By the Committee on Budget

576-03468-12 20121988__

A bill to be entitled

An act relating to Medicaid; amending s. 383.15, F.S.; revising legislative intent relating to funding for regional perinatal intensive care centers; amending s. 409.8132, F.S.; revising a cross-reference; amending s. 409.814, F.S.; deleting a prohibition preventing children who are eligible for coverage under a state health benefit plan from being eligible for services provided through the subsidized program; revising cross-references; requiring a completed application, including a clinical screening, for enrollment in the Children's Medical Services Network; amending s. 409.902, F.S.; providing for the creation an Internet-based system for determining eligibility for the Medicaid and Kidcare programs, contingent on the appropriation; providing system business objectives and requirements; requiring the Department of Children and Family Services to develop the system; requiring the system to be completed and implemented by specified dates; providing a governance structure pending implementation of the program, including an executive steering committee and a project management team; amending s. 409.905, F.S.; limiting the number of paid hospital emergency department visits for nonpregnant adults; authorizing the Agency for Health Care Administration to request approval by the Legislative Budget Commission of hospital rate adjustments; providing components for the agency's plan to convert inpatient hospital rates to a

prospective payment system; revising dates for submitting the plan and implementing the system; amending 409.908, F.S.; conforming a cross-reference; authorizing the Agency for Health Care Administration to accept voluntary intergovernmental transfers of local taxes and other qualified revenue from counties, municipalities, or special taxing districts in order to fund certain costs; limiting the use of intergovernmental transfer funds for hospital reimbursements; prohibiting the inclusion of certain hospital costs in the capitation rates for prepaid health plans; providing for the inclusion of certain hospital costs in capitation rates for prepaid health plans if funded by intergovernmental transfers; incorporating a transferred provision; amending s. 409.911, F.S.; updating references to data used for calculations in the disproportionate share program; repealing s. 409.9112, F.S., relating to the disproportionate share program for regional perinatal intensive care centers; amending s. 409.9113, F.S.; conforming a cross-reference; authorizing the agency to distribute moneys in the disproportionate share program for teaching hospitals; repealing s. 409.9117, F.S., relating to the primary care disproportionate share program; amending s. 409.912, F.S.; revising the conditions for contracting with certain managed care plans for behavioral health care services; deleting requirements for assigning certain MediPass recipients to managed care plans for behavioral health care

services; requiring the assignment of recipients to provider service networks; amending s. 409.9121, F.S.; revising legislative findings relating to the Medicaid program; amending s. 409.9122, F.S.; providing criteria and procedures relating to recipient enrollment choice and assignment among Medicaid managed care plans and MediPass; deleting transferred provisions relating to school districts; amending s. 409.9123, F.S.; revising provisions relating to the publication of quality measures for managed care plans; reenacting s. 409.9126, F.S., relating to children with special health care needs; amending s. 409.915, F.S.; specifying criteria for determining a county's eligible recipients; providing for payment of billings that have been denied by the county from the county's tax revenues; providing for refunds; providing for the transfer of certain refunds to the Lawton Chiles Endowment Fund; amending ss. 409.979 and 430.04, F.S.; deleting references to the Adult Day Health Care Waiver in provisions relating to Medicaid eligibility and duties and responsibilities of the Department of Elderly Affairs; amending s. 31, chapter 2009-223, Laws of Florida, as amended, and redesignating that section as s. 409.9132, F.S.; expanding the home health agency monitoring pilot project statewide; amending s. 32, chapter 2009-223, Laws of Florida, and redesignating that section as s. 409.9133, F.S.; expanding the comprehensive care management pilot project for home health services

statewide and including private-duty nursing and personal care services; providing an additional site in Broward County for the Program of All-Inclusive Care for the Elderly; providing that a public hospital located in trauma service area 2 which has local funds available for intergovernmental transfers may have its reimbursement rates adjusted after a certain date; providing effective dates.

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

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

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

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

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

409.8132 Medikids program component.—

(6) ELIGIBILITY.—

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

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

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

(1) A child who is eligible for Medicaid coverage under s. 409.903 or s. 409.904 must be enrolled in Medicaid and is not eligible to receive health benefits under any other health benefits coverage authorized under the Florida Kidcare program.

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

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

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

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

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

(b) ~~(c)~~ A child who is seeking premium assistance for the

Florida Kidcare program through employer-sponsored group coverage, if the child has been covered by the same employer's group coverage during the 60 days before the family submitted ~~prior to the family's submitting~~ an application for determination of eligibility under the program.

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

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

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

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

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

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

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

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

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

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

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

9. Domestic violence led to loss of coverage.

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

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

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

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

(7) Once a child is enrolled in the Florida Kidcare program, the child is eligible for coverage ~~under the program~~ for 12 months without a redetermination or reverification of eligibility~~,~~ if the family continues to pay the applicable premium. Eligibility for program components funded through Title

XXI of the Social Security Act terminates ~~shall terminate~~ when a child attains the age of 19. A child who has not attained the age of 5 and who has been determined eligible for the Medicaid program is eligible for coverage for 12 months without a redetermination or reverification of eligibility.

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

(9) In determining the eligibility of a child, an assets test is not required. Each applicant shall provide documentation during the application process and the redetermination process, including, but not limited to, the following:

(a) ~~Each applicant's~~ Proof of family income, which must ~~shall~~ be verified electronically to determine financial eligibility for the Florida Kidcare program. Written documentation, which may include wages and earnings statements or pay stubs, W-2 forms, or a copy of the applicant's most

recent federal income tax return, is ~~shall be~~ required only if ~~the~~ electronic verification is not available or does not substantiate the applicant's income.

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

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

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

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

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

(10) Subject to paragraph (4)(a) ~~(4)(b)~~, the Florida Kidcare program shall withhold benefits from an enrollee if the program obtains evidence that the enrollee is no longer eligible, submitted incorrect or fraudulent information in order to establish eligibility, or failed to provide verification of eligibility. The applicant or enrollee shall be notified that because of such evidence program benefits will be withheld unless the applicant or enrollee contacts a designated representative of the program by a specified date, which must be within 10 working days after the date of notice, to discuss and resolve the matter. The program shall make every effort to resolve the matter within a timeframe that will not cause benefits to be withheld from an eligible enrollee.

(11) The following individuals may be subject to

prosecution in accordance with s. 414.39:

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

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

Section 4. Section 409.902, Florida Statutes, is amended to read:

409.902 Designated single state agency; eligibility determinations ~~payment requirements; program title; release of medical records~~.—

(1) The Agency for Health Care Administration is designated as the single state agency authorized to make payments for medical assistance and related services under Title XIX of the Social Security Act. These payments shall be made, subject to any limitations or directions provided ~~for~~ in the General Appropriations Act, only for services included in the program, ~~shall be made~~ only on behalf of eligible individuals, and ~~shall be made~~ only to qualified providers in accordance with federal requirements for Title XIX of the Social Security Act and ~~the provisions of~~ state law. This program of medical assistance is designated the "Medicaid program."

(2) The Department of Children and Family Services is responsible for determining Medicaid eligibility ~~determinations~~, including, but not limited to, policy, rules, and the agreement

with the Social Security Administration for Medicaid eligibility ~~determinations~~ for Supplemental Security Income recipients, as well as the actual determination of eligibility. As a condition of Medicaid eligibility, subject to federal approval, the agency ~~for Health Care Administration~~ and the department must ~~of Children and Family Services shall~~ ensure that each recipient of Medicaid consents to the release of her or his medical records to the agency ~~for Health Care Administration~~ and the Medicaid Fraud Control Unit of the Department of Legal Affairs.

(3) ~~(2)~~ Eligibility is restricted to United States citizens and to lawfully admitted noncitizens who meet the criteria provided in s. 414.095(3).

(a) Citizenship or immigration status must be verified. For noncitizens, this includes verification of the validity of documents with the United States Citizenship and Immigration Services using the federal SAVE verification process.

(b) State funds may not be used to provide medical services to individuals who do not meet the requirements of this subsection unless the services are necessary to treat an emergency medical condition or are for pregnant women. Such services are authorized only to the extent provided under federal law and in accordance with federal regulations as provided in 42 C.F.R. s. 440.255.

(4) To the extent funds are appropriated, the department shall collaborate with the agency to develop an Internet-based system for determining eligibility for the Medicaid and Kidcare programs which complies with all applicable federal and state laws and requirements.

(a) The system must accomplish the following primary

business objectives:

1. Provide individuals and families with a single access point to information that explains benefits, premiums, and cost-sharing available through Medicaid, Kidcare, or any other state or federal health insurance exchange.

2. Enable timely, accurate, and efficient enrollment of eligible persons into available assistance programs.

3. Prevent eligibility fraud.

4. Allow for detailed financial analysis of eligibility-based cost drivers.

(b) The system must include, but need not be limited to, the following business and functional requirements:

1. Allowing for the completion and submission of an online application for determining eligibility which accepts the use of electronic signatures.

2. Including a process that enables automatic enrollment of qualified individuals into Medicaid, Kidcare, or any other state or federal exchange that offers cost-sharing benefits for the purchase of health insurance.

3. Allowing for the determination of Medicaid eligibility based on modified adjusted gross income by using information submitted in the application and information accessed and verified through automated and secure interfaces with authorized databases.

4. Including the ability to determine specific categories of Medicaid eligibility and interface with the Florida Medicaid Management Information System to support such determination, using federally approved assessment methodologies, of state and federal financial participation rates for persons in each

eligibility category.

5. Allowing for the accurate and timely processing of eligibility claims and adjudications.

6. Aligning with and incorporating all applicable state and federal laws, requirements, and standards, including the information technology security requirements established under s. 282.318 and the accessibility standards established under part II of chapter 282.

7. Producing transaction data, reports, and performance information that contributes to an evaluation of the program, continuous improvement in business operations, and increased transparency and accountability.

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

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

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

1. The director of the department's Economic Self-Sufficiency Services Program Office shall have overall responsibility for the project.

2. The project shall be governed by an executive steering committee composed of three department staff members appointed by the Secretary of Children and Family Services; three agency staff members, including at least two state Medicaid program staff members, appointed by the Secretary of Health Care Administration; and one staff member from Children's Medical Services within the Department of Health appointed by the

Surgeon General.

3. The executive steering committee shall have overall responsibility for ensuring that the project meets its primary business objectives and shall:

a. Provide management direction and support to the project management team.

b. Review and approve any changes to the project's scope, schedule, and budget.

c. Review, approve, and determine whether to proceed with any major deliverable project.

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

4. A project management team shall be appointed by and work under the direction of the executive steering committee. The project management team shall:

a. Provide planning, management, and oversight of the project.

b. Submit an operational work plan and provide quarterly updates to the plan to the executive steering committee. The plan must specify project milestones, deliverables, and expenditures.

c. Submit written monthly project status reports to the executive steering committee.

Section 5. Subsections (5) of section 409.905, Florida Statutes, is amended to read:

409.905 Mandatory Medicaid services.—The agency may make payments for the following services, which are required of the

state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law. Mandatory services rendered by providers in mobile units to Medicaid recipients may be restricted by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, number of services, or any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216.

(5) HOSPITAL INPATIENT SERVICES.—The agency shall pay for all covered services provided for the medical care and treatment of a Medicaid 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 nonpregnant ~~Medicaid~~ recipient 21 years of age or older to 45 days per fiscal year ~~or the number of days necessary to comply with the General Appropriations Act~~. Effective August 1, 2012, the agency shall limit payment for hospital emergency department visits for a nonpregnant recipient 21 years of age or older to six visits per fiscal year.

(a) The agency may ~~is authorized to~~ implement reimbursement and utilization management reforms in order to comply with any limitations or directions in the General Appropriations Act, which may include, but are not limited to: prior authorization

for inpatient psychiatric days; prior authorization for nonemergency hospital inpatient admissions for individuals 21 years of age and older; authorization of emergency and urgent-care admissions within 24 hours after admission; enhanced utilization and concurrent review programs for highly utilized services; reduction or elimination of covered days of service; adjusting reimbursement ceilings for variable costs; adjusting reimbursement ceilings for fixed and property costs; and implementing target rates of increase. The agency may limit prior authorization for hospital inpatient services to selected diagnosis-related groups, based on an analysis of the cost and potential for unnecessary hospitalizations represented by certain diagnoses. Admissions for normal delivery and newborns are exempt from ~~requirements for~~ prior authorization requirements. In implementing ~~the provisions of~~ this section related to prior authorization, the agency must ~~shall~~ ensure that the process for authorization is accessible 24 hours per day, 7 days per week and authorization is automatically granted if ~~when~~ not denied within 4 hours after the request. Authorization procedures must include steps for the review of denials. Upon implementing the prior authorization program for hospital inpatient services, the agency shall discontinue its hospital retrospective review program.

(b) A licensed hospital maintained primarily for the care and treatment of patients having mental disorders or mental diseases is not eligible to participate in the hospital inpatient portion of the Medicaid program except as provided under ~~in~~ federal law. However, the department shall apply for a waiver, within 9 months after June 5, 1991, designed to provide

hospitalization services for mental health reasons to children and adults in the most cost-effective and lowest cost setting possible. Such waiver must ~~shall~~ include a request for the opportunity to pay for care in hospitals known under federal law as "institutions for mental disease" or "IMD's." The waiver proposal may not ~~shall~~ propose ~~no~~ additional aggregate cost to the state or Federal Government, and shall be conducted in Hillsborough County, Highlands County, Hardee County, Manatee County, and Polk County. The waiver proposal may incorporate competitive bidding for hospital services, comprehensive brokering, prepaid capitated arrangements, or other mechanisms deemed by the department to show promise in reducing the cost of acute care and increasing the effectiveness of preventive care. When developing the waiver proposal, the department shall take into account price, quality, accessibility, linkages of the hospital to community services and family support programs, plans of the hospital to ensure the earliest discharge possible, and the comprehensiveness of the mental health and other health care services offered by participating providers.

(c) The agency shall implement a methodology for establishing base reimbursement rates for each hospital based on allowable costs~~,~~ as defined by the agency. Rates shall be calculated annually and take effect July 1 of each year based on the most recent complete and accurate cost report submitted by each hospital. Adjustments may not be made to the rates after September 30 of the state fiscal year in which the rate takes effect, except that the agency may request that adjustments be approved by the Legislative Budget Commission when needed due to insufficient commitments or collections of intergovernmental

transfers under s. 409.908(1) or s. 409.908(4). Errors in cost reporting or calculation of rates discovered after September 30 must be reconciled in a subsequent rate period. The agency may not make any adjustment to a hospital's reimbursement rate more than 5 years after a hospital is notified of an audited rate established by the agency. The prohibition against ~~requirement that~~ the agency making ~~may not make~~ any adjustment to a hospital's reimbursement rate more than 5 years after a hospital is notified of an audited rate established by the agency is remedial and applies ~~shall apply~~ to actions by providers involving Medicaid claims for hospital services. Hospital rates shall be subject to such limits or ceilings as may be established in law or described in the agency's hospital reimbursement plan. Specific exemptions to the limits or ceilings may be provided in the General Appropriations Act.

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

(e) The agency may develop and implement a program to

reduce the number of hospital readmissions among the non-Medicare population eligible in areas 9, 10, and 11.

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

1. The plan must:

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

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

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

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

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

f. Estimate potential funding for each hospital with a Medicaid provider agreement, based on the DRGs and estimated workload;

g. Propose supplemental DRG payments to augment hospital

reimbursements based on patient acuity and individual hospital characteristics, including classification as a children's hospital, rural hospital, trauma center, burn unit, and other characteristics that could warrant higher reimbursements; and

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

2. The agency, through a competitive procurement pursuant to chapter 287, shall engage a consultant with expertise and experience in the implementation of DRG systems for hospital reimbursement to develop the DRG plan under subparagraph 1.

3. The agency shall submit the ~~Medicaid~~ DRG plan, identifying all steps necessary for the transition and any costs associated with plan implementation, to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than December 1, 2012 ~~January 1, 2013~~. Upon receiving legislative authorization, the agency shall begin making the necessary changes to fiscal agent coding by June 1, 2013, with a target date of November 1, 2013, for full implementation of the DRG system of hospital reimbursement. If, during implementation of this paragraph, the agency determines that these timeframes might not be achievable, the agency shall report to the Legislative Budget Commission the status of its implementation efforts, the reasons the timeframes might not be achievable, and proposals for new timeframes.

Section 6. Paragraph (c) of subsection (1) of section 409.908, Florida Statutes, is amended, paragraph (e) is added to

that subsection, and subsections (4) and (21) of that section are amended, to read:

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

adjustment is consistent with legislative intent.

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

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

(e) The agency may accept voluntary intergovernmental transfers of local taxes and other qualified revenue from counties, municipalities, or special taxing districts under paragraphs (a) and (b) or the General Appropriations Act for the purpose of funding the costs of special Medicaid payments to hospitals, the costs of exempting hospitals from reimbursement ceilings, or the costs of buying back hospital Medicaid trend adjustments authorized under the General Appropriations Act, except that the use of these intergovernmental transfers for fee-for-service payments to hospitals is limited to the proportionate use of such funds accepted by the agency under subsection (4). As used in this paragraph, the term "proportionate use" means that the use of intergovernmental transfer funds under this subsection must be in the same proportion to the use of such funds under subsection (4)

relative to the need for funding hospital costs under each subsection.

(4) Subject to any limitations or directions provided ~~for~~ in the General Appropriations Act, ~~alternative health plans, health maintenance organizations, and~~ prepaid health plans, including health maintenance organizations, prepaid provider service networks, and other capitated managed care plans, shall be reimbursed a fixed, prepaid amount negotiated, or competitively bid pursuant to s. 287.057~~,~~ by the agency and prospectively paid to the provider monthly for each Medicaid recipient enrolled. The amount may not exceed the average amount the agency determines it would have paid, based on claims experience, for recipients in the same or similar category of eligibility. The agency shall calculate capitation rates on a regional basis and~~, beginning September 1, 1995,~~ shall include age-band differentials in such calculations.

(a) Effective September 1, 2012:

1. The costs of special Medicaid payments to hospitals, the costs of exempting hospitals from reimbursement ceilings, and the costs of buying back hospital Medicaid trend adjustments authorized under the General Appropriations Act, which are funded through intergovernmental transfers, may not be included as inpatient or outpatient costs in the calculation of prepaid health plan capitations under this part. This provision must be construed so that inpatient hospital costs included in the calculation of prepaid health plan capitations are identical to those represented by county billing rates under s. 409.915.

2. Prepaid health plans may not reimburse hospitals for the costs described in subparagraph 1., except that plans may

contract with hospitals to pay inpatient per diems that are between 95 percent and 105 percent of the county billing rate. Hospitals and prepaid health plans may negotiate mutually acceptable higher rates for medically complex care.

(b) Notwithstanding paragraph (a):

1. In order to fund the inclusion of costs described in paragraph (a) in the calculation of capitations paid to prepaid health plans, the agency may accept voluntary intergovernmental transfers of local taxes and other qualified revenue from counties, municipalities, or special taxing districts. After securing commitments from counties, municipalities, or special taxing districts to contribute intergovernmental transfers for that purpose, the agency shall develop capitation payments for prepaid health plans which include the costs described in paragraph (a) if those components of the capitation are funded through intergovernmental transfers and not with general revenue. The rate-setting methodology must preserve federal matching funds for the intergovernmental transfers collected under this paragraph and result in actuarially sound rates. The agency has the discretion to perform this function using supplemental capitation payments.

2. The amounts included in a prepaid health plan's capitations or supplemental capitations under this paragraph for funding the costs described in paragraph (a) must be used exclusively by the prepaid health plan to enhance hospital payments and be calculated by the agency as accurately as possible to equal the costs described in paragraph (a) which the prepaid health plan actually incurs and for which intergovernmental transfers have been secured.

(21) The agency shall reimburse school districts that ~~which~~ certify the state match pursuant to ss. 409.9071 and 1011.70 for the federal portion of the school district's allowable costs to deliver the services, based on the reimbursement schedule. The school district shall determine the costs for delivering services as authorized in ss. 409.9071 and 1011.70 for which the state match will be certified.

(a) School districts participating in the certified school match program pursuant to this subsection and s. 1011.70 shall be reimbursed by Medicaid, subject to the limitations of s. 1011.70(1), for a Medicaid-eligible child participating in the services, as authorized under s. 1011.70 and as provided in s. 409.9071, regardless of whether the child is enrolled in MediPass or a managed care plan. Managed care plans and school districts shall make good faith efforts to execute agreements regarding the coordinated provision of services authorized under s. 1011.70. County health departments delivering school-based services pursuant to ss. 381.0056 and 381.0057 shall be reimbursed by Medicaid for the federal share for a Medicaid-eligible child who receives Medicaid-covered services in a school setting, regardless of whether the child is enrolled in MediPass or a managed care plan. Managed care plans and county health departments shall make good faith efforts to execute agreements regarding the coordinated provision of services to a Medicaid-eligible child. To ensure continuity of care for Medicaid patients, the agency, the Department of Health, and the Department of Education shall develop procedures for ensuring that a student's managed care plan or MediPass primary care provider receives information relating to services provided in

accordance with ss. 381.0056, 381.0057, 409.9071, and 1011.70.

(b) Reimbursement of school-based providers is contingent on such providers being enrolled as Medicaid providers and meeting the qualifications contained in 42 C.F.R. s. 440.110, unless otherwise waived by the federal Centers for Medicare and Medicaid Services ~~Health Care Financing Administration~~. Speech therapy providers who are certified through the Department of Education pursuant to rule 6A-4.0176, Florida Administrative Code, are eligible for reimbursement for services that are provided on school premises. An ~~Any~~ employee of the school district who has been fingerprinted and has received a criminal background check in accordance with Department of Education rules and guidelines is ~~shall be~~ exempt from any agency requirements relating to criminal background checks.

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

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

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

(a) "Adjusted patient days" means the sum of acute care patient days and intensive care patient days as reported to the agency ~~for Health Care Administration~~, divided by the ratio of inpatient revenues generated from acute, intensive, ambulatory, and ancillary patient services to gross revenues.

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

(c) "Charity care" or "uncompensated charity care" means that portion of hospital charges reported to the agency ~~for Health Care Administration~~ for which there is no compensation, other than restricted or unrestricted revenues provided to a hospital by local governments or tax districts, regardless of the method of payment, for care provided to a patient whose family income for the 12 months preceding the determination is less than or equal to 200 percent of the federal poverty level, unless the amount of hospital charges due from the patient exceeds 25 percent of the annual family income. However, ~~in no case shall~~ the hospital charges for a patient whose family income exceeds four times the federal poverty level for a family of four may not be considered charity.

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

(e) "Hospital" means a health care institution licensed as

a hospital pursuant to chapter 395, but does not include ambulatory surgical centers.

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

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

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

(b) If the agency ~~for Health Care Administration~~ does not have the prescribed 3 years of audited disproportionate share data as noted in paragraph (a) for a hospital, the agency shall use the average of the years of the audited disproportionate share data as noted in paragraph (a) which is available.

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

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

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

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

409.9113 Disproportionate share program for teaching hospitals.—In addition to the payments made under s. ~~ss.~~ 409.911

~~and 409.9112~~, the agency shall make disproportionate share payments to teaching hospitals, as defined in s. 408.07, for their increased costs associated with medical education programs and for tertiary health care services provided to the indigent. This system of payments must conform to federal requirements and distribute funds in each fiscal year for which an appropriation is made by making quarterly Medicaid payments. Notwithstanding s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients. ~~For the 2011-2012 state fiscal year,~~ The agency shall distribute the moneys provided in the General Appropriations Act to statutorily defined teaching hospitals and family practice teaching hospitals, as defined in s. 395.805, pursuant to this section. The funds provided for statutorily defined teaching hospitals shall be distributed as provided in the General Appropriations Act. The funds provided for family practice teaching hospitals shall be distributed equally among family practice teaching hospitals.

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

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

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

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

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

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

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

(c) A service index that comprises three components:

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

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

3. Total Medicaid payments to each hospital for direct

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

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

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

$$TAP = THAF \times A$$

Where:

TAP = total additional payment.

THAF = teaching hospital allocation factor.

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

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

Section 11. Paragraphs (b) and (d) of subsection (4) of section 409.912, Florida Statutes, are amended to read:

409.912 Cost-effective purchasing of health care.—The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery

of quality medical care. To ensure that medical services are effectively utilized, the agency may, in any case, require a confirmation or second physician's opinion of the correct diagnosis for purposes of authorizing future services under the Medicaid program. This section does not restrict access to emergency services or poststabilization care services as defined in 42 C.F.R. part 438.114. Such confirmation or second opinion shall be rendered in a manner approved by the agency. The agency shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services. The agency shall contract with a vendor to monitor and evaluate the clinical practice patterns of providers in order to identify trends that are outside the normal practice patterns of a provider's professional peers or the national guidelines of a provider's professional association. The vendor must be able to provide information and counseling to a provider whose practice patterns are outside the norms, in consultation with the agency, to improve patient care and reduce inappropriate utilization. The agency may mandate prior authorization, drug therapy management, or disease management participation for certain populations of Medicaid beneficiaries, certain drug classes, or particular drugs to prevent fraud, abuse, overuse, and possible

dangerous drug interactions. The Pharmaceutical and Therapeutics Committee shall make recommendations to the agency on drugs for which prior authorization is required. The agency shall inform the Pharmaceutical and Therapeutics Committee of its decisions regarding drugs subject to prior authorization. The agency is authorized to limit the entities it contracts with or enrolls as Medicaid providers by developing a provider network through provider credentialing. The agency may competitively bid single-source-provider contracts if procurement of goods or services results in demonstrated cost savings to the state without limiting access to care. The agency may limit its network based on the assessment of beneficiary access to care, provider availability, provider quality standards, time and distance standards for access to care, the cultural competence of the provider network, demographic characteristics of Medicaid beneficiaries, practice and provider-to-beneficiary standards, appointment wait times, beneficiary use of services, provider turnover, provider profiling, provider licensure history, previous program integrity investigations and findings, peer review, provider Medicaid policy and billing compliance records, clinical and medical record audits, and other factors. Providers are not entitled to enrollment in the Medicaid provider network. The agency shall determine instances in which allowing Medicaid beneficiaries to purchase durable medical equipment and other goods is less expensive to the Medicaid program than long-term rental of the equipment or goods. The agency may establish rules to facilitate purchases in lieu of long-term rentals in order to protect against fraud and abuse in the Medicaid program as defined in s. 409.913. The agency may seek federal waivers

necessary to administer these policies.

(4) The agency may contract with:

(b) An entity that is providing comprehensive behavioral health care services to certain Medicaid recipients through a capitated, prepaid arrangement pursuant to the federal waiver provided ~~for~~ by s. 409.905(5). Such entity must be licensed under chapter 624, chapter 636, or chapter 641, or authorized under paragraph (c) or paragraph (d), and must possess the clinical systems and operational competence to manage risk and provide comprehensive behavioral health care to Medicaid recipients. As used in this paragraph, the term "comprehensive behavioral health care services" means covered mental health and substance abuse treatment services that are available to Medicaid recipients. The secretary of the Department of Children and Family Services shall approve provisions of procurements related to children in the department's care or custody before enrolling such children in a prepaid behavioral health plan. Any contract awarded under this paragraph must be competitively procured. In developing the behavioral health care prepaid plan procurement document, the agency must ~~shall~~ ensure that the ~~procurement~~ document requires the contractor to develop and implement a plan that ensures ~~to ensure~~ compliance with s. 394.4574 related to services provided to residents of licensed assisted living facilities that hold a limited mental health license. Except as provided in subparagraph 5., and except in counties where the Medicaid managed care pilot program is authorized pursuant to s. 409.91211, the agency shall seek federal approval to contract with a single entity meeting these requirements to provide comprehensive behavioral health care

services to all Medicaid recipients not enrolled in a Medicaid managed care plan authorized under s. 409.91211, a provider service network authorized under paragraph (d), or a Medicaid health maintenance organization in an AHCA area. In an AHCA area where the Medicaid managed care pilot program is authorized pursuant to s. 409.91211 in one or more counties, the agency may procure a contract with a single entity to serve the remaining counties as an AHCA area or the remaining counties may be included with an adjacent AHCA area and are subject to this paragraph. Each entity must offer a sufficient choice of providers in its network to ensure recipient access to care and the opportunity to select a provider with whom they are satisfied. The network must ~~shall~~ include all public mental health hospitals. To ensure unimpaired access to behavioral health care services by Medicaid recipients, all contracts issued pursuant to this paragraph must require 80 percent of the capitation paid to the managed care plan, including health maintenance organizations and capitated provider service networks, to be expended for the provision of behavioral health care services. If the managed care plan expends less than 80 percent of the capitation paid for the provision of behavioral health care services, the difference shall be returned to the agency. The agency shall provide the plan with a certification letter indicating the amount of capitation paid during each calendar year for behavioral health care services pursuant to this section. The agency may reimburse for substance abuse treatment services on a fee-for-service basis until the agency finds that adequate funds are available for capitated, prepaid arrangements.

1. The agency shall modify the contracts with the entities providing comprehensive inpatient and outpatient mental health care services to Medicaid recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk Counties, to include substance abuse treatment services.

2. Except as provided in subparagraph 5., the agency and the Department of Children and Family Services shall contract with managed care entities in each AHCA area except area 6 or arrange to provide comprehensive inpatient and outpatient mental health and substance abuse services through capitated prepaid arrangements to all Medicaid recipients who are eligible to participate in such plans under federal law and regulation. In AHCA areas where eligible individuals number less than 150,000, the agency shall contract with a single managed care plan to provide comprehensive behavioral health services to all recipients who are not enrolled in a Medicaid health maintenance organization, a provider service network authorized under paragraph (d), or a Medicaid capitated managed care plan authorized under s. 409.91211. The agency may contract with more than one comprehensive behavioral health provider to provide care to recipients who are not enrolled in a Medicaid capitated managed care plan authorized under s. 409.91211, a provider service network authorized under paragraph (d), or a Medicaid health maintenance organization in AHCA areas where the eligible population exceeds 150,000. In an AHCA area where the Medicaid managed care pilot program is authorized pursuant to s. 409.91211 in one or more counties, the agency may procure a contract with a single entity to serve the remaining counties as an AHCA area or the remaining counties may be included with an

adjacent AHCA area and shall be subject to this paragraph. Contracts for comprehensive behavioral health providers awarded pursuant to this section shall be competitively procured. Both for-profit and not-for-profit corporations are eligible to compete. Managed care plans contracting with the agency under subsection (3) or paragraph (d) shall provide and receive payment for the same comprehensive behavioral health benefits as provided in AHCA rules, including handbooks incorporated by reference. In AHCA area 11, prior to any fiscal year for which the agency expects the number of MediPass enrollees in that area to exceed 150,000, the agency shall seek to contract with at least two comprehensive behavioral health care providers to provide behavioral health care to recipients in that area who are enrolled in, or assigned to, the MediPass program, and the agency must offer one. ~~One~~ of the behavioral health care contracts to ~~must be with~~ the existing public hospital-operated provider service network ~~pilot project,~~ as described in paragraph (d), for the purpose of demonstrating the cost-effectiveness of the provision of quality mental health services through a public hospital-operated managed care model. Payment shall be ~~at an agreed-upon~~ capitated ~~rate~~ to ensure cost savings. ~~Of the recipients in area 11 who are assigned to MediPass under s. 409.9122(2)(k), a minimum of 50,000 of those MediPass-enrolled recipients shall be assigned to the existing provider service network in area 11 for their behavioral care.~~

3. Children residing in a statewide inpatient psychiatric program, or in a Department of Juvenile Justice or a Department of Children and Family Services residential program approved as a Medicaid behavioral health overlay services provider may not

be included in a behavioral health care prepaid health plan or any other Medicaid managed care plan pursuant to this paragraph.

4. Traditional community mental health providers under contract with the Department of Children and Family Services pursuant to part IV of chapter 394, child welfare providers under contract with the Department of Children and Family Services in areas 1 and 6, and inpatient mental health providers licensed pursuant to chapter 395 must be offered an opportunity to accept or decline a contract to participate in a ~~any~~ provider network for prepaid behavioral health services.

5. All Medicaid-eligible children, except children in area 1 and children in Highlands County, Hardee County, Polk County, or Manatee County of area 6, which ~~that~~ are open for child welfare services in the statewide automated child welfare information system, shall receive their behavioral health care services through a specialty prepaid plan operated by community-based lead agencies through a single agency or formal agreements among several agencies. The agency shall work with the specialty plan to develop clinically effective, evidence-based alternatives as a downward substitution for the statewide inpatient psychiatric program and similar residential care and institutional services. The specialty prepaid plan must result in savings to the state comparable to savings achieved in other Medicaid managed care and prepaid programs. Such plan must provide mechanisms to maximize state and local revenues. The specialty prepaid plan shall be developed by the agency and the Department of Children and Family Services. The agency may seek federal waivers to implement this initiative. Medicaid-eligible children whose cases are open for child welfare services in the

statewide automated child welfare information system and who reside in AHCA area 10 shall be enrolled in a capitated provider service network or other capitated managed care plan, which, in coordination with available community-based care providers specified in s. 409.1671, must ~~shall~~ provide sufficient medical, developmental, and behavioral health services to meet the needs of these children.

This paragraph expires October 1, 2014.

(d)1. A provider service network, which may be reimbursed on a fee-for-service or prepaid basis. Prepaid provider service networks shall receive per-member, per-month payments. A provider service network that does not choose to be a prepaid plan shall receive fee-for-service rates with a shared savings settlement. The fee-for-service option shall be available to a provider service network only for the first 2 years of the plan's operation or until the contract year beginning September 1, 2014, whichever is later. The agency shall annually conduct cost reconciliations to determine the amount of cost savings achieved by fee-for-service provider service networks for the dates of service in the period being reconciled. Only payments for covered services for dates of service within the reconciliation period and paid within 6 months after the last date of service in the reconciliation period shall be included. The agency shall perform the necessary adjustments for the inclusion of claims incurred but not reported within the reconciliation for claims that could be received and paid by the agency after the 6-month claims processing time lag. The agency shall provide the results of the reconciliations to the fee-for-

service provider service networks within 45 days after the end of the reconciliation period. The fee-for-service provider service networks shall review and provide written comments or a letter of concurrence to the agency within 45 days after receipt of the reconciliation results. This reconciliation shall be considered final.

2. A provider service network that ~~which~~ is reimbursed by the agency on a prepaid basis is ~~shall be~~ exempt from parts I and III of chapter 641, but must comply with the solvency requirements in s. 641.2261(2) and meet appropriate financial reserve, quality assurance, and patient rights requirements ~~as~~ established by the agency.

3. The agency shall assign Medicaid recipients ~~assigned~~ to a provider service network in accordance with s. 409.9122 or s. 409.91211, as applicable ~~shall be chosen equally from those who would otherwise have been assigned to prepaid plans and MediPass~~. The agency may ~~is authorized to~~ seek federal Medicaid waivers as necessary to implement ~~the provisions of~~ this section. This subparagraph expires October 1, 2014.

4. A provider service network is a network established or organized and operated by a health care provider, or group of affiliated health care providers, including minority physician networks and emergency room diversion programs that meet the requirements of s. 409.91211, which provides a substantial proportion of the health care items and services under a contract directly through the provider or affiliated group of providers and may make arrangements with physicians or other health care professionals, health care institutions, or any combination of such individuals or institutions to assume all or

part of the financial risk on a prospective basis for the provision of basic health services by the physicians, by other health professionals, or through the institutions. The health care providers must have a controlling interest in the governing body of the provider service network organization.

Section 12. Section 409.9121, Florida Statutes, is amended to read:

409.9121 Legislative findings and intent.—The Legislature ~~hereby~~ finds that the Medicaid program ~~has experienced an annual growth rate of approximately 28 percent per year for the past 5 years, and is consuming more than half of all new general revenue growth. The present Medicaid system~~ must be reoriented to emphasize, to the maximum extent possible, the delivery of health care through entities and mechanisms that ~~which~~ are designed to contain costs, to emphasize preventive and primary care, and to promote access and continuity of care. The Legislature further finds that the concept of "managed care" best encompasses these multiple goals. ~~The Legislature also finds that, with the cooperation of the physician community, MediPass, the Medicaid primary care case management program, is responsible for ensuring that there is a sufficient supply of primary care to provide access to preventive and primary care services to Medicaid recipients.~~ Therefore, the Legislature declares its intent that the Medicaid program require, to the maximum extent practicable and permitted by federal law, that all Medicaid recipients be enrolled in a managed care program.

Section 13. Subsections (1), (2), (4), (5), and (12) of section 409.9122, Florida Statutes, are amended to read:

409.9122 Mandatory Medicaid managed care enrollment;

programs and procedures.—

(1) It is the intent of the Legislature that Medicaid managed care ~~the MediPass program~~ be cost-effective, provide quality health care, ~~and~~ improve access to health services, and ~~that the program~~ be implemented statewide. Medicaid managed care shall consist of the enrollment of Medicaid recipients in the MediPass program or managed care plans for comprehensive medical services. This subsection expires October 1, 2014.

(2)~~(a)~~ The agency shall enroll all Medicaid recipients in a managed care plan or MediPass ~~all Medicaid recipients~~, except those ~~Medicaid~~ recipients who are~~:~~ in an institution,~~;~~ enrolled in the Medicaid medically needy program,~~;~~ or eligible for both Medicaid and Medicare. Upon enrollment, recipients may ~~individuals will be able to~~ change their managed care option during the 90-day opt out period required by federal Medicaid regulations. The agency may ~~is authorized to~~ seek the necessary Medicaid state plan amendment to implement this policy. ~~However,~~

(a) To the extent permitted by federal law, the agency may enroll a recipient in a managed care plan or MediPass ~~a Medicaid recipient~~ who is exempt from mandatory managed care enrollment if~~, provided that~~:

1. The recipient's decision to enroll in a managed care plan or MediPass is voluntary;

2. ~~If~~ The recipient chooses to enroll in a managed care plan and~~,~~ the agency has determined that the managed care plan provides specific programs and services that ~~which~~ address the special health needs of the recipient; and

3. The agency receives any necessary waivers from the federal Centers for Medicare and Medicaid Services.

~~School districts participating in the certified school match program pursuant to ss. 409.908(21) and 1011.70 shall be reimbursed by Medicaid, subject to the limitations of s. 1011.70(1), for a Medicaid-eligible child participating in the services as authorized in s. 1011.70, as provided for in s. 409.9071, regardless of whether the child is enrolled in MediPass or a managed care plan. Managed care plans shall make a good faith effort to execute agreements with school districts regarding the coordinated provision of services authorized under s. 1011.70. County health departments delivering school-based services pursuant to ss. 381.0056 and 381.0057 shall be reimbursed by Medicaid for the federal share for a Medicaid-eligible child who receives Medicaid-covered services in a school setting, regardless of whether the child is enrolled in MediPass or a managed care plan. Managed care plans shall make a good faith effort to execute agreements with county health departments regarding the coordinated provision of services to a Medicaid-eligible child. To ensure continuity of care for Medicaid patients, the agency, the Department of Health, and the Department of Education shall develop procedures for ensuring that a student's managed care plan or MediPass provider receives information relating to services provided in accordance with ss. 381.0056, 381.0057, 409.9071, and 1011.70.~~

(b) A Medicaid recipient <u>may</u> ~~shall~~ not be enrolled in or assigned to a managed care plan or MediPass unless the managed care plan or MediPass has complied with the quality-of-care standards specified in paragraphs (3)(a) and (b), respectively.

(c) <u>A</u> Medicaid <u>recipient eligible for managed care</u>

enrollment ~~recipients~~ shall have a choice of managed care options ~~plans or MediPass~~. The Agency for Health Care Administration, the Department of Health, the Department of Children and Family Services, and the Department of Elderly Affairs shall cooperate to ensure that each ~~Medicaid~~ recipient receives clear and easily understandable information that meets the following requirements:

1. Explains the concept of managed care~~, including MediPass~~.

2. Provides information on the comparative performance of managed care options available to the recipient ~~plans and MediPass~~ in the areas of quality, credentialing, preventive health programs, network size and availability, and patient satisfaction.

3. Explains where additional information on each managed care option ~~plan and MediPass~~ in the recipient's area can be obtained.

4. Explains that recipients have the right to choose their managed care coverage at the time they first enroll in Medicaid and again at regular intervals set by the agency. However, if a recipient does not choose a managed care option ~~plan or MediPass~~, the agency shall ~~will~~ assign the recipient ~~to a managed care plan or MediPass~~ according to the criteria specified in this section.

5. Explains the recipient's right to complain, file a grievance, or change his or her managed care option as specified in this section ~~plans or MediPass providers if the recipient is not satisfied with the managed care plan or MediPass~~.

(d) The agency shall develop a mechanism for providing

information to Medicaid recipients for the purpose of choosing ~~making~~ a managed care option ~~plan or MediPass selection~~. Examples of such mechanisms ~~may~~ include, but are not ~~be~~ limited to, interactive information systems, mailings, and mass marketing materials. Managed care plans and MediPass providers may not provide ~~are prohibited from providing~~ inducements to ~~Medicaid~~ recipients to select their plans or prejudice ~~from prejudicing Medicaid~~ recipients against other managed care plans or MediPass providers.

(e) Medicaid recipients who are already enrolled in a managed care plan or MediPass shall be offered the opportunity to change managed care plans or MediPass providers, as applicable, on a staggered basis, as defined by the agency. All ~~Medicaid~~ recipients shall have 30 days in which to choose a managed care option ~~make a choice of managed care plans or MediPass providers~~. Those ~~Medicaid~~ recipients who do not make a choice shall be assigned in accordance with paragraph (f). ~~To facilitate continuity of care, for a Medicaid recipient who is also a recipient of Supplemental Security Income (SSI), prior to assigning the SSI recipient to a managed care plan or MediPass, the agency shall determine whether the SSI recipient has an ongoing relationship with a MediPass provider or managed care plan, and if so, the agency shall assign the SSI recipient to that MediPass provider or managed care plan. Those SSI recipients who do not have such a provider relationship shall be assigned to a managed care plan or MediPass provider in accordance with paragraph (f).~~

1. During the 30-day choice period:

a. A recipient residing in a county in which two or more

managed care plans are eligible to accept Medicaid enrollees, including a recipient who was enrolled in MediPass at the commencement of his or her 30-day choice period, shall choose from those managed care plans. A recipient may opt out of his or her choice and choose a different managed care plan during the 90-day opt out period.

b. A recipient residing in a county in which only one managed care plan is eligible to accept Medicaid enrollees shall choose the managed care plan or a MediPass provider. A recipient who chooses the managed care plan may opt out of the plan and choose a MediPass provider during the 90-day opt out period.

c. A recipient residing in a county in which no managed care plan is accepting Medicaid enrollees shall choose a MediPass provider.

2. For the purposes of recipient choice, if a managed care plan reaches its enrollment capacity, as determined by the agency, the plan may not accept additional Medicaid enrollees until the agency determines that the plan's enrollment is sufficiently less than its enrollment capacity, due to a decline in enrollment or by an increase in enrollment capacity. If a managed care plan notifies the agency of its intent to exit a county, the plan may not accept additional Medicaid enrollees in that county before the exit date.

3. As used in this paragraph, when referring to recipient choice, the term "managed care plans" includes health maintenance organizations, exclusive provider organizations, provider service networks, minority physician networks, Children's Medical Services Networks, and pediatric emergency department diversion programs authorized by this chapter or the

General Appropriations Act.

4. The agency shall seek federal waiver authority or a state plan amendment consistent with 42 U.S.C. 1396u-2(a)(1), as needed, to implement this paragraph.

(f) If a Medicaid recipient does not choose a managed care option:

1. If the recipient resides in a county in which two or more managed care plans are accepting Medicaid enrollees, the agency shall assign the recipient, including a recipient who was enrolled in MediPass at the commencement of his or her 30-day choice period, to one of those managed care plans. A recipient assigned to a managed care plan under this subparagraph may opt out of the managed care plan and enroll in a different managed care plan during the 90-day opt out period. The agency shall seek to make assignments among the managed care plans on an even basis under the criteria in subparagraph 6.

2. If the recipient resides in a county in which only one managed care plan is accepting Medicaid enrollees, the agency shall assign the recipient, including a recipient who was enrolled in MediPass at the commencement of his or her 30-day choice period, to the managed care plan. A recipient assigned to a managed care plan under this subparagraph may opt out of the managed care plan and choose a MediPass provider during the 90-day opt out period.

3. If the recipient resides in a county in which no managed care plan is accepting Medicaid enrollees, the agency shall assign the recipient to a MediPass provider.

4. For the purpose of assignment, if a managed care plan reaches its enrollment capacity, as determined by the agency,

the plan may not accept additional Medicaid enrollees until the agency determines that the plan's enrollment is sufficiently less than its enrollment capacity, due to a decline in enrollment or by an increase in enrollment capacity. If a managed care plan notifies the agency of its intent to exit a county, the agency may not assign additional Medicaid enrollees to the plan in that county before the exit date. ~~plan or MediPass provider, the agency shall assign the Medicaid recipient to a managed care plan or MediPass provider. Medicaid recipients eligible for managed care plan enrollment who are subject to mandatory assignment but who fail to make a choice shall be assigned to managed care plans until an enrollment of 35 percent in MediPass and 65 percent in managed care plans, of all those eligible to choose managed care, is achieved. Once this enrollment is achieved, the assignments shall be divided in order to maintain an enrollment in MediPass and managed care plans which is in a 35 percent and 65 percent proportion, respectively. Thereafter, assignment of Medicaid recipients who fail to make a choice shall be based proportionally on the preferences of recipients who have made a choice in the previous period. Such proportions shall be revised at least quarterly to reflect an update of the preferences of Medicaid recipients. The agency shall disproportionately assign Medicaid-eligible recipients who are required to but have failed to make a choice of managed care plan or MediPass to the Children's Medical Services Network as defined in s. 391.021, exclusive provider organizations, provider service networks, minority physician networks, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act, in~~

~~such manner as the agency deems appropriate, until the agency has determined that the networks and programs have sufficient numbers to be operated economically.~~

5. As used in ~~For purposes of~~ this paragraph, when referring to assignment, the term "managed care plans" includes health maintenance organizations, exclusive provider organizations, provider service networks, minority physician networks, Children's Medical Services Network, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act.

6. When making assignments, the agency shall consider ~~take into account~~ the following criteria, as applicable:

a.~~1.~~ Whether a managed care plan has sufficient network capacity to meet the need of members.

b.~~2.~~ Whether the managed care plan ~~or MediPass~~ has previously enrolled the recipient as a member, or one of the managed care plan's primary care providers or a MediPass primary care provider ~~providers~~ has previously provided health care to the recipient.

c.~~3.~~ Whether the agency has knowledge that the recipient ~~member~~ has previously expressed a preference for a particular managed care plan or MediPass primary care provider ~~as indicated by Medicaid fee-for-service claims data,~~ but has failed to make a choice.

d.~~4.~~ Whether the managed care plan's or MediPass primary care providers are geographically accessible to the recipient's residence.

e. If the recipient was already enrolled in a managed care plan at the commencement of his or her 30-day choice period and

fails to choose a different option, the recipient must remain enrolled in that same managed care plan.

f. To facilitate continuity of care for a Medicaid recipient who is also a recipient of Supplemental Security Income (SSI), before assigning the SSI recipient, the agency shall determine whether the SSI recipient has an ongoing relationship with a managed care plan or a MediPass primary care provider, and if so, the agency shall assign the SSI recipient to that managed care plan or MediPass provider, as applicable. However, if the recipient has an ongoing relationship with a MediPass primary care provider who is included in the provider network of one or more managed care plans, the agency shall assign the recipient to one of those managed care plans.

g. If the recipient is diagnosed with HIV/AIDS and resides in Broward County, Miami-Dade County, or Palm Beach County, the agency shall assign the Medicaid recipient to a managed care plan that is a health maintenance organization authorized under chapter 641, that was under contract with the agency on July 1, 2011, and that offers a delivery system in partnership with a university-based teaching and research-oriented organization specializing in providing health care services and treatment for individuals diagnosed with HIV/AIDS. Recipients not diagnosed with HIV/AIDS may not be assigned under this paragraph to a managed care plan that specializes in HIV/AIDS.

7. The agency shall seek federal waiver authority or a state plan amendment consistent with 42 U.S.C. 1396u-2(a)(4)(D), as needed, to implement this paragraph.

(g) When more than one managed care plan or MediPass provider meets the criteria specified in paragraph (f), the

agency shall make recipient assignments consecutively by family unit.

(h) The agency may not engage in practices that ~~are designed to~~ favor one managed care plan over another or that ~~are designed to~~ influence Medicaid recipients to enroll in MediPass rather than in a managed care plan or to enroll in a managed care plan rather than in MediPass, as applicable. This subsection does not prohibit the agency from reporting on the performance of MediPass or any managed care plan, as measured by performance criteria developed by the agency.

(i) After a recipient has made his or her selection or ~~has~~ been enrolled in a managed care plan or MediPass, the recipient shall have 90 days to exercise the opportunity to voluntarily disenroll and select another managed care option ~~plan or MediPass~~. After 90 days, no further changes may be made except for good cause. Good cause includes, but is not limited to, poor quality of care, lack of access to necessary specialty services, an unreasonable delay or denial of service, or fraudulent enrollment. The agency shall develop criteria for good cause disenrollment for chronically ill and disabled populations who are assigned to managed care plans if more appropriate care is available through the MediPass program. The agency must make a determination as to whether good cause exists. However, the agency may require a recipient to use the managed care plan's or MediPass grievance process prior to the agency's determination of good cause, except in cases in which immediate risk of permanent damage to the recipient's health is alleged. The grievance process, if used ~~when utilized~~, must be completed in time to permit the recipient to disenroll by the first day of

the second month after the month the disenrollment request was made. If the managed care plan or MediPass, as a result of the grievance process, approves an enrollee's request to disenroll, the agency is not required to make a determination in the case. The agency must make a determination and take final action on a recipient's request so that disenrollment occurs by ~~no later than~~ the first day of the second month after the month the request was made. If the agency fails to act within the specified timeframe, the recipient's request to disenroll is deemed to be approved as of the date agency action was required. Recipients who disagree with the agency's finding that good cause does not exist for disenrollment shall be advised of their right to pursue a Medicaid fair hearing to dispute the agency's finding.

(j) Consistent with 42 U.S.C. 1396u-2(a)(4)(A) or under federal waiver authority, as needed, the agency shall ~~apply for a federal waiver from the Centers for Medicare and Medicaid Services to~~ lock eligible Medicaid recipients into a managed care plan or MediPass for 12 months after an ~~open~~ enrollment period, except for the 90-day opt out period and good cause disenrollment. After 12 months' enrollment, a recipient may select another managed care ~~plan or MediPass provider~~. However, ~~nothing shall prevent~~ a Medicaid recipient may not be prevented from changing primary care providers within the managed care plan or MediPass program, as applicable, during the 12-month period.

(k) The agency shall maintain MediPass provider networks in all counties, including those counties in which two or more managed care plans are accepting Medicaid enrollees. ~~When a~~

~~Medicaid recipient does not choose a managed care plan or MediPass provider, the agency shall assign the Medicaid recipient to a managed care plan, except in those counties in which there are fewer than two managed care plans accepting Medicaid enrollees, in which case assignment shall be to a managed care plan or a MediPass provider. Medicaid recipients in counties with fewer than two managed care plans accepting Medicaid enrollees who are subject to mandatory assignment but who fail to make a choice shall be assigned to managed care plans until an enrollment of 35 percent in MediPass and 65 percent in managed care plans, of all those eligible to choose managed care, is achieved. Once that enrollment is achieved, the assignments shall be divided in order to maintain an enrollment in MediPass and managed care plans which is in a 35 percent and 65 percent proportion, respectively. For purposes of this paragraph, when referring to assignment, the term "managed care plans" includes exclusive provider organizations, provider service networks, Children's Medical Services Network, minority physician networks, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act. When making assignments, the agency shall take into account the following criteria:~~

~~1. A managed care plan has sufficient network capacity to meet the need of members.~~

~~2. The managed care plan or MediPass has previously enrolled the recipient as a member, or one of the managed care plan's primary care providers or MediPass providers has previously provided health care to the recipient.~~

~~3. The agency has knowledge that the member has previously~~

~~expressed a preference for a particular managed care plan or MediPass provider as indicated by Medicaid fee-for-service claims data, but has failed to make a choice.~~

~~4. The managed care plan's or MediPass primary care providers are geographically accessible to the recipient's residence.~~

~~5. The agency has authority to make mandatory assignments based on quality of service and performance of managed care plans.~~

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

(l)~~(m)~~ Notwithstanding ~~the provisions of~~ chapter 287, the agency may~~, at its discretion,~~ renew cost-effective contracts for choice counseling services once or more for such periods as the agency may decide. However, all such renewals may not combine to exceed a total period longer than the term of the original contract.

This subsection expires October 1, 2014.

(4)(a) Each female recipient may select as her primary care provider an obstetrician/gynecologist who has agreed to participate within a managed care plan's provider network or as

a MediPass primary care case manager, as applicable.

(b) The agency shall establish a complaints and grievance process to assist Medicaid recipients enrolled in the MediPass program to resolve complaints and grievances. The agency shall investigate reports of quality-of-care grievances which remain unresolved to the satisfaction of the enrollee.

This subsection expires October 1, 2014.

(5)(a) The agency shall work cooperatively with the Social Security Administration to identify recipients ~~beneficiaries~~ who are jointly eligible for Medicare and Medicaid and shall develop cooperative programs to encourage these recipients ~~beneficiaries~~ to enroll in a Medicare participating health maintenance organization or prepaid health plans.

(b) The agency shall work cooperatively with the Department of Elderly Affairs to assess the potential cost-effectiveness of providing managed care enrollment ~~MediPass~~ to recipients ~~beneficiaries~~ who are jointly eligible for Medicare and Medicaid on a voluntary choice basis. If the agency determines that enrollment of these recipients ~~beneficiaries~~ in managed care ~~MediPass~~ has the potential for being cost-effective for the state, the agency shall offer managed care enrollment ~~MediPass~~ to these recipients ~~beneficiaries~~ on a voluntary choice basis in the counties where managed care is available ~~MediPass operates~~.

This subsection expires October 1, 2014.

(12) The agency shall include in its calculation of the hospital inpatient component of a Medicaid health maintenance organization's capitation rate any special payments, including,

but not limited to, upper payment limit or disproportionate share hospital payments, made to qualifying hospitals through the fee-for-service program. The agency may seek federal waiver approval or state plan amendment as needed to implement this adjustment. This subsection expires September 1, 2012.

Section 14. Section 409.9123, Florida Statutes, is amended to read:

409.9123 Quality-of-care reporting. ~~In order to promote competition between Medicaid managed care plans and MediPass based on quality-of-care indicators,~~ The agency shall annually develop and publish a set of measures of managed care plan performance based on quality-of-care indicators. This information shall be made available to each Medicaid recipient who makes a choice of a managed care plan in her or his area. This information must ~~shall~~ be easily understandable to the ~~Medicaid~~ recipient and ~~shall~~ use nationally recognized standards wherever possible. In formulating this information, the agency shall, at a minimum, consider ~~take into account at least~~ the following:

(1) The recommendations of the National Committee for Quality Assurance Medicaid HEDIS Task Force.

(2) Requirements and recommendations of the Centers for Medicare and Medicaid Services ~~Health Care Financing Administration~~.

(3) Recommendations of the managed care industry.

Section 15. For the purpose of incorporating the amendment made by this act to section 409.9122, Florida Statutes, in a reference thereto, subsection (1) of section 409.9126, Florida Statutes, is reenacted to read:

409.9126 Children with special health care needs.—

(1) Except as provided in subsection (4), children eligible for Children's Medical Services who receive Medicaid benefits, and other Medicaid-eligible children with special health care needs, shall be exempt from the provisions of s. 409.9122 and shall be served through the Children's Medical Services network established in chapter 391.

Section 16. Effective upon this act becoming a law, subsections (4) through (6) of section 409.915, Florida Statutes, are amended, and subsections (7) through (11) are added to that section, to read:

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

(4) Each county shall contribute ~~pay into the General Revenue Fund, unallocated,~~ its pro rata share of the total county participation based upon statements rendered by the agency ~~in consultation with the counties~~. The agency shall render such statements monthly based on each county's eligible recipients. For purposes of this section, each county's eligible recipients shall be determined by the recipients' address information contained in the federally approved Medicaid eligibility system within the Department of Children and Family Services. The process developed under subsection (10) may be used for cases in which the Medicaid eligibility system's address information may indicate a need for revision.

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

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

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

(7) By September 1, 2012, the agency shall certify to the Department of Revenue, for each county, an amount equal to 85 percent of each county's billings through April 30, 2012, which remain unpaid.

(8)(a) Beginning with the October 2012 distribution, the Department of Revenue shall reduce each county's distributions pursuant to s. 218.26 by one thirty-sixth of the amount certified by the agency under subsection (7) for that county.

However, the amount of the reduction may not exceed 50 percent of each county's distribution. If, after 36 months, the reductions for each county do not equal the total amount initially certified by the agency, the Department of Revenue shall continue to reduce each distribution by up to 50 percent until the total amount certified is reached. The amounts by which the distributions are reduced shall be transferred to the General Revenue Fund.

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

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

(b) As an assurance to holders of bonds issued before the effective date of this act to which distributions made pursuant to s. 218.61 are pledged, or bonds issued to refund such bonds which mature no later than the bonds they refunded and which result in a reduction of debt service payable in each fiscal year, the amount available for distribution to a county shall remain as provided by law and continue to be subject to any lien or claim on behalf of the bondholders. The Department of Revenue must ensure that any reductions in amounts distributed pursuant to paragraph (a) does not reduce the amount of distribution to a county below the amount necessary for the payment of principal and interest on the bonds and the amount necessary to comply with any covenant under the bond resolution or other documents relating to the issuance of the bonds.

(10) The Department of Revenue shall pay certified refund requests in accordance with a process developed by the agency and the department which:

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

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

(c) Requires the department to issue the refund for the certified amount to the county from the General Revenue Fund.

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

Officer shall transfer from the General Revenue Fund to the Lawton Chiles Endowment Fund an amount equal to the amounts transferred to the General Revenue Fund in the previous fiscal year pursuant to subsections (8) and (9), reduced by the amount of refunds paid pursuant to subsection (10), which are in excess of the official estimate for medical hospital fees for such previous fiscal year adopted by the Revenue Estimating Conference on January 12, 2012, as reflected in the conference's workpapers. By July 20 of each year, the Office of Economic and Demographic Research shall certify the amount to be transferred to the Chief Financial Officer. Such transfers must be made before July 31 of each year until the total transfers for all years equal $265 million. The Office of Economic and Demographic Research shall publish the official estimates reflected in the conference's workpapers on its website.

Section 17. Subsection (2) of section 409.979, Florida Statutes, is amended to read:

409.979 Eligibility.—

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

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

(b) The Aged and Disabled Adult Waiver.

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

(c)~~(d)~~ The Consumer-Directed Care Plus Program as described

in s. 409.221.

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

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

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

Section 18. Subsection (15) of section 430.04, Florida Statutes, is amended to read:

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

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

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

(b) The Aged and Disabled Adult Waiver.

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

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

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

(e) ~~(f)~~ The Long-Term Care Community-Based Diversion Pilot Project as described in s. 430.705.

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

The department shall develop a transition plan for recipients receiving services in long-term care Medicaid waivers for elders or disabled adults on the date eligible plans become available in each recipient’s region defined in s. 409.981(2) to enroll those recipients in eligible plans. This subsection expires October 1, 2014.

Section 19. Section 31 of chapter 2009-223, Laws of

Florida, as amended by section 44 of chapter 2010-151, Laws of Florida, is redesignated as section 409.9132, Florida Statutes, and amended to read:

409.9132 ~~Section 31.~~ Pilot project to monitor home health services.—The agency ~~for Health Care Administration~~ shall expand the ~~develop and implement a~~ home health agency monitoring pilot project in Miami-Dade County on a statewide basis effective July 1, 2012, except in counties in which the program will not be cost-effective, as determined by the agency ~~by January 1, 2010~~. The agency shall contract with a vendor to verify the utilization and delivery of home health services and provide an electronic billing interface for home health services. The contract must require the creation of a program to submit claims electronically for the delivery of home health services. The program must verify telephonically visits for the delivery of home health services using voice biometrics. The agency may seek amendments to the Medicaid state plan and waivers of federal laws, as necessary, to implement or expand the pilot project. Notwithstanding s. 287.057(3)(f), ~~Florida Statutes,~~ the agency must award the contract through the competitive solicitation process and may use the current contract to expand the home health agency monitoring pilot project to include additional counties as authorized under this section. ~~The agency shall submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives evaluating the pilot project by February 1, 2011.~~

Section 20. Section 32 of chapter 2009-223, Laws of Florida, is redesignated as section 409.9133, Florida Statutes, and amended to read:

409.9133 ~~Section 32.~~ Pilot project for home health care management.—The agency ~~for Health Care Administration~~ shall expand the ~~implement a~~ comprehensive care management pilot project for home health services statewide and include private-duty nursing and personal care services effective July 1, 2012, except in counties in which the program will not be cost-effective, as determined by the agency ~~by January 1, 2010~~. The program must include~~, which includes~~ face-to-face assessments by a nurse licensed pursuant to chapter 464, ~~Florida Statutes,~~ consultation with physicians ordering services to substantiate the medical necessity for services, and on-site or desk reviews of recipients' medical records ~~in Miami-Dade County~~. The agency may ~~enter into a~~ contract with a qualified organization to implement or expand the pilot project. The agency may use the current contract to expand the comprehensive care management pilot project to include the additional services and counties authorized under this section. The agency may seek amendments to the Medicaid state plan and waivers of federal laws, as necessary, to implement or expand the pilot project.

Section 21. Notwithstanding s. 430.707, Florida Statutes, and subject to federal approval of an additional site for the Program of All-Inclusive Care for the Elderly (PACE), the Agency for Health Care Administration shall contract with a current PACE organization authorized to provide PACE services in Southeast Florida to develop and operate a PACE program in Broward County to serve frail elders who reside in Broward County. The organization shall be exempt from chapter 641, Florida Statutes. The agency, in consultation with the Department of Elderly Affairs and subject to an appropriation,

shall approve up to 150 initial enrollee slots in the Broward program established by the organization.

Section 22. Effective upon this act becoming a law and for the 2011-2012 state fiscal year only, a public hospital located in trauma service area 2 which has local funds available for intergovernmental transfers that allow for exemptions from inpatient and outpatient reimbursement limitations may, notwithstanding s. 409.905(5)(c), Florida Statues, have its reimbursement rates adjusted after September 30 of the state fiscal year in which the rates take effect.

Section 23. Except as otherwise expressly provided in this act and except for this section, which shall take effect upon this act becoming a law, this act shall take effect July 1. 2012.