not distribute moneys under the primary care
705 disproportionate share program.
706 (2) ~~(1)~~ If federal funds are available for disproportionate
707 share programs in addition to those otherwise provided by law,
708 there shall be created a primary care disproportionate share
709 program.
710 (3) ~~(2)~~ The following formula shall be used by the agency
711 to calculate the total amount earned for hospitals that
712 participate in the primary care disproportionate share program:
713
714 TAE = HDSP/THDSP
715
716 Where:
717 TAE = total amount earned by a hospital participating in
718 the primary care disproportionate share program.
719 HDSP = the prior state fiscal year primary care
720 disproportionate share payment to the individual hospital.

721 THDSP = the prior state fiscal year total primary care
722 disproportionate share payments to all hospitals.
723 (4) ~~(3)~~ The total additional payment for hospitals that
724 participate in the primary care disproportionate share program
725 shall be calculated by the agency as follows:
726
727 TAP = TAE x TA
728
729 Where:
730 TAP = total additional payment for a primary care hospital.
731 TAE = total amount earned by a primary care hospital.
732 TA = total appropriation for the primary care
733 disproportionate share program.
734 (5) ~~(4)~~ In the establishment and funding of this program,
735 the agency shall use the following criteria in addition to those
736 specified in s. 409.911, payments may not be made to a hospital
737 unless the hospital agrees to:
738 (a) Cooperate with a Medicaid prepaid health plan, if one
739 exists in the community.
740 (b) Ensure the availability of primary and specialty care
741 physicians to Medicaid recipients who are not enrolled in a
742 prepaid capitated arrangement and who are in need of access to
743 such physicians.
744 (c) Coordinate and provide primary care services free of
745 charge, except copayments, to all persons with incomes up to 100
746 percent of the federal poverty level who are not otherwise
747 covered by Medicaid or another program administered by a
748 governmental entity, and to provide such services based on a

749 sliding fee scale to all persons with incomes up to 200 percent
750 of the federal poverty level who are not otherwise covered by
751 Medicaid or another program administered by a governmental
752 entity, except that eligibility may be limited to persons who
753 reside within a more limited area, as agreed to by the agency
754 and the hospital.
755 (d) Contract with any federally qualified health center,
756 if one exists within the agreed geopolitical boundaries,
757 concerning the provision of primary care services, in order to
758 guarantee delivery of services in a nonduplicative fashion, and
759 to provide for referral arrangements, privileges, and
760 admissions, as appropriate. The hospital shall agree to provide
761 at an onsite or offsite facility primary care services within 24
762 hours to which all Medicaid recipients and persons eligible
763 under this paragraph who do not require emergency room services
764 are referred during normal daylight hours.
765 (e) Cooperate with the agency, the county, and other
766 entities to ensure the provision of certain public health
767 services, case management, referral and acceptance of patients,
768 and sharing of epidemiological data, as the agency and the
769 hospital find mutually necessary and desirable to promote and
770 protect the public health within the agreed geopolitical
771 boundaries.
772 (f) In cooperation with the county in which the hospital
773 resides, develop a low-cost, outpatient, prepaid health care
774 program to persons who are not eligible for the Medicaid
775 program, and who reside within the area.

776 (g) Provide inpatient services to residents within the
777 area who are not eligible for Medicaid or Medicare, and who do
778 not have private health insurance, regardless of ability to pay,
779 on the basis of available space, except that nothing shall
780 prevent the hospital from establishing bill collection programs
781 based on ability to pay.
782 (h) Work with the Florida Healthy Kids Corporation, the
783 Florida Health Care Purchasing Cooperative, and business health
784 coalitions, as appropriate, to develop a feasibility study and
785 plan to provide a low-cost comprehensive health insurance plan
786 to persons who reside within the area and who do not have access
787 to such a plan.
788 (i) Work with public health officials and other experts to
789 provide community health education and prevention activities
790 designed to promote healthy lifestyles and appropriate use of
791 health services.
792 (j) Work with the local health council to develop a plan
793 for promoting access to affordable health care services for all
794 persons who reside within the area, including, but not limited
795 to, public health services, primary care services, inpatient
796 services, and affordable health insurance generally.
797
798 Any hospital that fails to comply with any of the provisions of
799 this subsection, or any other contractual condition, may not
800 receive payments under this section until full compliance is
801 achieved.
802 Section 13. Present subsection (5), paragraph (c) of
803 subsection (21), and subsection (29) of section 409.912, Florida

804 Statutes, are amended, present subsections (6) through (53) are
805 redesignated as subsections (5) through (52), respectively, and
806 subsections (53) and (54) are added to that section, to read:
807 409.912 Cost-effective purchasing of health care.--The
808 agency shall purchase goods and services for Medicaid recipients
809 in the most cost-effective manner consistent with the delivery
810 of quality medical care. To ensure that medical services are
811 effectively utilized, the agency may, in any case, require a
812 confirmation or second physician's opinion of the correct
813 diagnosis for purposes of authorizing future services under the
814 Medicaid program. This section does not restrict access to
815 emergency services or poststabilization care services as defined
816 in 42 C.F.R. part 438.114. Such confirmation or second opinion
817 shall be rendered in a manner approved by the agency. The agency
818 shall maximize the use of prepaid per capita and prepaid
819 aggregate fixed-sum basis services when appropriate and other
820 alternative service delivery and reimbursement methodologies,
821 including competitive bidding pursuant to s. 287.057, designed
822 to facilitate the cost-effective purchase of a case-managed
823 continuum of care. The agency shall also require providers to
824 minimize the exposure of recipients to the need for acute
825 inpatient, custodial, and other institutional care and the
826 inappropriate or unnecessary use of high-cost services. The
827 agency shall contract with a vendor to monitor and evaluate the
828 clinical practice patterns of providers in order to identify
829 trends that are outside the normal practice patterns of a
830 provider's professional peers or the national guidelines of a
831 provider's professional association. The vendor must be able to

832 provide information and counseling to a provider whose practice
833 patterns are outside the norms, in consultation with the agency,
834 to improve patient care and reduce inappropriate utilization.
835 The agency may mandate prior authorization, drug therapy
836 management, or disease management participation for certain
837 populations of Medicaid beneficiaries, certain drug classes, or
838 particular drugs to prevent fraud, abuse, overuse, and possible
839 dangerous drug interactions. The Pharmaceutical and Therapeutics
840 Committee shall make recommendations to the agency on drugs for
841 which prior authorization is required. The agency shall inform
842 the Pharmaceutical and Therapeutics Committee of its decisions
843 regarding drugs subject to prior authorization. The agency is
844 authorized to limit the entities it contracts with or enrolls as
845 Medicaid providers by developing a provider network through
846 provider credentialing. The agency may competitively bid single-
847 source-provider contracts if procurement of goods or services
848 results in demonstrated cost savings to the state without
849 limiting access to care. The agency may limit its network based
850 on the assessment of beneficiary access to care, provider
851 availability, provider quality standards, time and distance
852 standards for access to care, the cultural competence of the
853 provider network, demographic characteristics of Medicaid
854 beneficiaries, practice and provider-to-beneficiary standards,
855 appointment wait times, beneficiary use of services, provider
856 turnover, provider profiling, provider licensure history,
857 previous program integrity investigations and findings, peer
858 review, provider Medicaid policy and billing compliance records,
859 clinical and medical record audits, and other factors. Providers

860 shall not be entitled to enrollment in the Medicaid provider
861 network. The agency shall determine instances in which allowing
862 Medicaid beneficiaries to purchase durable medical equipment and
863 other goods is less expensive to the Medicaid program than long-
864 term rental of the equipment or goods. The agency may establish
865 rules to facilitate purchases in lieu of long-term rentals in
866 order to protect against fraud and abuse in the Medicaid program
867 as defined in s. 409.913. The agency may seek federal waivers
868 necessary to administer these policies.
869 ~~(5) The Agency for Health Care Administration, in~~
870 ~~partnership with the Department of Elderly Affairs, shall create~~
871 ~~an integrated, fixed-payment delivery program for Medicaid~~
872 ~~recipients who are 60 years of age or older or dually eligible~~
873 ~~for Medicare and Medicaid. The Agency for Health Care~~
874 ~~Administration shall implement the integrated program initially~~
875 ~~on a pilot basis in two areas of the state. The pilot areas~~
876 ~~shall be Area 7 and Area 11 of the Agency for Health Care~~
877 ~~Administration. Enrollment in the pilot areas shall be on a~~
878 ~~voluntary basis and in accordance with approved federal waivers~~
879 ~~and this section. The agency and its program contractors and~~
880 ~~providers shall not enroll any individual in the integrated~~
881 ~~program because the individual or the person legally responsible~~
882 ~~for the individual fails to choose to enroll in the integrated~~
883 ~~program. Enrollment in the integrated program shall be~~
884 ~~exclusively by affirmative choice of the eligible individual or~~
885 ~~by the person legally responsible for the individual. The~~
886 ~~integrated program must transfer all Medicaid services for~~
887 ~~eligible elderly individuals who choose to participate into an~~

888 ~~integrated-care management model designed to serve Medicaid~~
889 ~~recipients in the community. The integrated program must combine~~
890 ~~all funding for Medicaid services provided to individuals who~~
891 ~~are 60 years of age or older or dually eligible for Medicare and~~
892 ~~Medicaid into the integrated program, including funds for~~
893 ~~Medicaid home and community-based waiver services; all Medicaid~~
894 ~~services authorized in ss. 409.905 and 409.906, excluding funds~~
895 ~~for Medicaid nursing home services unless the agency is able to~~
896 ~~demonstrate how the integration of the funds will improve~~
897 ~~coordinated care for these services in a less costly manner; and~~
898 ~~Medicare coinsurance and deductibles for persons dually eligible~~
899 ~~for Medicaid and Medicare as prescribed in s. 409.908(13).~~
900 ~~(a) Individuals who are 60 years of age or older or dually~~
901 ~~eligible for Medicare and Medicaid and enrolled in the~~
902 ~~developmental disabilities waiver program, the family and~~
903 ~~supported-living waiver program, the project AIDS care waiver~~
904 ~~program, the traumatic brain injury and spinal cord injury~~
905 ~~waiver program, the consumer-directed care waiver program, and~~
906 ~~the program of all-inclusive care for the elderly program, and~~
907 ~~residents of institutional care facilities for the~~
908 ~~developmentally disabled, must be excluded from the integrated~~
909 ~~program.~~
910 ~~(b) Managed care entities who meet or exceed the agency's~~
911 ~~minimum standards are eligible to operate the integrated~~
912 ~~program. Entities eligible to participate include managed care~~
913 ~~organizations licensed under chapter 641, including entities~~
914 ~~eligible to participate in the nursing home diversion program,~~
915 ~~other qualified providers as defined in s. 430.703(7), community~~

916 ~~care for the elderly lead agencies, and other state-certified~~
917 ~~community service networks that meet comparable standards as~~
918 ~~defined by the agency, in consultation with the Department of~~
919 ~~Elderly Affairs and the Office of Insurance Regulation, to be~~
920 ~~financially solvent and able to take on financial risk for~~
921 ~~managed care. Community service networks that are certified~~
922 ~~pursuant to the comparable standards defined by the agency are~~
923 ~~not required to be licensed under chapter 641. Managed care~~
924 ~~entities who operate the integrated program shall be subject to~~
925 ~~s. 408.7056. Eligible entities shall choose to serve enrollees~~
926 ~~who are dually eligible for Medicare and Medicaid, enrollees who~~
927 ~~are 60 years of age or older, or both.~~
928 ~~(c) The agency must ensure that the capitation-rate-~~
929 ~~setting methodology for the integrated program is actuarially~~
930 ~~sound and reflects the intent to provide quality care in the~~
931 ~~least restrictive setting. The agency must also require~~
932 ~~integrated-program providers to develop a credentialing system~~
933 ~~for service providers and to contract with all Gold Seal nursing~~
934 ~~homes, where feasible, and exclude, where feasible, chronically~~
935 ~~poor-performing facilities and providers as defined by the~~
936 ~~agency. The integrated program must develop and maintain an~~
937 ~~informal provider grievance system that addresses provider~~
938 ~~payment and contract problems. The agency shall also establish a~~
939 ~~formal grievance system to address those issues that were not~~
940 ~~resolved through the informal grievance system. The integrated~~
941 ~~program must provide that if the recipient resides in a~~
942 ~~noncontracted residential facility licensed under chapter 400 or~~
943 ~~chapter 429 at the time of enrollment in the integrated program,~~

944 ~~the recipient must be permitted to continue to reside in the~~
945 ~~noncontracted facility as long as the recipient desires. The~~
946 ~~integrated program must also provide that, in the absence of a~~
947 ~~contract between the integrated-program provider and the~~
948 ~~residential facility licensed under chapter 400 or chapter 429,~~
949 ~~current Medicaid rates must prevail. The integrated-program~~
950 ~~provider must ensure that electronic nursing home claims that~~
951 ~~contain sufficient information for processing are paid within 10~~
952 ~~business days after receipt. Alternately, the integrated-program~~
953 ~~provider may establish a capitated payment mechanism to~~
954 ~~prospectively pay nursing homes at the beginning of each month.~~
955 ~~The agency and the Department of Elderly Affairs must jointly~~
956 ~~develop procedures to manage the services provided through the~~
957 ~~integrated program in order to ensure quality and recipient~~
958 ~~choice.~~
959 ~~(d) The Office of Program Policy Analysis and Government~~
960 ~~Accountability, in consultation with the Auditor General, shall~~
961 ~~comprehensively evaluate the pilot project for the integrated,~~
962 ~~fixed-payment delivery program for Medicaid recipients created~~
963 ~~under this subsection. The evaluation shall begin as soon as~~
964 ~~Medicaid recipients are enrolled in the managed care pilot~~
965 ~~program plans and shall continue for 24 months thereafter. The~~
966 ~~evaluation must include assessments of each managed care plan in~~
967 ~~the integrated program with regard to cost savings; consumer~~
968 ~~education, choice, and access to services; coordination of care;~~
969 ~~and quality of care. The evaluation must describe administrative~~
970 ~~or legal barriers to the implementation and operation of the~~
971 ~~pilot program and include recommendations regarding statewide~~

972 ~~expansion of the pilot program. The office shall submit its~~
973 ~~evaluation report to the Governor, the President of the Senate,~~
974 ~~and the Speaker of the House of Representatives no later than~~
975 ~~December 31, 2009.~~
976 ~~(e) The agency may seek federal waivers or Medicaid state~~
977 ~~plan amendments and adopt rules as necessary to administer the~~
978 ~~integrated program. The agency may implement the approved~~
979 ~~federal waivers and other provisions as specified in this~~
980 ~~subsection.~~
981 ~~(f) No later than December 31, 2007, the agency shall~~
982 ~~provide a report to the Governor, the President of the Senate,~~
983 ~~and the Speaker of the House of Representatives containing an~~
984 ~~analysis of the merits and challenges of seeking a waiver to~~
985 ~~implement a voluntary program that integrates payments and~~
986 ~~services for dually enrolled Medicare and Medicaid recipients~~
987 ~~who are 65 years of age or older.~~
988 (20)~~(21)~~ Any entity contracting with the agency pursuant
989 to this section to provide health care services to Medicaid
990 recipients is prohibited from engaging in any of the following
991 practices or activities:
992 (c) Granting or offering of any monetary or other valuable
993 consideration for enrollment, except as authorized by subsection
994 (23) ~~(24)~~.
995 (28)~~(29)~~ The agency shall perform enrollments and
996 disenrollments for Medicaid recipients who are eligible for
997 MediPass or managed care plans. Notwithstanding the prohibition
998 contained in paragraph (20)~~(21)~~(f), managed care plans may
999 perform preenrollments of Medicaid recipients under the

1000 supervision of the agency or its agents. For the purposes of
1001 this section, "preenrollment" means the provision of marketing
1002 and educational materials to a Medicaid recipient and assistance
1003 in completing the application forms, but shall not include
1004 actual enrollment into a managed care plan. An application for
1005 enrollment shall not be deemed complete until the agency or its
1006 agent verifies that the recipient made an informed, voluntary
1007 choice. The agency, in cooperation with the Department of
1008 Children and Family Services, may test new marketing initiatives
1009 to inform Medicaid recipients about their managed care options
1010 at selected sites. The agency shall report to the Legislature on
1011 the effectiveness of such initiatives. The agency may contract
1012 with a third party to perform managed care plan and MediPass
1013 enrollment and disenrollment services for Medicaid recipients
1014 and is authorized to adopt rules to implement such services. The
1015 agency may adjust the capitation rate only to cover the costs of
1016 a third-party enrollment and disenrollment contract, and for
1017 agency supervision and management of the managed care plan
1018 enrollment and disenrollment contract.
1019 (53) The agency shall develop and implement a home health
1020 agency monitoring pilot project in Miami-Dade County by January
1021 1, 2010. The agency shall contract with a vendor to verify the
1022 utilization and the delivery of home health services and provide
1023 an electronic billing interface for home health services. The
1024 contract must require the creation of a program to submit claims
1025 for the home health services electronically. The program must
1026 verify visits for the delivery of home health services
1027 telephonically using voice biometrics. The agency may seek

1028 amendments to the Medicaid state plan and waivers of federal
1029 laws, as necessary, to implement the pilot project.
1030 Notwithstanding s. 287.057(5)(f), the agency must award the
1031 contract through the competitive solicitation process. The
1032 agency shall submit a report to the Governor, the President of
1033 the Senate, and the Speaker of the House of Representatives
1034 evaluating the pilot project by February 1, 2011.
1035 (54) The agency shall implement a comprehensive care
1036 management pilot project in Miami-Dade County for home health
1037 services by January 1, 2010, which includes face-to-face
1038 assessments by a state-licensed nurse, consultation with
1039 physicians ordering services to substantiate the medical
1040 necessity for services, and onsite or desk reviews of
1041 recipients' medical records. The agency may enter into a
1042 contract with a qualified organization to implement the pilot
1043 project. The agency may seek amendments to the Medicaid state
1044 plan and waivers of federal laws, as necessary, to implement the
1045 pilot project.
1046 Section 14. Paragraphs (e), (l), (p), and (w) of
1047 subsection (3) and subsection (12) of section 409.91211, Florida
1048 Statutes, are amended to read:
1049 409.91211 Medicaid managed care pilot program.--
1050 (3) The agency shall have the following powers, duties,
1051 and responsibilities with respect to the pilot program:
1052 (e) To implement policies and guidelines for phasing in
1053 financial risk for approved provider service networks over a 5-
1054 year ~~3-year~~ period. These policies and guidelines must include
1055 an option for a provider service network to be paid fee-for-

1056 service rates. For any provider service network established in a
1057 managed care pilot area, the option to be paid fee-for-service
1058 rates shall include a savings-settlement mechanism that is
1059 consistent with s. 409.912(43) ~~(44)~~. This model shall be
1060 converted to a risk-adjusted capitated rate no later than the
1061 beginning of the sixth ~~fourth~~ year of operation, and may be
1062 converted earlier at the option of the provider service network.
1063 Federally qualified health centers may be offered an opportunity
1064 to accept or decline a contract to participate in any provider
1065 network for prepaid primary care services.
1066 (l) To implement a system that prohibits capitated managed
1067 care plans, their representatives, and providers employed by or
1068 contracted with the capitated managed care plans from recruiting
1069 persons eligible for or enrolled in Medicaid, from providing
1070 inducements to Medicaid recipients to select a particular
1071 capitated managed care plan, and from prejudicing Medicaid
1072 recipients against other capitated managed care plans. The
1073 system shall require the entity performing choice counseling to
1074 determine if the recipient has made a choice of a plan or has
1075 opted out because of duress, threats, payment to the recipient,
1076 or incentives promised to the recipient by a third party. If the
1077 choice counseling entity determines that the decision to choose
1078 a plan was unlawfully influenced or a plan violated any of the
1079 provisions of s. 409.912(20) ~~(21)~~, the choice counseling entity
1080 shall immediately report the violation to the agency's program
1081 integrity section for investigation. Verification of choice
1082 counseling by the recipient shall include a stipulation that the
1083 recipient acknowledges the provisions of this subsection.

1084 (p) To implement standards for plan compliance, including,
1085 but not limited to, standards for quality assurance and
1086 performance improvement, standards for peer or professional
1087 reviews, grievance policies, and policies for maintaining
1088 program integrity. The agency shall develop a data-reporting
1089 system, seek input from managed care plans in order to establish
1090 requirements for patient-encounter reporting, and ensure that
1091 the data reported is accurate and complete.
1092 1. In performing the duties required under this section,
1093 the agency shall work with managed care plans to establish a
1094 uniform system to measure and monitor outcomes for a recipient
1095 of Medicaid services.
1096 2. The system shall use financial, clinical, and other
1097 criteria based on pharmacy, medical services, and other data
1098 that is related to the provision of Medicaid services,
1099 including, but not limited to:
1100 a. The Health Plan Employer Data and Information Set
1101 (HEDIS) or measures that are similar to HEDIS.
1102 b. Member satisfaction.
1103 c. Provider satisfaction.
1104 d. Report cards on plan performance and best practices.
1105 e. Compliance with the requirements for prompt payment of
1106 claims under ss. 627.613, 641.3155, and 641.513.
1107 f. Utilization and quality data for the purpose of
1108 ensuring access to medically necessary services, including
1109 underutilization or inappropriate denial of services.
1110 3. The agency shall require the managed care plans that
1111 have contracted with the agency to establish a quality assurance

1112 system that incorporates the provisions of s. 409.912(26) ~~(27)~~
1113 and any standards, rules, and guidelines developed by the
1114 agency.
1115 4. The agency shall establish an encounter database in
1116 order to compile data on health services rendered by health care
1117 practitioners who provide services to patients enrolled in
1118 managed care plans in the demonstration sites. The encounter
1119 database shall:
1120 a. Collect the following for each type of patient
1121 encounter with a health care practitioner or facility,
1122 including:
1123 (I) The demographic characteristics of the patient.
1124 (II) The principal, secondary, and tertiary diagnosis.
1125 (III) The procedure performed.
1126 (IV) The date and location where the procedure was
1127 performed.
1128 (V) The payment for the procedure, if any.
1129 (VI) If applicable, the health care practitioner's
1130 universal identification number.
1131 (VII) If the health care practitioner rendering the
1132 service is a dependent practitioner, the modifiers appropriate
1133 to indicate that the service was delivered by the dependent
1134 practitioner.
1135 b. Collect appropriate information relating to
1136 prescription drugs for each type of patient encounter.
1137 c. Collect appropriate information related to health care
1138 costs and utilization from managed care plans participating in
1139 the demonstration sites.

1140 5. To the extent practicable, when collecting the data the
1141 agency shall use a standardized claim form or electronic
1142 transfer system that is used by health care practitioners,
1143 facilities, and payors.
1144 6. Health care practitioners and facilities in the
1145 demonstration sites shall electronically submit, and managed
1146 care plans participating in the demonstration sites shall
1147 electronically receive, information concerning claims payments
1148 and any other information reasonably related to the encounter
1149 database using a standard format as required by the agency.
1150 7. The agency shall establish reasonable deadlines for
1151 phasing in the electronic transmittal of full encounter data.
1152 8. The system must ensure that the data reported is
1153 accurate and complete.
1154 (w) To implement procedures to minimize the risk of
1155 Medicaid fraud and abuse in all plans operating in the Medicaid
1156 managed care pilot program authorized in this section.
1157 1. The agency shall ensure that applicable provisions of
1158 this chapter and chapters 414, 626, 641, and 932 which relate to
1159 Medicaid fraud and abuse are applied and enforced at the
1160 demonstration project sites.
1161 2. Providers must have the certification, license, and
1162 credentials that are required by law and waiver requirements.
1163 3. The agency shall ensure that the plan is in compliance
1164 with s. 409.912 (20) and (21) ~~and (22)~~.
1165 4. The agency shall require that each plan establish
1166 functions and activities governing program integrity in order to

1167 reduce the incidence of fraud and abuse. Plans must report
1168 instances of fraud and abuse pursuant to chapter 641.
1169 5. The plan shall have written administrative and
1170 management arrangements or procedures, including a mandatory
1171 compliance plan, which are designed to guard against fraud and
1172 abuse. The plan shall designate a compliance officer who has
1173 sufficient experience in health care.
1174 6.a. The agency shall require all managed care plan
1175 contractors in the pilot program to report all instances of
1176 suspected fraud and abuse. A failure to report instances of
1177 suspected fraud and abuse is a violation of law and subject to
1178 the penalties provided by law.
1179 b. An instance of fraud and abuse in the managed care
1180 plan, including, but not limited to, defrauding the state health
1181 care benefit program by misrepresentation of fact in reports,
1182 claims, certifications, enrollment claims, demographic
1183 statistics, or patient-encounter data; misrepresentation of the
1184 qualifications of persons rendering health care and ancillary
1185 services; bribery and false statements relating to the delivery
1186 of health care; unfair and deceptive marketing practices; and
1187 false claims actions in the provision of managed care, is a
1188 violation of law and subject to the penalties provided by law.
1189 c. The agency shall require that all contractors make all
1190 files and relevant billing and claims data accessible to state
1191 regulators and investigators and that all such data is linked
1192 into a unified system to ensure consistent reviews and
1193 investigations.

1194 (12) For purposes of this section, the term "capitated
1195 managed care plan" includes health insurers authorized under
1196 chapter 624, exclusive provider organizations authorized under
1197 chapter 627, health maintenance organizations authorized under
1198 chapter 641, the Children's Medical Services Network under
1199 chapter 391, and provider service networks that elect to be paid
1200 fee-for-service for up to 5 ~~3~~ years as authorized under this
1201 section.
1202 Section 15. Subsection (18) is added to section 430.04,
1203 Florida Statutes, to read:
1204 430.04 Duties and responsibilities of the Department of
1205 Elderly Affairs.--The Department of Elderly Affairs shall:
1206 (18) Administer all Medicaid waivers and programs relating
1207 to elders and their appropriations. The waivers include, but are
1208 not limited to, the following:
1209 (a) Alzheimer's Dementia-Specific Medicaid Waiver as
1210 defined in s. 430.502(7),(8), and (9).
1211 (b) Assisted Living for the Elderly Medicaid waiver.
1212 (c) Aged and Disabled Adult Medicaid waiver.
1213 (d) Adult Day Health Care waiver.
1214 (e) Consumer-Directed Care Plus Program as defined in s.
1215 409.221.
1216 (f) Program for All-inclusive Care for the Elderly.
1217 (g) Long-Term Care Community-Based Diversion Project as
1218 defined in s. 430.705.
1219 (h) Channeling services waiver for frail elders.
1220 Section 16. Section 430.707, Florida Statutes, is amended
1221 to read:

1222 430.707 Contracts.--
1223 (1) The department, in consultation with the agency, shall
1224 select and contract with managed care organizations and, on a
1225 prepaid basis, with other qualified providers as defined in s.
1226 430.703(7) to provide long-term care within community diversion
1227 pilot project areas. All providers shall report quarterly to the
1228 department regarding the entity's compliance with all the
1229 financial and quality assurance requirements of the contract.
1230 (2) The department, in consultation with the agency, may
1231 contract with entities <u>that</u> ~~which~~ have submitted an application
1232 as a community nursing home diversion project as of July 1,
1233 1998, to provide benefits pursuant to the "Program of All-
1234 inclusive Care for the Elderly" as established in Pub. L. No.
1235 105-33. For the purposes of this community nursing home
1236 diversion project, such entities <u>are</u> ~~shall be~~ exempt from the
1237 requirements of chapter 641~~,~~ if the entity is a private,
1238 nonprofit, superior-rated nursing home <u>and if</u> ~~with~~ at least 50
1239 percent of its residents <u>are</u> eligible for Medicaid. <u>The agency,</u>
1240 <u>in consultation with the department, shall accept and forward to</u>
1241 <u>the Centers for Medicare and Medicaid Services an application</u>
1242 <u>for expansion of the pilot project from an entity that provides</u>
1243 <u>benefits pursuant to the Program of All-inclusive Care for the</u>
1244 <u>Elderly and that is in good standing with the agency, the</u>
1245 <u>department, and the Centers for Medicare and Medicaid Services.</u>
1246 Section 17. Paragraph (d) of subsection (1) of section
1247 408.040, Florida Statutes, is amended to read:
1248 408.040 Conditions and monitoring.--
1249 (1)

1250 (d) If a nursing home is located in a county in which a
1251 long-term care community diversion pilot project has been
1252 implemented under s. 430.705 ~~or in a county in which an~~
1253 ~~integrated, fixed-payment delivery program for Medicaid~~
1254 ~~recipients who are 60 years of age or older or dually eligible~~
1255 ~~for Medicare and Medicaid has been implemented under s.~~
1256 ~~409.912(5)~~, the nursing home may request a reduction in the
1257 percentage of annual patient days used by residents who are
1258 eligible for care under Title XIX of the Social Security Act,
1259 which is a condition of the nursing home's certificate of need.
1260 The agency shall automatically grant the nursing home's request
1261 if the reduction is not more than 15 percent of the nursing
1262 home's annual Medicaid-patient-days condition. A nursing home
1263 may submit only one request every 2 years for an automatic
1264 reduction. A requesting nursing home must notify the agency in
1265 writing at least 60 days in advance of its intent to reduce its
1266 annual Medicaid-patient-days condition by not more than 15
1267 percent. The agency must acknowledge the request in writing and
1268 must change its records to reflect the revised certificate-of-
1269 need condition. This paragraph expires June 30, 2011.
1270 Section 18. Subsection (4) of section 409.91195, Florida
1271 Statutes, is amended to read:
1272 409.91195 Medicaid Pharmaceutical and Therapeutics
1273 Committee.--There is created a Medicaid Pharmaceutical and
1274 Therapeutics Committee within the agency for the purpose of
1275 developing a Medicaid preferred drug list.
1276 (4) Upon recommendation of the committee, the agency shall
1277 adopt a preferred drug list as described in s. 409.912(38)~~(39)~~.

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

V

1278 To the extent feasible, the committee shall review all drug
1279 classes included on the preferred drug list every 12 months, and
1280 may recommend additions to and deletions from the preferred drug
1281 list, such that the preferred drug list provides for medically
1282 appropriate drug therapies for Medicaid patients which achieve
1283 cost savings contained in the General Appropriations Act.
1284 Section 19. Subsection (1) of section 409.91196, Florida
1285 Statutes, is amended to read:
1286 409.91196 Supplemental rebate agreements; public records
1287 and public meetings exemption.--
1288 (1) The rebate amount, percent of rebate, manufacturer's
1289 pricing, and supplemental rebate, and other trade secrets as
1290 defined in s. 688.002 that the agency has identified for use in
1291 negotiations, held by the Agency for Health Care Administration
1292 under s. 409.912<u>(38)</u>~~(39)~~(a)7. are confidential and exempt from
1293 s. 119.07(1) and s. 24(a), Art. I of the State Constitution.
1294 Section 20. Subsection (4) of section 641.386, Florida
1295 Statutes, is amended to read:
1296 641.386 Agent licensing and appointment required;
1297 exceptions.--
1298 (4) All agents and health maintenance organizations shall
1299 comply with and be subject to the applicable provisions of ss.
1300 641.309 and 409.912<u>(20)</u>~~(21)~~, and all companies and entities
1301 appointing agents shall comply with s. 626.451, when marketing
1302 for any health maintenance organization licensed pursuant to
1303 this part, including those organizations under contract with the
1304 Agency for Health Care Administration to provide health care
1305 services to Medicaid recipients or any private entity providing

1306 health care services to Medicaid recipients pursuant to a
1307 prepaid health plan contract with the Agency for Health Care
1308 Administration.
1309 Section 21. This act shall take effect July 1, 2009.