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1 A bill to be entitled
2 An act relating to health care; creating s. 395.7017,
3 F.S.; authorizing the Agency for Health Care
4 Administration to adopt rules related to the Public
5 Medical Assistance Trust Fund; amending s. 409.815,
6 F.S.; revising behavioral health services and dental
7 services coverage under the Kidcare program; revising
8 methods by which payments are made to federally
9 qualified health centers and rural health clinics;
10 amending s. 409.818, F.S.; revising the manner by
11 which quality assurance and access standards are
12 monitored in the Kidcare program; amending s. 409.904,
13 F.S.; revising the expiration date of provisions
14 authorizing the federal waiver for certain persons age
15 65 and over or who have a disability; revising the
16 expiration date of provisions authorizing a specified
17 medically needy program; amending s. 409.905, F.S.;
18 authorizing the Agency for Health Care Administration
19 to require prior authorization of care based on
20 utilization rates; requiring a home health agency to
21 submit a plan of care and documentation of a
22 recipient's medical condition to the Agency for Health
23 Care Administration when requesting prior
24 authorization; prohibiting the Agency for Health Care
25 Administration from paying for home health services
26 unless specified requirements are satisfied; revising
27 the criteria for adjusting a hospital's inpatient per
28 diem rate; amending s. 409.906, F.S., relating to
29 optional Medicaid services; providing limitations on

30 the provision of adult vision services; amending s.
31 409.9082, F.S.; authorizing an exemption from the
32 nursing home quality assessment to a nursing facility
33 that has a certain number of indigent census days;
34 revising the purposes of the use of quality assessment
35 and federal matching funds; deleting an option for
36 discontinuing the nursing home quality assessment;
37 creating s. 409.9083, F.S.; providing definitions;
38 providing for a quality assessment to be imposed upon
39 privately operated intermediate care facility
40 providers for the developmentally disabled; requiring
41 the agency to calculate the quality assessment rate
42 annually; providing requirements for reporting and
43 collecting the assessment; specifying the purposes of
44 the assessment and an order of priority; requiring
45 that the agency seek federal authorization to
46 implement the act; specifying circumstances requiring
47 discontinuance of the quality assessment; authorizing
48 the agency to impose certain penalties against
49 providers that fail to pay the assessment; requiring
50 the agency to adopt rules; providing for future
51 repeal; amending s. 409.911, F.S.; updating the data
52 to be used in calculating disproportionate share;
53 providing a formula for payment of disproportionate
54 share dollars to provider service network hospitals;
55 amending s. 409.9112, F.S.; continuing the prohibition
56 against distributing moneys under the perinatal
57 intensive care centers disproportionate share program;
58 amending s. 409.9113, F.S.; continuing authorization

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59 for the distribution of moneys to teaching hospitals
60 under the disproportionate share program; amending s.
61 409.9117, F.S.; continuing the prohibition against
62 distributing moneys for the primary care
63 disproportionate share program; amending s. 409.9119,
64 F.S.; authorizing the agency to make disproportionate
65 share payments to certain hospitals; amending s.
66 409.912, F.S.; providing that the continuance of the
67 integrated, fixed-payment delivery pilot program for
68 certain elderly or dually eligible recipients is
69 contingent upon an appropriation; providing that
70 certain providers be paid in accordance with the
71 appropriate fee schedule for services provided to
72 eligible Medicaid recipients; authorizing the agency
73 to seek waiver authority; amending s. 409.91211, F.S.;
74 revising the timeline for phasing in financial risk
75 for provider service networks; amending s. 409.9122,
76 F.S.; revising and clarifying the procedure for a
77 Medicaid recipient to change managed care plans or
78 MediPass providers; amending s. 409.916, F.S.;
79 requiring that quality assessment fees received from
80 Medicaid providers be deposited into the Grants and
81 Donations Trust Fund; amending s. 430.04, F.S.;
82 requiring the Department of Elderly Affairs to
83 administer all Medicaid waivers and programs relating
84 to elders; amending s. 430.707, F.S.; requiring the
85 agency, in consultation with the Department of Elderly
86 Affairs, to accept and forward to the Centers for
87 Medicare and Medicaid Services an application for

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88 expansion of a pilot project from an entity that
89 provides certain benefits under a federal program;
90 requiring the agency, in consultation with the
91 Department of Elderly Affairs, to contract with a
92 hospice organization to be a site for the Program of
93 All-inclusive Care for the Elderly; directing the
94 Agency for Health Care Administration to establish
95 pilot projects in Miami-Dade County relating to home
96 health services; providing an effective date.
97
98 Be It Enacted by the Legislature of the State of Florida:
99
100 Section 1. Section 395.7017, Florida Statutes, is created
101 to read:
102 395.7017 Rulemaking authority.—The agency may adopt rules
103 pursuant to ss. 120.536 and 120.54 to implement the provisions
104 of this part, which shall include the authority to define terms
105 and determine the date of imposition and the determination of
106 the process for determination, collection, and imposition of the
107 Public Medical Assistance Trust Fund assessment and related
108 fines.
109 Section 2. Paragraphs (g) and (q) of subsection (2) of
110 section 409.815, Florida Statutes, are amended, and paragraph
111 (w) is added to that subsection, to read:
112 409.815 Health benefits coverage; limitations.—
113 (2) BENCHMARK BENEFITS.—In order for health benefits
114 coverage to qualify for premium assistance payments for an
115 eligible child under ss. 409.810-409.820, the health benefits
116 coverage, except for coverage under Medicaid and Medikids, must

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117 include the following minimum benefits, as medically necessary.
118 (g) *Behavioral health services.*—
119 1. Mental health benefits include:
120 a. Inpatient services, limited to ~~not more than~~ 30
121 inpatient days per contract year for psychiatric admissions, or
122 residential services in facilities licensed under s. 394.875(6)
123 or s. 395.003 in lieu of inpatient psychiatric admissions;
124 however, a minimum of 10 of the 30 days shall be available only
125 for inpatient psychiatric services if ~~when~~ authorized by a
126 physician; and
127 b. Outpatient services, including outpatient visits for
128 psychological or psychiatric evaluation, diagnosis, and
129 treatment by a licensed mental health professional, limited to ~~a~~
130 ~~maximum of~~ 40 outpatient visits each contract year.
131 2. Substance abuse services include:
132 a. Inpatient services, limited to ~~not more than~~ 7 inpatient
133 days per contract year for medical detoxification only and 30
134 days of residential services; and
135 b. Outpatient services, including evaluation, diagnosis,
136 and treatment by a licensed practitioner, limited to ~~a maximum~~
137 ~~of~~ 40 outpatient visits per contract year.
138
139 Effective October 1, 2009, covered services include inpatient
140 and outpatient services for mental and nervous disorders as
141 defined in the most recent edition of the Diagnostic and
142 Statistical Manual of Mental Disorders published by the American
143 Psychiatric Association. Such benefits include psychological or
144 psychiatric evaluation, diagnosis, and treatment by a licensed
145 mental health professional and inpatient, outpatient, and

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146 residential treatment of substance abuse disorders. Any benefit
147 limitations, including duration of services, number of visits,
148 or number of days for hospitalization or residential services,
149 shall not be any less favorable than those for physical
150 illnesses generally. The program may also implement appropriate
151 financial incentives, peer review, utilization requirements, and
152 other methods used for the management of benefits provided for
153 other medical conditions in order to reduce service costs and
154 utilization without compromising quality of care.
155 (q) *Dental services.*—Effective October 1, 2009, dental
156 services shall be covered as required under federal law and may
157 also include those dental benefits provided to children by the
158 Florida Medicaid program under s. 409.906(6).
159 (w) *Reimbursement of federally qualified health centers and*
160 *rural health clinics.*—Effective October 1, 2009, payments for
161 services provided to enrollees by federally qualified health
162 centers and rural health clinics under this section shall be
163 reimbursed using the Medicaid Prospective Payment System as
164 provided for under s. 2107(e)(1)(D) of the Social Security Act.
165 If such services are paid for by health insurers or health care
166 providers under contract with the Florida Healthy Kids
167 Corporation, such entities are responsible for this payment. The
168 agency may seek any available federal grants to assist with this
169 transition.
170 Section 3. Paragraph (c) of subsection (3) of section
171 409.818, Florida Statutes, is amended to read:
172 409.818 Administration.—In order to implement ss. 409.810-
173 409.820, the following agencies shall have the following duties:
174 (3) The Agency for Health Care Administration, under the

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175 authority granted in s. 409.914(1), shall:
176 (c) Monitor compliance with quality assurance and access
177 standards developed under s. 409.820 and in accordance with s.
178 2103(f) of the Social Security Act, 42 U.S.C. 1397cc(f).
179
180 The agency is designated the lead state agency for Title XXI of
181 the Social Security Act for purposes of receipt of federal
182 funds, for reporting purposes, and for ensuring compliance with
183 federal and state regulations and rules.
184 Section 4. Subsections (1) and (2) of section 409.904,
185 Florida Statutes, are amended to read:
186 409.904 Optional payments for eligible persons.—The agency
187 may make payments for medical assistance and related services on
188 behalf of the following persons who are determined to be
189 eligible subject to the income, assets, and categorical
190 eligibility tests set forth in federal and state law. Payment on
191 behalf of these Medicaid eligible persons is subject to the
192 availability of moneys and any limitations established by the
193 General Appropriations Act or chapter 216.
194 (1) Effective January 1, 2006, and Subject to federal
195 waiver approval, a person who is age 65 or older or is
196 determined to be disabled, whose income is at or below 88
197 percent of the federal poverty level, whose assets do not exceed
198 established limitations, and who is not eligible for Medicare
199 or, if eligible for Medicare, is also eligible for and receiving
200 Medicaid-covered institutional care services, hospice services,
201 or home and community-based services. The agency shall seek
202 federal authorization through a waiver to provide this coverage.
203 This subsection expires December 31, 2010 ~~June 30, 2009~~.

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204 (2)(a) A family, a pregnant woman, a child under age 21, a
205 person age 65 or over, or a blind or disabled person, who would
206 be eligible under any group listed in s. 409.903(1), (2), or
207 (3), except that the income or assets of such family or person
208 exceed established limitations. For a family or person in one of
209 these coverage groups, medical expenses are deductible from
210 income in accordance with federal requirements in order to make
211 a determination of eligibility. A family or person eligible
212 under the coverage known as the "medically needy," is eligible
213 to receive the same services as other Medicaid recipients, with
214 the exception of services in skilled nursing facilities and
215 intermediate care facilities for the developmentally disabled.
216 This paragraph ~~subsection~~ expires December 31, 2010 ~~June 30,~~
217 ~~2009~~.
218 (b) Effective January 1, 2011 ~~July 1, 2009~~, a pregnant
219 woman or a child younger than 21 years of age who would be
220 eligible under any group listed in s. 409.903, except that the
221 income or assets of such group exceed established limitations.
222 For a person in one of these coverage groups, medical expenses
223 are deductible from income in accordance with federal
224 requirements in order to make a determination of eligibility. A
225 person eligible under the coverage known as the "medically
226 needy" is eligible to receive the same services as other
227 Medicaid recipients, with the exception of services in skilled
228 nursing facilities and intermediate care facilities for the
229 developmentally disabled.
230 Section 5. Subsections (4) and (5) of section 409.905,
231 Florida Statutes, are amended to read:
232 409.905 Mandatory Medicaid services.—The agency may make

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233 payments for the following services, which are required of the
234 state by Title XIX of the Social Security Act, furnished by
235 Medicaid providers to recipients who are determined to be
236 eligible on the dates on which the services were provided. Any
237 service under this section shall be provided only when medically
238 necessary and in accordance with state and federal law.
239 Mandatory services rendered by providers in mobile units to
240 Medicaid recipients may be restricted by the agency. Nothing in
241 this section shall be construed to prevent or limit the agency
242 from adjusting fees, reimbursement rates, lengths of stay,
243 number of visits, number of services, or any other adjustments
244 necessary to comply with the availability of moneys and any
245 limitations or directions provided for in the General
246 Appropriations Act or chapter 216.
247 (4) HOME HEALTH CARE SERVICES.—The agency shall pay for
248 nursing and home health aide services, supplies, appliances, and
249 durable medical equipment, necessary to assist a recipient
250 living at home. An entity that provides services pursuant to
251 this subsection shall be licensed under part III of chapter 400.
252 These services, equipment, and supplies, or reimbursement
253 therefor, may be limited as provided in the General
254 Appropriations Act and do not include services, equipment, or
255 supplies provided to a person residing in a hospital or nursing
256 facility.
257 (a) In providing home health care services, the agency may
258 require prior authorization of care based on diagnosis,
259 utilization rates, or billing rates. The agency shall require
260 prior authorization for visits for home health services that are
261 not associated with a skilled nursing visit when the home health

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262 agency billing rates exceed the state average by 50 percent or
263 more. The home health agency must submit the recipient's plan of
264 care and documentation that supports the recipient's diagnosis
265 to the agency when requesting prior authorization.
266 (b) The agency shall implement a comprehensive utilization
267 management program that requires prior authorization of all
268 private duty nursing services, an individualized treatment plan
269 that includes information about medication and treatment orders,
270 treatment goals, methods of care to be used, and plans for care
271 coordination by nurses and other health professionals. The
272 utilization management program shall also include a process for
273 periodically reviewing the ongoing use of private duty nursing
274 services. The assessment of need shall be based on a child's
275 condition, family support and care supplements, a family's
276 ability to provide care, and a family's and child's schedule
277 regarding work, school, sleep, and care for other family
278 dependents. When implemented, the private duty nursing
279 utilization management program shall replace the current
280 authorization program used by the Agency for Health Care
281 Administration and the Children's Medical Services program of
282 the Department of Health. The agency may competitively bid on a
283 contract to select a qualified organization to provide
284 utilization management of private duty nursing services. The
285 agency is authorized to seek federal waivers to implement this
286 initiative.
287 (c) The agency may not pay for home health services unless
288 the services are medically necessary and:
289 1. The services are ordered by a physician.
290 2. The written prescription for the services is signed and

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291 dated by the recipient's physician before the development of a
292 plan of care and before any request requiring prior
293 authorization.
294 3. The physician ordering the services is not employed,
295 under contract with, or otherwise affiliated with the home
296 health agency rendering the services. However, this subparagraph
297 does not apply to a home health agency affiliated with a
298 retirement community, of which the parent corporation or a
299 related legal entity owns a rural health clinic certified under
300 42 C.F.R. part 491, subpart A, ss. 1-11, a nursing home licensed
301 under part II of chapter 400, or an apartment or single-family
302 home for independent living. For purposes of this subparagraph,
303 the agency may, on a case-by-case basis, provide an exception
304 for medically fragile children who are younger than 21 years of
305 age.
306 4. The physician ordering the services has examined the
307 recipient within the 30 days preceding the initial request for
308 the services and biannually thereafter.
309 5. The written prescription for the services includes the
310 recipient's acute or chronic medical condition or diagnosis, the
311 home health service required, and, for skilled nursing services,
312 the frequency and duration of the services.
313 6. The national provider identifier, Medicaid
314 identification number, or medical practitioner license number of
315 the 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 (5) HOSPITAL INPATIENT SERVICES.—The agency shall pay for
319 all covered services provided for the medical care and treatment

of a recipient who is admitted as an inpatient by a licensed physician or dentist to a hospital licensed under part I of chapter 395. However, the agency shall limit the payment for inpatient hospital services for a Medicaid recipient 21 years of age or older to 45 days or the number of days necessary to comply with the General Appropriations Act.

(c) The agency ~~for Health Care Administration~~ shall adjust a hospital’s current inpatient per diem rate to reflect the cost of serving the Medicaid population at that institution if:

1. The hospital experiences an increase in Medicaid caseload by more than 25 percent in any year, primarily resulting from the closure of a hospital in the same service area occurring after July 1, 1995;

2. The hospital’s Medicaid per diem rate is at least 25 percent below the Medicaid per patient cost for that year; or

3. The hospital is located in a county that has six ~~five~~ or fewer general acute care hospitals, began offering obstetrical services on or after September 1999, and has submitted a request in writing to the agency for a rate adjustment after July 1, 2000, but before September 30, 2000, in which case such hospital’s Medicaid inpatient per diem rate shall be adjusted to cost, effective July 1, 2002.

By ~~No later than~~ October 1 of each year, the agency must provide estimated costs for any adjustment in a hospital inpatient per diem rate ~~pursuant to this paragraph~~ to the Executive Office of the Governor, the House of Representatives General Appropriations Committee, and the Senate Appropriations Committee. Before the agency implements a change in a hospital’s

349 inpatient per diem rate pursuant to this paragraph, the
350 Legislature must have specifically appropriated sufficient funds
351 in the General Appropriations Act to support the increase in
352 cost as estimated by the agency.
353 Section 6. Subsection (23) of section 409.906, Florida
354 Statutes, is amended to read:
355 409.906 Optional Medicaid services.—Subject to specific
356 appropriations, the agency may make payments for services which
357 are optional to the state under Title XIX of the Social Security
358 Act and are furnished by Medicaid providers to recipients who
359 are determined to be eligible on the dates on which the services
360 were provided. Any optional service that is provided shall be
361 provided only when medically necessary and in accordance with
362 state and federal law. Optional services rendered by providers
363 in mobile units to Medicaid recipients may be restricted or
364 prohibited by the agency. Nothing in this section shall be
365 construed to prevent or limit the agency from adjusting fees,
366 reimbursement rates, lengths of stay, number of visits, or
367 number of services, or making any other adjustments necessary to
368 comply with the availability of moneys and any limitations or
369 directions provided for in the General Appropriations Act or
370 chapter 216. If necessary to safeguard the state's systems of
371 providing services to elderly and disabled persons and subject
372 to the notice and review provisions of s. 216.177, the Governor
373 may direct the Agency for Health Care Administration to amend
374 the Medicaid state plan to delete the optional Medicaid service
375 known as "Intermediate Care Facilities for the Developmentally
376 Disabled." Optional services may include:
377 (23) VISUAL SERVICES.—The agency may pay for visual

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378 examinations, eyeglasses, and eyeglass repairs for a recipient
379 if they are prescribed by a licensed physician specializing in
380 diseases of the eye or by a licensed optometrist. Eyeglass
381 frames ~~Eyeglasses~~ for adult recipients shall be limited to one
382 pair ~~two pairs per year~~ per recipient every 2 years, except a
383 second ~~third~~ pair may be provided during that period after prior
384 authorization. Eyeglass lenses for adult recipients shall be
385 limited to one pair per year except a second pair may be
386 provided during that period after prior authorization.
387 Section 7. Paragraph (d) is added to subsection (3) of
388 section 409.9082, Florida Statutes, as created by section 1 of
389 chapter 2009-4, Laws of Florida, and subsections (4) and (6) of
390 that section are amended, to read:
391 409.9082 Quality assessment on nursing home facility
392 providers; exemptions; purpose; federal approval required;
393 remedies.—
394 (3)
395 (d) Effective July 1, 2009, the agency may exempt from the
396 quality assessment or apply a lower quality assessment rate to a
397 qualified public, nonstate-owned or operated nursing home
398 facility whose total annual indigent census days are greater
399 than 25 percent of the facility's total annual census days.
400 (4) The purpose of the nursing home facility quality
401 assessment is to ensure continued quality of care. Collected
402 assessment funds shall be used to obtain federal financial
403 participation through the Medicaid program to make Medicaid
404 payments for nursing home facility services up to the amount of
405 nursing home facility Medicaid rates as calculated in accordance
406 with the approved state Medicaid plan in effect on December 31,

407 2007. The quality assessment and federal matching funds shall be
408 used exclusively for the following purposes and in the following
409 order of priority:
410 (a) To reimburse the Medicaid share of the quality
411 assessment as a pass-through, Medicaid-allowable cost;
412 (b) To increase to each nursing home facility’s Medicaid
413 rate, as needed, an amount that restores the rate reductions
414 implemented January 1, 2008, ~~and~~ January 1, 2009, and March 1,
415 2009;
416 (c) To increase to each nursing home facility’s Medicaid
417 rate, as needed, an amount that restores any rate reductions for
418 the 2009-2010 ~~2008-2009~~ fiscal year; and
419 (d) To increase each nursing home facility’s Medicaid rate
420 that accounts for the portion of the total assessment not
421 included in paragraphs (a)-(c) which begins a phase-in to a
422 pricing model for the operating cost component.
423 (6) The quality assessment shall terminate and the agency
424 shall discontinue the imposition, assessment, and collection of
425 the nursing facility quality assessment if ~~any of the following~~
426 ~~occur:~~
427 ~~(a)~~ the agency does not obtain necessary federal approval
428 for the nursing home facility quality assessment or the payment
429 rates required by subsection (4)~~; or~~
430 ~~(b) The weighted average Medicaid rate paid to nursing home~~
431 ~~facilities is reduced below the weighted average Medicaid rate~~
432 ~~to nursing home facilities in effect on December 31, 2008, plus~~
433 ~~any future annual amount of the quality assessment and the~~
434 ~~applicable matching federal funds~~. Upon termination ~~of the~~
435 ~~quality assessment~~, all collected assessment revenues, less any

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436 amounts expended by the agency, shall be returned on a pro rata
437 basis to the nursing facilities that paid them.
438 Section 8. Section 409.9083, Florida Statutes, is created
439 to read:
440 409.9083 Quality assessment on privately operated
441 intermediate care facilities for the developmentally disabled;
442 exemptions; purpose; federal approval required; remedies.—
443 (1) As used in this section, the term:
444 (a) "Intermediate care facility for the developmentally
445 disabled" or "ICF/DD" means a privately operated intermediate
446 care facility for the developmentally disabled licensed under
447 part VIII of chapter 400.
448 (b) "Net patient service revenue" means gross revenues from
449 services provided to ICF/DD facility residents, less reductions
450 from gross revenue resulting from an inability to collect
451 payment of charges. Net patient service revenue excludes
452 nonresident care revenues such as gain or loss on asset
453 disposal, prior year revenue, donations, and physician billings,
454 and all outpatient revenues. Reductions from gross revenue
455 include bad debts; contractual adjustments; uncompensated care;
456 administrative, courtesy, and policy discounts and adjustments;
457 and other such revenue deductions.
458 (c) "Resident day" means a calendar day of care provided to
459 an ICF/DD facility resident, including the day of admission and
460 excluding the day of discharge, except that, when admission and
461 discharge occur on the same day, 1 day of care exists.
462 (2) Effective October 1, 2009, there is imposed upon each
463 intermediate care facility for the developmentally disabled a
464 quality assessment. The aggregated amount of assessments for all

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465 ICF/DDs in a given year shall be an amount not exceeding the
466 maximum percentage allowed under federal law of the total
467 aggregate net patient service revenue of assessed facilities.
468 The agency shall calculate the quality assessment rate annually
469 on a per-resident-day basis as reported by the facilities. The
470 per-resident-day assessment rate shall be uniform. Each facility
471 shall report monthly to the agency its total number of resident
472 days and shall remit an amount equal to the assessment rate
473 times the reported number of days. The agency shall collect, and
474 each facility shall pay, the quality assessment each month. The
475 agency shall collect the assessment from facility providers no
476 later than the 15th of the next succeeding calendar month. The
477 agency shall notify providers of the quality assessment rate and
478 provide a standardized form to complete and submit with
479 payments. The collection of the quality assessment shall
480 commence no sooner than 15 days after the agency's initial
481 payment to the facilities that implement the increased Medicaid
482 rates containing the elements prescribed in subsection (3) and
483 monthly thereafter. Intermediate care facilities for the
484 developmentally disabled may increase their rates to incorporate
485 the assessment but may not create a separate line-item charge
486 for the purpose of passing through the assessment to residents.
487 (3) The purpose of the facility quality assessment is to
488 ensure continued quality of care. Collected assessment funds
489 shall be used to obtain federal financial participation through
490 the Medicaid program to make Medicaid payments for ICF/DD
491 services up to the amount of the Medicaid rates for such
492 facilities as calculated in accordance with the approved state
493 Medicaid plan in effect on April 1, 2008. The quality assessment

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494 and federal matching funds shall be used exclusively for the
495 following purposes and in the following order of priority to:
496 (a) Reimburse the Medicaid share of the quality assessment
497 as a pass-through, Medicaid-allowable cost.
498 (b) Increase each privately operated ICF/DD Medicaid rate,
499 as needed, by an amount that restores the rate reductions
500 implemented on October 1, 2008.
501 (c) Increase each ICF/DD Medicaid rate, as needed, by an
502 amount that restores any rate reductions for the 2008-2009
503 fiscal year and the 2009-2010 fiscal year.
504 (d) Increase payments to such facilities to fund covered
505 services to Medicaid beneficiaries.
506 (4) The agency shall seek necessary federal approval in the
507 form of state plan amendments in order to implement the
508 provisions of this section.
509 (5)(a) The quality assessment shall terminate and the
510 agency shall discontinue the imposition, assessment, and
511 collection of the quality assessment if the agency does not
512 obtain necessary federal approval for the facility quality
513 assessment or the payment rates required by subsection (3).
514 (b) Upon termination of the quality assessment, all
515 collected assessment revenues, less any amounts expended by the
516 agency, shall be returned on a pro rata basis to the facilities
517 that paid such assessments.
518 (6) The agency may seek any of the following remedies for
519 failure of any ICF/DD provider to timely pay its assessment:
520 (a) Withholding any medical assistance reimbursement
521 payments until the assessment amount is recovered.
522 (b) Suspending or revoking the facility’s license.

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523 (c) Imposing a fine of up to $1,000 per day for each
524 delinquent payment, not to exceed the amount of the assessment.
525 (7) The agency shall adopt rules necessary to administer
526 this section.
527 (8) This section is repealed October 1, 2011.
528 Section 9. Paragraph (a) of subsection (2) of section
529 409.911, Florida Statutes, is amended, present subsections (5),
530 (6), (7), (8), and (9) are renumbered as subsections (6), (7),
531 (8), (9), and (10), respectively, and a new subsection (5) is
532 added to that section, to read:
533 409.911 Disproportionate share program.—Subject to specific
534 allocations established within the General Appropriations Act
535 and any limitations established pursuant to chapter 216, the
536 agency shall distribute, pursuant to this section, moneys to
537 hospitals providing a disproportionate share of Medicaid or
538 charity care services by making quarterly Medicaid payments as
539 required. Notwithstanding the provisions of s. 409.915, counties
540 are exempt from contributing toward the cost of this special
541 reimbursement for hospitals serving a disproportionate share of
542 low-income patients.
543 (2) The agency for Health Care Administration shall use the
544 following actual audited data to determine the Medicaid days and
545 charity care to be used in calculating the disproportionate
546 share payment:
547 (a) The average of the ~~2002,~~ 2003, ~~and~~ 2004, and 2005
548 audited disproportionate share data to determine each hospital's
549 Medicaid days and charity care for the 2009-2010 ~~2008-2009~~ state
550 fiscal year.
551 (5) The following formula shall be used to pay

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552 disproportionate share dollars to provider service network (PSN)
553 hospitals:
554 DSHP = TAAPSNH X (IHPSND X THPSND)
555 Where:
556 DSHP = Disproportionate share hospital payments.
557 TAAPSNH = Total amount available for PSN hospitals.
558 IHPSND = Individual hospital PSN days.
559 THPSND = Total of all hospital PSN days.
560
561 For purposes of this paragraph, the PSN inpatient days shall be
562 provided in the General Appropriations Act.
563 Section 10. Section 409.9112, Florida Statutes, is amended
564 to read:
565 409.9112 Disproportionate share program for regional
566 perinatal intensive care centers.—In addition to the payments
567 made under s. 409.911, the agency for Health Care Administration
568 shall design and implement a system for of making
569 disproportionate share payments to those hospitals that
570 participate in the regional perinatal intensive care center
571 program established pursuant to chapter 383. The This system of
572 payments must shall conform to with federal requirements and
573 shall distribute funds in each fiscal year for which an
574 appropriation is made by making quarterly Medicaid payments.
575 Notwithstanding the provisions of s. 409.915, counties are
576 exempt from contributing toward the cost of this special
577 reimbursement for hospitals serving a disproportionate share of
578 low-income patients. For the 2009-2010 state fiscal year 2008-
579 2009, the agency may shall not distribute moneys under the
580 regional perinatal intensive care centers disproportionate share

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581 program.
582 (1) The following formula shall be used by the agency to
583 calculate the total amount earned for hospitals that participate
584 in the regional perinatal intensive care center program:
585 TAE = HDSP/THDSP
586
587 Where:
588 TAE = total amount earned by a regional perinatal intensive
589 care center.
590 HDSP = the prior state fiscal year regional perinatal
591 intensive care center disproportionate share payment to the
592 individual hospital.
593 THDSP = the prior state fiscal year total regional
594 perinatal intensive care center disproportionate share payments
595 to all hospitals.
596 (2) The total additional payment for hospitals that
597 participate in the regional perinatal intensive care center
598 program shall be calculated by the agency as follows:
599 TAP = TAE x TA
600
601 Where:
602 TAP = total additional payment for a regional perinatal
603 intensive care center.
604 TAE = total amount earned by a regional perinatal intensive
605 care center.
606 TA = total appropriation for the regional perinatal
607 intensive care center disproportionate share program.
608 (3) In order to receive payments under this section, a
609 hospital must be participating in the regional perinatal

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610 intensive care center program pursuant to chapter 383 and must
611 meet the following additional requirements:
612 (a) Agree to conform to all departmental and agency
613 requirements to ensure high quality in the provision of
614 services, including criteria adopted by departmental and agency
615 rule concerning staffing ratios, medical records, standards of
616 care, equipment, space, and such other standards and criteria as
617 the department and agency deem appropriate as specified by rule.
618 (b) Agree to provide information to the department and
619 agency, in a form and manner to be prescribed by rule of the
620 department and agency, concerning the care provided to all
621 patients in neonatal intensive care centers and high-risk
622 maternity care.
623 (c) Agree to accept all patients for neonatal intensive
624 care and high-risk maternity care, regardless of ability to pay,
625 on a functional space-available basis.
626 (d) Agree to develop arrangements with other maternity and
627 neonatal care providers in the hospital's region for the
628 appropriate receipt and transfer of patients in need of
629 specialized maternity and neonatal intensive care services.
630 (e) Agree to establish and provide a developmental
631 evaluation and services program for certain high-risk neonates,
632 as prescribed and defined by rule of the department.
633 (f) Agree to sponsor a program of continuing education in
634 perinatal care for health care professionals within the region
635 of the hospital, as specified by rule.
636 (g) Agree to provide backup and referral services to the
637 ~~department's~~ county health departments and other low-income
638 perinatal providers within the hospital's region, including the

639 development of written agreements between these organizations
640 and the hospital.
641 (h) Agree to arrange for transportation for high-risk
642 obstetrical patients and neonates in need of transfer from the
643 community to the hospital or from the hospital to another more
644 appropriate facility.
645 (4) Hospitals which fail to comply with any of the
646 conditions in subsection (3) or the applicable rules of the
647 department and agency may ~~shall~~ not receive any payments under
648 this section until full compliance is achieved. A hospital which
649 is not in compliance in two or more consecutive quarters may
650 ~~shall~~ not receive its share of the funds. Any forfeited funds
651 shall be distributed by the remaining participating regional
652 perinatal intensive care center program hospitals.
653 Section 11. Section 409.9113, Florida Statutes, is amended
654 to read:
655 409.9113 Disproportionate share program for teaching
656 hospitals.—In addition to the payments made under ss. 409.911
657 and 409.9112, the agency ~~for Health Care Administration~~ shall
658 make disproportionate share payments to statutorily defined
659 teaching hospitals for their increased costs associated with
660 medical education programs and for tertiary health care services
661 provided to the indigent. This system of payments must ~~shall~~
662 conform to ~~with~~ federal requirements and ~~shall~~ distribute funds
663 in each fiscal year for which an appropriation is made by making
664 quarterly Medicaid payments. Notwithstanding s. 409.915,
665 counties are exempt from contributing toward the cost of this
666 special reimbursement for hospitals serving a disproportionate
667 share of low-income patients. For the 2009-2010 state fiscal

668 year ~~2008-2009~~, the agency shall distribute the moneys provided
669 in the General Appropriations Act to statutorily defined
670 teaching hospitals and family practice teaching hospitals under
671 the teaching hospital disproportionate share program. The funds
672 provided for statutorily defined teaching hospitals shall be
673 distributed in the same proportion as the state fiscal year
674 2003-2004 teaching hospital disproportionate share funds were
675 distributed or as otherwise provided in the General
676 Appropriations Act. The funds provided for family practice
677 teaching hospitals shall be distributed equally among family
678 practice teaching hospitals.
679 (1) On or before September 15 of each year, the agency ~~for~~
680 ~~Health Care Administration~~ shall calculate an allocation
681 fraction to be used for distributing funds to state statutory
682 teaching hospitals. Subsequent to the end of each quarter of the
683 state fiscal year, the agency shall distribute to each statutory
684 teaching hospital, as defined in s. 408.07, an amount determined
685 by multiplying one-fourth of the funds appropriated for this
686 purpose by the Legislature times such hospital’s allocation
687 fraction. The allocation fraction for each such hospital shall
688 be determined by the sum of the following three primary factors,
689 divided by three~~. The primary factors are~~:
690 (a) The number of nationally accredited graduate medical
691 education programs offered by the hospital, including programs
692 accredited by the Accreditation Council for Graduate Medical
693 Education and the combined Internal Medicine and Pediatrics
694 programs acceptable to both the American Board of Internal
695 Medicine and the American Board of Pediatrics at the beginning
696 of the state fiscal year preceding the date on which the

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697 allocation fraction is calculated. The numerical value of this
698 factor is the fraction that the hospital represents of the total
699 number of programs, where the total is computed for all state
700 statutory teaching hospitals.
701 (b) The number of full-time equivalent trainees in the
702 hospital, which comprises two components:
703 1. The number of trainees enrolled in nationally accredited
704 graduate medical education programs, as defined in paragraph
705 (a). Full-time equivalents are computed using the fraction of
706 the year during which each trainee is primarily assigned to the
707 given institution, over the state fiscal year preceding the date
708 on which the allocation fraction is calculated. The numerical
709 value of this factor is the fraction that the hospital
710 represents of the total number of full-time equivalent trainees
711 enrolled in accredited graduate programs, where the total is
712 computed for all state statutory teaching hospitals.
713 2. The number of medical students enrolled in accredited
714 colleges of medicine and engaged in clinical activities,
715 including required clinical clerkships and clinical electives.
716 Full-time equivalents are computed using the fraction of the
717 year during which each trainee is primarily assigned to the
718 given institution, over the course of the state fiscal year
719 preceding the date on which the allocation fraction is
720 calculated. The numerical value of this factor is the fraction
721 that the given hospital represents of the total number of full-
722 time equivalent students enrolled in accredited colleges of
723 medicine, where the total is computed for all state statutory
724 teaching hospitals.
725

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

755 factor is the fraction that each hospital represents of the
756 total of such Medicaid payments, where the total is computed for
757 all state statutory teaching hospitals.
758
759 The primary factor for the service index is computed as the sum
760 of these three components, divided by three.
761 (2) By October 1 of each year, the agency shall use the
762 following formula to calculate the maximum additional
763 disproportionate share payment for statutorily defined teaching
764 hospitals:
765 TAP = THAF x A
766
767 Where:
768 TAP = total additional payment.
769 THAF = teaching hospital allocation factor.
770 A = amount appropriated for a teaching hospital
771 disproportionate share program.
772 Section 12. Section 409.9117, Florida Statutes, is amended
773 to read:
774 409.9117 Primary care disproportionate share program.—For
775 the 2009-2010 state fiscal year ~~2008-2009~~, the agency shall not
776 distribute moneys under the primary care disproportionate share
777 program.
778 (1) If federal funds are available for disproportionate
779 share programs in addition to those otherwise provided by law,
780 there shall be created a primary care disproportionate share
781 program.
782 (2) The following formula shall be used by the agency to
783 calculate the total amount earned for hospitals that participate

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784 in the primary care disproportionate share program:
785 TAE = HDSP/THDSP
786
787 Where:
788 TAE = total amount earned by a hospital participating in
789 the primary care disproportionate share program.
790 HDSP = the prior state fiscal year primary care
791 disproportionate share payment to the individual hospital.
792 THDSP = the prior state fiscal year total primary care
793 disproportionate share payments to all hospitals.
794 (3) The total additional payment for hospitals that
795 participate in the primary care disproportionate share program
796 shall be calculated by the agency as follows:
797 TAP = TAE x TA
798
799 Where:
800 TAP = total additional payment for a primary care hospital.
801 TAE = total amount earned by a primary care hospital.
802 TA = total appropriation for the primary care
803 disproportionate share program.
804 (4) In the establishment and funding of this program, the
805 agency shall use the following criteria in addition to those
806 specified in s. 409.911, and payments may not be made to a
807 hospital unless the hospital agrees to:
808 (a) Cooperate with a Medicaid prepaid health plan, if one
809 exists in the community.
810 (b) Ensure the availability of primary and specialty care
811 physicians to Medicaid recipients who are not enrolled in a
812 prepaid capitated arrangement and who are in need of access to

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813 such physicians.
814 (c) Coordinate and provide primary care services free of
815 charge, except copayments, to all persons with incomes up to 100
816 percent of the federal poverty level who are not otherwise
817 covered by Medicaid or another program administered by a
818 governmental entity, and to provide such services based on a
819 sliding fee scale to all persons with incomes up to 200 percent
820 of the federal poverty level who are not otherwise covered by
821 Medicaid or another program administered by a governmental
822 entity, except that eligibility may be limited to persons who
823 reside within a more limited area, as agreed to by the agency
824 and the hospital.
825 (d) Contract with any federally qualified health center, if
826 one exists within the agreed geopolitical boundaries, concerning
827 the provision of primary care services, in order to guarantee
828 delivery of services in a nonduplicative fashion, and to provide
829 for referral arrangements, privileges, and admissions, as
830 appropriate. The hospital shall agree to provide at an onsite or
831 offsite facility primary care services within 24 hours to which
832 all Medicaid recipients and persons eligible under this
833 paragraph who do not require emergency room services are
834 referred during normal daylight hours.
835 (e) Cooperate with the agency, the county, and other
836 entities to ensure the provision of certain public health
837 services, case management, referral and acceptance of patients,
838 and sharing of epidemiological data, as the agency and the
839 hospital find mutually necessary and desirable to promote and
840 protect the public health within the agreed geopolitical
841 boundaries.

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842 (f) In cooperation with the county in which the hospital
843 resides, develop a low-cost, outpatient, prepaid health care
844 program to persons who are not eligible for the Medicaid
845 program, and who reside within the area.
846 (g) Provide inpatient services to residents within the area
847 who are not eligible for Medicaid or Medicare, and who do not
848 have private health insurance, regardless of ability to pay, on
849 the basis of available space, except that hospitals may not be
850 prevented ~~nothing shall prevent the hospital~~ from establishing
851 bill collection programs based on ability to pay.
852 (h) Work with the Florida Healthy Kids Corporation, the
853 Florida Health Care Purchasing Cooperative, and business health
854 coalitions, as appropriate, to develop a feasibility study and
855 plan to provide a low-cost comprehensive health insurance plan
856 to persons who reside within the area and who do not have access
857 to such a plan.
858 (i) Work with public health officials and other experts to
859 provide community health education and prevention activities
860 designed to promote healthy lifestyles and appropriate use of
861 health services.
862 (j) Work with the local health council to develop a plan
863 for promoting access to affordable health care services for all
864 persons who reside within the area, including, but not limited
865 to, public health services, primary care services, inpatient
866 services, and affordable health insurance generally.
867
868 Any hospital that fails to comply with any of the provisions of
869 this subsection, or any other contractual condition, may not
870 receive payments under this section until full compliance is

871 achieved.
872 Section 13. Section 409.9119, Florida Statutes, is amended
873 to read:
874 409.9119 Disproportionate share program for specialty
875 hospitals for children.—In addition to the payments made under
876 s. 409.911, the Agency for Health Care Administration shall
877 develop and implement a system under which disproportionate
878 share payments are made to those hospitals that are licensed by
879 the state as specialty hospitals for children and were licensed
880 on January 1, 2000, as specialty hospitals for children. This
881 system of payments must conform to federal requirements and must
882 distribute funds in each fiscal year for which an appropriation
883 is made by making quarterly Medicaid payments. Notwithstanding
884 s. 409.915, counties are exempt from contributing toward the
885 cost of this special reimbursement for hospitals that serve a
886 disproportionate share of low-income patients. The agency may
887 make disproportionate share payments to specialty hospitals for
888 children as provided for ~~Payments are subject to specific~~
889 ~~appropriations~~ in the General Appropriations Act.
890 (1) Unless specified in the General Appropriations Act, the
891 agency shall use the following formula to calculate the total
892 amount earned for hospitals that participate in the specialty
893 hospital for children disproportionate share program:
894 TAE = DSR x BMPD x MD
895
896 Where:
897 TAE = total amount earned by a specialty hospital for
898 children.
899 DSR = disproportionate share rate.

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900 BMPD = base Medicaid per diem.
901 MD = Medicaid days.
902 (2) The agency shall calculate the total additional payment
903 for hospitals that participate in the specialty hospital for
904 children disproportionate share program as follows:

$$TAP = \left(\frac{TAE \times TA}{STAE}\right)$$

905
906
907 Where:
908 TAP = total additional payment for a specialty hospital for
909 children.
910 TAE = total amount earned by a specialty hospital for
911 children.
912 TA = total appropriation for the specialty hospital for
913 children disproportionate share program.
914 STAE = sum of total amount earned by each hospital that
915 participates in the specialty hospital for children
916 disproportionate share program.
917 (3) A hospital may not receive any payments under this
918 section until it achieves full compliance with the applicable
919 rules of the agency. A hospital that is not in compliance for
920 two or more consecutive quarters may not receive its share of
921 the funds. Any forfeited funds must be distributed to the
922 remaining participating specialty hospitals for children that
923 are in compliance.
924 Section 14. Paragraph (g) is added to subsection (5) of
925 section 409.912, Florida Statutes, and subsection (8) of that

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926 section, is amended to read:
927 409.912 Cost-effective purchasing of health care.—The
928 agency shall purchase goods and services for Medicaid recipients
929 in the most cost-effective manner consistent with the delivery
930 of quality medical care. To ensure that medical services are
931 effectively utilized, the agency may, in any case, require a
932 confirmation or second physician's opinion of the correct
933 diagnosis for purposes of authorizing future services under the
934 Medicaid program. This section does not restrict access to
935 emergency services or poststabilization care services as defined
936 in 42 C.F.R. part 438.114. Such confirmation or second opinion
937 shall be rendered in a manner approved by the agency. The agency
938 shall maximize the use of prepaid per capita and prepaid
939 aggregate fixed-sum basis services when appropriate and other
940 alternative service delivery and reimbursement methodologies,
941 including competitive bidding pursuant to s. 287.057, designed
942 to facilitate the cost-effective purchase of a case-managed
943 continuum of care. The agency shall also require providers to
944 minimize the exposure of recipients to the need for acute
945 inpatient, custodial, and other institutional care and the
946 inappropriate or unnecessary use of high-cost services. The
947 agency shall contract with a vendor to monitor and evaluate the
948 clinical practice patterns of providers in order to identify
949 trends that are outside the normal practice patterns of a
950 provider's professional peers or the national guidelines of a
951 provider's professional association. The vendor must be able to
952 provide information and counseling to a provider whose practice
953 patterns are outside the norms, in consultation with the agency,
954 to improve patient care and reduce inappropriate utilization.

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955 The agency may mandate prior authorization, drug therapy
956 management, or disease management participation for certain
957 populations of Medicaid beneficiaries, certain drug classes, or
958 particular drugs to prevent fraud, abuse, overuse, and possible
959 dangerous drug interactions. The Pharmaceutical and Therapeutics
960 Committee shall make recommendations to the agency on drugs for
961 which prior authorization is required. The agency shall inform
962 the Pharmaceutical and Therapeutics Committee of its decisions
963 regarding drugs subject to prior authorization. The agency is
964 authorized to limit the entities it contracts with or enrolls as
965 Medicaid providers by developing a provider network through
966 provider credentialing. The agency may competitively bid single-
967 source-provider contracts if procurement of goods or services
968 results in demonstrated cost savings to the state without
969 limiting access to care. The agency may limit its network based
970 on the assessment of beneficiary access to care, provider
971 availability, provider quality standards, time and distance
972 standards for access to care, the cultural competence of the
973 provider network, demographic characteristics of Medicaid
974 beneficiaries, practice and provider-to-beneficiary standards,
975 appointment wait times, beneficiary use of services, provider
976 turnover, provider profiling, provider licensure history,
977 previous program integrity investigations and findings, peer
978 review, provider Medicaid policy and billing compliance records,
979 clinical and medical record audits, and other factors. Providers
980 shall not be entitled to enrollment in the Medicaid provider
981 network. The agency shall determine instances in which allowing
982 Medicaid beneficiaries to purchase durable medical equipment and
983 other goods is less expensive to the Medicaid program than long-

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984 term rental of the equipment or goods. The agency may establish
985 rules to facilitate purchases in lieu of long-term rentals in
986 order to protect against fraud and abuse in the Medicaid program
987 as defined in s. 409.913. The agency may seek federal waivers
988 necessary to administer these policies.
989 (5) The Agency for Health Care Administration, in
990 partnership with the Department of Elderly Affairs, shall create
991 an integrated, fixed-payment delivery program for Medicaid
992 recipients who are 60 years of age or older or dually eligible
993 for Medicare and Medicaid. The Agency for Health Care
994 Administration shall implement the integrated program initially
995 on a pilot basis in two areas of the state. The pilot areas
996 shall be Area 7 and Area 11 of the Agency for Health Care
997 Administration. Enrollment in the pilot areas shall be on a
998 voluntary basis and in accordance with approved federal waivers
999 and this section. The agency and its program contractors and
1000 providers shall not enroll any individual in the integrated
1001 program because the individual or the person legally responsible
1002 for the individual fails to choose to enroll in the integrated
1003 program. Enrollment in the integrated program shall be
1004 exclusively by affirmative choice of the eligible individual or
1005 by the person legally responsible for the individual. The
1006 integrated program must transfer all Medicaid services for
1007 eligible elderly individuals who choose to participate into an
1008 integrated-care management model designed to serve Medicaid
1009 recipients in the community. The integrated program must combine
1010 all funding for Medicaid services provided to individuals who
1011 are 60 years of age or older or dually eligible for Medicare and
1012 Medicaid into the integrated program, including funds for

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1013 Medicaid home and community-based waiver services; all Medicaid
1014 services authorized in ss. 409.905 and 409.906, excluding funds
1015 for Medicaid nursing home services unless the agency is able to
1016 demonstrate how the integration of the funds will improve
1017 coordinated care for these services in a less costly manner; and
1018 Medicare coinsurance and deductibles for persons dually eligible
1019 for Medicaid and Medicare as prescribed in s. 409.908(13).
1020 (g) The implementation of the integrated, fixed-payment
1021 delivery program created under this subsection is subject to an
1022 appropriation in the General Appropriations Act.
1023 (8)(a) The agency may contract on a prepaid or fixed-sum
1024 basis with an exclusive provider organization to provide health
1025 care services to Medicaid recipients provided that the exclusive
1026 provider organization meets applicable managed care plan
1027 requirements in this section, ss. 409.9122, 409.9123, 409.9128,
1028 and 627.6472, and other applicable provisions of law.
1029 (b) For a period of no longer than 24 months after the
1030 effective date of this paragraph, when a member of an exclusive
1031 provider organization that is contracted by the agency to
1032 provide health care services to Medicaid recipients in rural
1033 areas without a health maintenance organization obtains services
1034 from a provider that participates in the Medicaid program in
1035 this state, the provider shall be paid in accordance with the
1036 appropriate fee schedule for services provided to eligible
1037 Medicaid recipients. The agency may seek waiver authority to
1038 implement this paragraph.
1039 Section 15. Paragraph (e) of subsection (3) and subsection
1040 (12) of section 409.91211, Florida Statutes, are amended to
1041 read:

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1042 409.91211 Medicaid managed care pilot program.—
1043 (3) The agency shall have the following powers, duties, and
1044 responsibilities with respect to the pilot program:
1045 (e) To implement policies and guidelines for phasing in
1046 financial risk for approved provider service networks that, for
1047 purposes of this paragraph, include the Children's Medical
1048 Services Network, over a 5-year ~~3-year~~ period. These policies
1049 and guidelines must include an option for a provider service
1050 network to be paid fee-for-service rates. For any provider
1051 service network established in a managed care pilot area, the
1052 option to be paid fee-for-service rates must ~~shall~~ include a
1053 savings-settlement mechanism that is consistent with s.
1054 409.912(44). This model must ~~shall~~ be converted to a risk-
1055 adjusted capitated rate by ~~no later than~~ the beginning of the
1056 sixth ~~fourth~~ year of operation, and may be converted earlier at
1057 the option of the provider service network. Federally qualified
1058 health centers may be offered an opportunity to accept or
1059 decline a contract to participate in any provider network for
1060 prepaid primary care services.
1061 (12) For purposes of this section, the term "capitated
1062 managed care plan" includes health insurers authorized under
1063 chapter 624, exclusive provider organizations authorized under
1064 chapter 627, health maintenance organizations authorized under
1065 chapter 641, the Children's Medical Services Network under
1066 chapter 391, and provider service networks that elect to be paid
1067 fee-for-service for up to 5 ~~3~~ years as authorized under this
1068 section.
1069 Section 16. Paragraph (e) of subsection (2) of section
1070 409.9122, Florida Statutes, is amended to read:

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1071 409.9122 Mandatory Medicaid managed care enrollment;
1072 programs and procedures.—
1073 (2)
1074 (e) Medicaid recipients who are already enrolled in a
1075 managed care plan or MediPass shall be offered the opportunity
1076 to change managed care plans or MediPass providers on a
1077 staggered basis, as defined by the agency. All Medicaid
1078 recipients shall have 30 days in which to make a choice of
1079 managed care plans or MediPass providers. ~~In counties that have~~
1080 ~~two or more managed care plans, a recipient already enrolled in~~
1081 ~~MediPass who fails to make a choice during the annual period~~
1082 ~~shall be assigned to a managed care plan if he or she is~~
1083 ~~eligible for enrollment in the managed care plan. The agency~~
1084 ~~shall apply for a state plan amendment or federal waiver~~
1085 ~~authority, if necessary, to implement the provisions of this~~
1086 ~~paragraph. All newly eligible Medicaid recipients shall have 30~~
1087 ~~days in which to make a choice of managed care plans or MediPass~~
1088 ~~providers.~~ Those Medicaid recipients who do not make a choice
1089 shall be assigned in accordance with paragraph (f). To
1090 facilitate continuity of care, for a Medicaid recipient who is
1091 also a recipient of Supplemental Security Income (SSI), prior to
1092 assigning the SSI recipient to a managed care plan or MediPass,
1093 the agency shall determine whether the SSI recipient has an
1094 ongoing relationship with a MediPass provider or managed care
1095 plan, and if so, the agency shall assign the SSI recipient to
1096 that MediPass provider or managed care plan. ~~If the SSI~~
1097 ~~recipient has an ongoing relationship with a managed care plan,~~
1098 ~~the agency shall assign the recipient to that managed care plan.~~
1099 Those SSI recipients who do not have such a provider

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1100 relationship shall be assigned to a managed care plan or
1101 MediPass provider in accordance with paragraph (f).
1102 Section 17. Subsection (4) is added to section 409.916,
1103 Florida Statutes, to read:
1104 409.916 Grants and Donations Trust Fund.—
1105 (4) Quality assessment fees received from Medicaid
1106 providers shall be deposited into the Grants and Donations Trust
1107 Fund and used for purposes established by law and the General
1108 Appropriations Act.
1109 Section 18. Subsection (18) is added to section 430.04,
1110 Florida Statutes, to read:
1111 430.04 Duties and responsibilities of the Department of
1112 Elderly Affairs.—The Department of Elderly Affairs shall:
1113 (18) Administer all Medicaid waivers and programs relating
1114 to elders and their appropriations. The waivers include, but are
1115 not limited to:
1116 (a) The Alzheimer's Dementia-Specific Medicaid Waiver as
1117 established in s. 430.502(7), (8), and (9).
1118 (b) The Assisted Living for the Frail Elderly Waiver.
1119 (c) The Aged and Disabled Adult Waiver.
1120 (d) The Adult Day Health Care Waiver.
1121 (e) The Consumer Directed Care Plus Program as defined in
1122 s. 409.221.
1123 (f) The Program for All-inclusive Care for the Elderly.
1124 (g) The Long-Term Care Community-Based Diversion Pilot
1125 Project as described in s. 430.705.
1126 (h) The Channeling Services Waiver for Frail Elders.
1127 Section 19. Section 430.707, Florida Statutes, is amended
1128 to read:

1129 430.707 Contracts.—
1130 (1) The department, in consultation with the agency, shall
1131 select and contract with managed care organizations and, on a
1132 prepaid basis, with other qualified providers as defined in s.
1133 430.703(7) to provide long-term care within community diversion
1134 pilot project areas. All providers shall report quarterly to the
1135 department regarding the entity's compliance with all the
1136 financial and quality assurance requirements of the contract.
1137 (2) The department, in consultation with the agency, may
1138 contract with entities that ~~which~~ have submitted an application
1139 as a community nursing home diversion project as of July 1,
1140 1998, to provide benefits pursuant to the "Program of All-
1141 inclusive Care for the Elderly" as established in Pub. L. No.
1142 105-33. For the purposes of this community nursing home
1143 diversion project, such entities are ~~shall be~~ exempt from the
1144 requirements of chapter 641~~,~~ if the entity is a private,
1145 nonprofit, superior-rated nursing home and if ~~with~~ at least 50
1146 percent of its residents are eligible for Medicaid. The agency,
1147 in consultation with the department, shall accept and forward to
1148 the Centers for Medicare and Medicaid Services an application
1149 for expansion of the pilot project from an entity that provides
1150 benefits pursuant to the Program of All-inclusive Care for the
1151 Elderly and that is in good standing with the agency, the
1152 department, and the Centers for Medicare and Medicaid Services.
1153 Section 20. Notwithstanding s. 430.707, Florida Statutes,
1154 and subject to federal approval of the application to be a site
1155 for the Program of All-inclusive Care for the Elderly, the
1156 Agency for Health Care Administration shall contract with one
1157 private, not-for-profit hospice organization located in

1158 Hillsborough County, which provides comprehensive services,
1159 including hospice care for frail and elderly persons. Such an
1160 entity shall be exempt from the requirements of chapter 641,
1161 Florida Statutes. The agency, in consultation with the
1162 Department of Elderly Affairs and subject to an appropriation,
1163 shall approve up to 100 initial enrollees in the Program of All-
1164 inclusive Care for the Elderly in Hillsborough County.
1165 Section 21. The Agency for Health Care Administration shall
1166 develop and implement a home health agency monitoring pilot
1167 project in Miami-Dade County by January 1, 2010. The agency
1168 shall contract with a vendor to verify the utilization and the
1169 delivery of home health services and provide an electronic
1170 billing interface for such services. The contract must require
1171 the creation of a program to submit claims for the home health
1172 services electronically. The program must verify visits for the
1173 delivery of home health services telephonically using voice
1174 biometrics. The agency may seek amendments to the Medicaid state
1175 plan and waivers of federal law, as necessary, to implement the
1176 pilot project. Notwithstanding s. 287.057(5)(f), Florida
1177 Statutes, the agency must award the contract through the
1178 competitive solicitation process. The agency shall submit a
1179 report to the Governor, the President of the Senate, and the
1180 Speaker of the House of Representatives evaluating the pilot
1181 project by February 1, 2011.
1182 Section 22. The Agency for Health Care Administration shall
1183 implement a comprehensive care management pilot project in
1184 Miami-Dade County for home health services by January 1, 2010,
1185 which includes face-to-face assessments by a state-licensed
1186 nurse, consultation with physicians ordering services to

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1187 substantiate the medical necessity for services, and on-site or
1188 desk reviews of recipients' medical records. The agency may
1189 enter into a contract with a qualified organization to implement
1190 the pilot project. The agency may seek amendments to the
1191 Medicaid state plan and waivers of federal law, as necessary, to
1192 implement the pilot project.
1193 Section 23. This act shall take effect July 1, 2009.

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