

1                                   A bill to be entitled  
2       An act relating to Medicaid services; amending s.  
3       409.902, F.S.; creating, subject to appropriation, an  
4       Internet-based system for eligibility determination  
5       for Medicaid and the Children's Health Insurance  
6       Program; requiring the system to accomplish specified  
7       business objectives; requiring the Department of  
8       Children and Family Services to develop the system  
9       contingent upon an appropriation; requiring the system  
10      to be completed and implemented by specified dates;  
11      requiring the department to implement a governance  
12      structure pending implementation of the program;  
13      providing for the membership and duties of an  
14      executive steering committee and a project management  
15      team; amending s. 409.905, F.S.; limiting payment for  
16      emergency room services for a nonpregnant Medicaid  
17      recipient 21 years of age or older under certain  
18      circumstances; amending s. 409.906, F.S.; eliminating  
19      Medicaid optional coverage for chiropractic services  
20      for a Medicaid recipient 21 years of age or older by a  
21      specified date; eliminating Medicaid optional coverage  
22      for podiatric services for a Medicaid recipient 21  
23      years of age or older by a specified date; amending s.  
24      409.911, F.S.; continuing the audited data specified  
25      for use in calculating amounts due to hospitals under  
26      the disproportionate share program; amending s.  
27      409.9112, F.S.; continuing the prohibition against  
28      distributing moneys under the disproportionate share

29 program for regional perinatal intensive care centers;  
 30 amending s. 409.9113, F.S.; continuing the  
 31 authorization for the distribution of moneys to  
 32 certain teaching hospitals under the disproportionate  
 33 share program; amending s. 409.9117, F.S.; continuing  
 34 the prohibition against distributing moneys under the  
 35 primary care disproportionate share program; amending  
 36 ss. 409.979 and 430.04, F.S.; deleting references to  
 37 the Adult Day Health Care Waiver in provisions  
 38 relating to Medicaid eligibility and duties and  
 39 responsibilities of the Department of Elderly Affairs;  
 40 amending s. 31, ch. 2009-223, Laws of Florida, as  
 41 amended, and redesignating the section as s. 409.9132,  
 42 F.S.; expanding the scope of the home health agency  
 43 monitoring pilot project; amending s. 32, ch. 2009-  
 44 223, Laws of Florida, and redesignating the section as  
 45 s. 409.9133, F.S.; expanding the scope of the  
 46 comprehensive care management pilot project for home  
 47 health services; authorizing the Agency for Health  
 48 Care Administration to contract with certain  
 49 organizations to provide services under the federal  
 50 Program of All-inclusive Care for the Elderly in  
 51 specified counties; exempting such organizations from  
 52 ch. 641, F.S., relating to health care services  
 53 programs; authorizing, subject to appropriation,  
 54 enrollment slots for the program in such counties;  
 55 providing an effective date.

56

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

58

59 Section 1. Subsections (3) through (8) are added to  
60 section 409.902, Florida Statutes, to read:

61 409.902 Designated single state agency; payment  
62 requirements; program title; release of medical records.-

63 (3) To the extent that funds are appropriated, the  
64 department shall collaborate with the Agency for Health Care  
65 Administration to develop an Internet-based system for  
66 eligibility determination for Medicaid and the Children's Health  
67 Insurance Program (CHIP) that complies with all applicable  
68 federal and state laws and requirements.

69 (4) The system shall accomplish the following primary  
70 business objectives:

71 (a) Provide individuals and families with a single point  
72 of access to information that explains benefits, premiums, and  
73 cost-sharing available through Medicaid, the Children's Health  
74 Insurance Program, or any other state or federal health  
75 insurance exchange.

76 (b) Enable timely, accurate, and efficient enrollment of  
77 eligible persons into available assistance programs.

78 (c) Prevent eligibility fraud.

79 (d) Allow for detailed financial analysis of eligibility-  
80 based cost drivers.

81 (5) The system shall include, but is not limited to, the  
82 following business and functional requirements:

83 (a) Allow for the completion and submission of an online  
84 application for eligibility determination that accepts the use

85 of electronic signatures.

86 (b) Include a process that enables automatic enrollment of  
 87 qualified individuals in Medicaid, the Children's Health  
 88 Insurance Program, or any other state or federal exchange that  
 89 offers cost-sharing benefits for the purchase of health  
 90 insurance.

91 (c) Allow for the determination of Medicaid eligibility  
 92 based on modified adjusted gross income by using information  
 93 submitted in the application and information accessed and  
 94 verified through automated and secure interfaces with authorized  
 95 databases.

96 (d) Include the ability to determine specific categories  
 97 of Medicaid eligibility and interfaces with the Florida Medicaid  
 98 Management Information System to support a determination, using  
 99 federally approved assessment methodologies, of state and  
 100 federal financial participation rates for persons in each  
 101 eligibility category.

102 (e) Allow for the accurate and timely processing of  
 103 eligibility claims and adjudications.

104 (f) Align with and incorporate all applicable state and  
 105 federal laws, requirements, and standards to include the  
 106 information technology security requirements established  
 107 pursuant to s. 282.318 and the accessibility standards  
 108 established under part II of chapter 282.

109 (g) Produce transaction data, reports, and performance  
 110 information that contribute to an evaluation of the program,  
 111 continuous improvement in business operations, and increased  
 112 transparency and accountability.

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

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

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

120 (a) The director of the Economic Self-Sufficiency Services  
 121 program office of the department shall have overall  
 122 responsibility for the project.

123 (b) The project shall be governed by an executive steering  
 124 committee that is composed of three staff members of the  
 125 department appointed by the Secretary of Children and Family  
 126 Services and three staff members of the Agency for Health Care  
 127 Administration, including at least two Florida Medicaid program  
 128 staff members, appointed by the Secretary of Health Care  
 129 Administration.

130 (c) The executive steering committee shall have the  
 131 overall responsibility for ensuring that the project meets its  
 132 primary business objectives and shall:

133 1. Provide management direction and support to the project  
 134 management team.

135 2. Review and approve any changes to the project's scope,  
 136 schedule, and budget.

137 3. Review, approve, and determine whether to proceed with  
 138 any major deliverable project.

139 4. Recommend suspension or termination of the project to  
 140 the Governor, the President of the Senate, and the Speaker of

141 the House of Representatives if the committee determines that  
 142 the primary business objectives cannot be achieved.

143 (d) A project management team shall be appointed by and  
 144 work under the direction of the executive steering committee.  
 145 The project management team shall:

146 1. Provide planning, management, and oversight of the  
 147 project.

148 2. Submit an operational work plan and provide quarterly  
 149 updates to the plan to the executive steering committee. The  
 150 plan must specify project milestones, deliverables, and  
 151 expenditures.

152 3. Submit written monthly project status reports to the  
 153 executive steering committee.

154 Section 2. Subsection (5) of section 409.905, Florida  
 155 Statutes, is amended to read:

156 409.905 Mandatory Medicaid services.—The agency may make  
 157 payments for the following services, which are required of the  
 158 state by Title XIX of the Social Security Act, furnished by  
 159 Medicaid providers to recipients who are determined to be  
 160 eligible on the dates on which the services were provided. Any  
 161 service under this section shall be provided only when medically  
 162 necessary and in accordance with state and federal law.  
 163 Mandatory services rendered by providers in mobile units to  
 164 Medicaid recipients may be restricted by the agency. Nothing in  
 165 this section shall be construed to prevent or limit the agency  
 166 from adjusting fees, reimbursement rates, lengths of stay,  
 167 number of visits, number of services, or any other adjustments  
 168 necessary to comply with the availability of moneys and any

169 limitations or directions provided for in the General  
 170 Appropriations Act or chapter 216.

171 (5) HOSPITAL INPATIENT SERVICES.—The agency shall pay for  
 172 all covered services provided for the medical care and treatment  
 173 of a recipient who is admitted as an inpatient by a licensed  
 174 physician or dentist to a hospital licensed under part I of  
 175 chapter 395. However, the agency shall limit the payment for  
 176 inpatient hospital services for a Medicaid recipient 21 years of  
 177 age or older to 45 days or the number of days necessary to  
 178 comply with the General Appropriations Act. The agency shall  
 179 also limit the payment for emergency room services for a  
 180 nonpregnant Medicaid recipient 21 years of age or older to 12  
 181 visits per fiscal year or the number of visits necessary to  
 182 comply with the General Appropriations Act.

183 (a) The agency may ~~is authorized to~~ implement  
 184 reimbursement and utilization management reforms in order to  
 185 comply with any limitations or directions in the General  
 186 Appropriations Act, which may include, but are not limited to:  
 187 prior authorization for inpatient psychiatric days; prior  
 188 authorization for nonemergency hospital inpatient admissions for  
 189 individuals 21 years of age and older; authorization of  
 190 emergency and urgent-care admissions within 24 hours after  
 191 admission; enhanced utilization and concurrent review programs  
 192 for highly utilized services; reduction or elimination of  
 193 covered days of service; adjusting reimbursement ceilings for  
 194 variable costs; adjusting reimbursement ceilings for fixed and  
 195 property costs; and implementing target rates of increase. The  
 196 agency may limit prior authorization for hospital inpatient

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197 services to selected diagnosis-related groups, based on an  
198 analysis of the cost and potential for unnecessary  
199 hospitalizations represented by certain diagnoses. Admissions  
200 for normal delivery and newborns are exempt from requirements  
201 for prior authorization. In implementing the provisions of this  
202 section related to prior authorization, the agency shall ensure  
203 that the process for authorization is accessible 24 hours per  
204 day, 7 days per week and authorization is automatically granted  
205 when not denied within 4 hours after the request. Authorization  
206 procedures must include steps for review of denials. Upon  
207 implementing the prior authorization program for hospital  
208 inpatient services, the agency shall discontinue its hospital  
209 retrospective review program.

210 (b) A licensed hospital maintained primarily for the care  
211 and treatment of patients having mental disorders or mental  
212 diseases is not eligible to participate in the hospital  
213 inpatient portion of the Medicaid program except as provided in  
214 federal law. However, the department shall apply for a waiver,  
215 within 9 months after June 5, 1991, designed to provide  
216 hospitalization services for mental health reasons to children  
217 and adults in the most cost-effective and lowest cost setting  
218 possible. Such waiver shall include a request for the  
219 opportunity to pay for care in hospitals known under federal law  
220 as "institutions for mental disease" or "IMD's." The waiver  
221 proposal shall propose no additional aggregate cost to the state  
222 or Federal Government, and shall be conducted in Hillsborough  
223 County, Highlands County, Hardee County, Manatee County, and  
224 Polk County. The waiver proposal may incorporate competitive

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

V



225 bidding for hospital services, comprehensive brokering, prepaid  
 226 capitated arrangements, or other mechanisms deemed by the  
 227 department to show promise in reducing the cost of acute care  
 228 and increasing the effectiveness of preventive care. When  
 229 developing the waiver proposal, the department shall take into  
 230 account price, quality, accessibility, linkages of the hospital  
 231 to community services and family support programs, plans of the  
 232 hospital to ensure the earliest discharge possible, and the  
 233 comprehensiveness of the mental health and other health care  
 234 services offered by participating providers.

235 (c) The agency shall implement a methodology for  
 236 establishing base reimbursement rates for each hospital based on  
 237 allowable costs, as defined by the agency. Rates shall be  
 238 calculated annually and take effect July 1 of each year based on  
 239 the most recent complete and accurate cost report submitted by  
 240 each hospital. Adjustments may not be made to the rates after  
 241 September 30 of the state fiscal year in which the rate takes  
 242 effect. Errors in cost reporting or calculation of rates  
 243 discovered after September 30 must be reconciled in a subsequent  
 244 rate period. The agency may not make any adjustment to a  
 245 hospital's reimbursement rate more than 5 years after a hospital  
 246 is notified of an audited rate established by the agency. The  
 247 requirement that the agency may not make any adjustment to a  
 248 hospital's reimbursement rate more than 5 years after a hospital  
 249 is notified of an audited rate established by the agency is  
 250 remedial and shall apply to actions by providers involving  
 251 Medicaid claims for hospital services. Hospital rates shall be  
 252 subject to such limits or ceilings as may be established in law

253 or described in the agency's hospital reimbursement plan.  
 254 Specific exemptions to the limits or ceilings may be provided in  
 255 the General Appropriations Act.

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

269 (e) The agency may develop and implement a program to  
 270 reduce the number of hospital readmissions among the non-  
 271 Medicare population eligible in areas 9, 10, and 11.

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

281 hospital expenditures. The agency shall submit the Medicaid DRG  
 282 plan, identifying all steps necessary for the transition and any  
 283 costs associated with plan implementation, to the Governor, the  
 284 President of the Senate, and the Speaker of the House of  
 285 Representatives no later than January 1, 2013.

286 Section 3. Subsections (7) and (19) of section 409.906,  
 287 Florida Statutes, are amended to read:

288 409.906 Optional Medicaid services.—Subject to specific  
 289 appropriations, the agency may make payments for services which  
 290 are optional to the state under Title XIX of the Social Security  
 291 Act and are furnished by Medicaid providers to recipients who  
 292 are determined to be eligible on the dates on which the services  
 293 were provided. Any optional service that is provided shall be  
 294 provided only when medically necessary and in accordance with  
 295 state and federal law. Optional services rendered by providers  
 296 in mobile units to Medicaid recipients may be restricted or  
 297 prohibited by the agency. Nothing in this section shall be  
 298 construed to prevent or limit the agency from adjusting fees,  
 299 reimbursement rates, lengths of stay, number of visits, or  
 300 number of services, or making any other adjustments necessary to  
 301 comply with the availability of moneys and any limitations or  
 302 directions provided for in the General Appropriations Act or  
 303 chapter 216. If necessary to safeguard the state's systems of  
 304 providing services to elderly and disabled persons and subject  
 305 to the notice and review provisions of s. 216.177, the Governor  
 306 may direct the Agency for Health Care Administration to amend  
 307 the Medicaid state plan to delete the optional Medicaid service  
 308 known as "Intermediate Care Facilities for the Developmentally

309 Disabled." Optional services may include:

310 (7) CHIROPRACTIC SERVICES.—Effective August 1, 2012, the  
 311 agency may pay for manual manipulation of the spine and initial  
 312 services, screening, and X rays provided to a Medicaid recipient  
 313 under the age of 21 by a licensed chiropractic physician.

314 (19) PODIATRIC SERVICES.—Effective August 1, 2012, the  
 315 agency may pay for services, including diagnosis and medical,  
 316 surgical, palliative, and mechanical treatment, related to  
 317 ailments of the human foot and lower leg, if provided to a  
 318 Medicaid recipient under the age of 21 by a podiatric physician  
 319 licensed under state law.

320 Section 4. Paragraph (a) of subsection (2) and paragraph  
 321 (d) of subsection (4) of section 409.911, Florida Statutes, are  
 322 amended to read:

323 409.911 Disproportionate share program.—Subject to  
 324 specific allocations established within the General  
 325 Appropriations Act and any limitations established pursuant to  
 326 chapter 216, the agency shall distribute, pursuant to this  
 327 section, moneys to hospitals providing a disproportionate share  
 328 of Medicaid or charity care services by making quarterly  
 329 Medicaid payments as required. Notwithstanding the provisions of  
 330 s. 409.915, counties are exempt from contributing toward the  
 331 cost of this special reimbursement for hospitals serving a  
 332 disproportionate share of low-income patients.

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

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

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

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

347 Section 5. Section 409.9112, Florida Statutes, is amended  
 348 to read:

349 409.9112 Disproportionate share program for regional  
 350 perinatal intensive care centers.—In addition to the payments  
 351 made under s. 409.911, the agency shall design and implement a  
 352 system for making disproportionate share payments to those  
 353 hospitals that participate in the regional perinatal intensive  
 354 care center program established pursuant to chapter 383. The  
 355 system of payments must conform to federal requirements and  
 356 distribute funds in each fiscal year for which an appropriation  
 357 is made by making quarterly Medicaid payments. Notwithstanding  
 358 s. 409.915, counties are exempt from contributing toward the  
 359 cost of this special reimbursement for hospitals serving a  
 360 disproportionate share of low-income patients. For the 2012-2013  
 361 ~~2011-2012~~ state fiscal year, the agency may not distribute  
 362 moneys under the regional perinatal intensive care centers  
 363 disproportionate share program.

364 (1) The following formula shall be used by the agency to

365 calculate the total amount earned for hospitals that participate  
 366 in the regional perinatal intensive care center program:

$$367 \quad \text{TAE} = \text{HDSP} / \text{THDSP}$$

368 Where:

369 TAE = total amount earned by a regional perinatal intensive  
 370 care center.

371 HDSP = the prior state fiscal year regional perinatal  
 372 intensive care center disproportionate share payment to the  
 373 individual hospital.

374 THDSP = the prior state fiscal year total regional  
 375 perinatal intensive care center disproportionate share payments  
 376 to all hospitals.

377 (2) The total additional payment for hospitals that  
 378 participate in the regional perinatal intensive care center  
 379 program shall be calculated by the agency as follows:

$$380 \quad \text{TAP} = \text{TAE} \times \text{TA}$$

381 Where:

382 TAP = total additional payment for a regional perinatal  
 383 intensive care center.

384 TAE = total amount earned by a regional perinatal intensive  
 385 care center.

386 TA = total appropriation for the regional perinatal  
 387 intensive care center disproportionate share program.

388 (3) In order to receive payments under this section, a  
 389 hospital must be participating in the regional perinatal  
 390 intensive care center program pursuant to chapter 383 and must  
 391 meet the following additional requirements:

392 (a) Agree to conform to all departmental and agency

393 requirements to ensure high quality in the provision of  
 394 services, including criteria adopted by departmental and agency  
 395 rule concerning staffing ratios, medical records, standards of  
 396 care, equipment, space, and such other standards and criteria as  
 397 the department and agency deem appropriate as specified by rule.

398 (b) Agree to provide information to the Department of  
 399 Health and the agency, in a form and manner prescribed by rule  
 400 of the department and agency, concerning the care provided to  
 401 all patients in neonatal intensive care centers and high-risk  
 402 maternity care.

403 (c) Agree to accept all patients for neonatal intensive  
 404 care and high-risk maternity care, regardless of ability to pay,  
 405 on a functional space-available basis.

406 (d) Agree to develop arrangements with other maternity and  
 407 neonatal care providers in the hospital's region for the  
 408 appropriate receipt and transfer of patients in need of  
 409 specialized maternity and neonatal intensive care services.

410 (e) Agree to establish and provide a developmental  
 411 evaluation and services program for certain high-risk neonates,  
 412 as prescribed and defined by rule of the department.

413 (f) Agree to sponsor a program of continuing education in  
 414 perinatal care for health care professionals within the region  
 415 of the hospital, as specified by rule.

416 (g) Agree to provide backup and referral services to the  
 417 county health departments and other low-income perinatal  
 418 providers within the hospital's region, including the  
 419 development of written agreements between these organizations  
 420 and the hospital.

421 (h) Agree to arrange for transportation for high-risk  
 422 obstetrical patients and neonates in need of transfer from the  
 423 community to the hospital or from the hospital to another more  
 424 appropriate facility.

425 (4) Hospitals that fail to comply with any of the  
 426 conditions in subsection (3) or the applicable rules of the  
 427 Department of Health and the agency may not receive any payments  
 428 under this section until full compliance is achieved. A hospital  
 429 that is not in compliance in two or more consecutive quarters  
 430 may not receive its share of the funds. Any forfeited funds  
 431 shall be distributed by the remaining participating regional  
 432 perinatal intensive care center program hospitals.

433 Section 6. Section 409.9113, Florida Statutes, is amended  
 434 to read:

435 409.9113 Disproportionate share program for teaching  
 436 hospitals.—In addition to the payments made under ss. 409.911  
 437 and 409.9112, the agency shall make disproportionate share  
 438 payments to teaching hospitals, as defined in s. 408.07, for  
 439 their increased costs associated with medical education programs  
 440 and for tertiary health care services provided to the indigent.  
 441 This system of payments must conform to federal requirements and  
 442 distribute funds in each fiscal year for which an appropriation  
 443 is made by making quarterly Medicaid payments. Notwithstanding  
 444 s. 409.915, counties are exempt from contributing toward the  
 445 cost of this special reimbursement for hospitals serving a  
 446 disproportionate share of low-income patients. For the 2012-2013  
 447 ~~2011-2012~~ state fiscal year, the agency shall distribute the  
 448 moneys provided in the General Appropriations Act to statutorily



449 defined teaching hospitals and family practice teaching  
 450 hospitals, as defined in s. 395.805, pursuant to this section.  
 451 The funds provided for statutorily defined teaching hospitals  
 452 shall be distributed as provided in the General Appropriations  
 453 Act. The funds provided for family practice teaching hospitals  
 454 shall be distributed equally among family practice teaching  
 455 hospitals.

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

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

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

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

490 2. The number of medical students enrolled in accredited  
 491 colleges of medicine and engaged in clinical activities,  
 492 including required clinical clerkships and clinical electives.  
 493 Full-time equivalents are computed using the fraction of the  
 494 year during which each trainee is primarily assigned to the  
 495 given institution, over the course of the state fiscal year  
 496 preceding the date on which the allocation fraction is  
 497 calculated. The numerical value of this factor is the fraction  
 498 that the given hospital represents of the total number of full-  
 499 time equivalent students enrolled in accredited colleges of  
 500 medicine, where the total is computed for all statutory teaching  
 501 hospitals.

502  
 503 The primary factor for full-time equivalent trainees is computed  
 504 as the sum of these two components, divided by two.

505 (c) A service index that comprises three components:  
 506 1. The Agency for Health Care Administration Service  
 507 Index, computed by applying the standard Service Inventory  
 508 Scores established by the agency to services offered by the  
 509 given hospital, as reported on Worksheet A-2 for the last fiscal  
 510 year reported to the agency before the date on which the  
 511 allocation fraction is calculated. The numerical value of this  
 512 factor is the fraction that the given hospital represents of the  
 513 total index values, where the total is computed for all  
 514 statutory teaching hospitals.

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

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

533  
 534 The primary factor for the service index is computed as the sum  
 535 of these three components, divided by three.

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

$$TAP = THAF \times A$$

540 Where:

541 TAP = total additional payment.

542 THAF = teaching hospital allocation factor.

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

545 Section 7. Section 409.9117, Florida Statutes, is amended  
 546 to read:

547 409.9117 Primary care disproportionate share program.—For  
 548 the 2012-2013 ~~2011-2012~~ state fiscal year, the agency shall not  
 549 distribute moneys under the primary care disproportionate share  
 550 program.

551 (1) If federal funds are available for disproportionate  
 552 share programs in addition to those otherwise provided by law, a  
 553 primary care disproportionate share program shall be  
 554 established.

555 (2) The following formula shall be used by the agency to  
 556 calculate the total amount earned for hospitals that participate  
 557 in the primary care disproportionate share program:

$$TAE = HDSP/THDSP$$

559 Where:

560 TAE = total amount earned by a hospital participating in

561 the primary care disproportionate share program.

562 HDSP = the prior state fiscal year primary care  
563 disproportionate share payment to the individual hospital.

564 THDSP = the prior state fiscal year total primary care  
565 disproportionate share payments to all hospitals.

566 (3) The total additional payment for hospitals that  
567 participate in the primary care disproportionate share program  
568 shall be calculated by the agency as follows:

569 
$$TAP = TAE \times TA$$

570 Where:

571 TAP = total additional payment for a primary care hospital.

572 TAE = total amount earned by a primary care hospital.

573 TA = total appropriation for the primary care  
574 disproportionate share program.

575 (4) In establishing and funding this program, the agency  
576 shall use the following criteria in addition to those specified  
577 in s. 409.911, and payments may not be made to a hospital unless  
578 the hospital agrees to:

579 (a) Cooperate with a Medicaid prepaid health plan, if one  
580 exists in the community.

581 (b) Ensure the availability of primary and specialty care  
582 physicians to Medicaid recipients who are not enrolled in a  
583 prepaid capitated arrangement and who are in need of access to  
584 such physicians.

585 (c) Coordinate and provide primary care services free of  
586 charge, except copayments, to all persons with incomes up to 100  
587 percent of the federal poverty level who are not otherwise  
588 covered by Medicaid or another program administered by a

589 governmental entity, and to provide such services based on a  
 590 sliding fee scale to all persons with incomes up to 200 percent  
 591 of the federal poverty level who are not otherwise covered by  
 592 Medicaid or another program administered by a governmental  
 593 entity, except that eligibility may be limited to persons who  
 594 reside within a more limited area, as agreed to by the agency  
 595 and the hospital.

596 (d) Contract with any federally qualified health center,  
 597 if one exists within the agreed geopolitical boundaries,  
 598 concerning the provision of primary care services, in order to  
 599 guarantee delivery of services in a nonduplicative fashion, and  
 600 to provide for referral arrangements, privileges, and  
 601 admissions, as appropriate. The hospital shall agree to provide  
 602 primary care services within 24 hours at an onsite or offsite  
 603 facility to which all Medicaid recipients and persons eligible  
 604 under this paragraph who do not require emergency room services  
 605 are referred during normal daylight hours.

606 (e) Cooperate with the agency, the county, and other  
 607 entities to ensure the provision of certain public health  
 608 services, case management, referral and acceptance of patients,  
 609 and sharing of epidemiological data, as the agency and the  
 610 hospital find mutually necessary and desirable to promote and  
 611 protect the public health within the agreed geopolitical  
 612 boundaries.

613 (f) In cooperation with the county in which the hospital  
 614 resides, develop a low-cost, outpatient, prepaid health care  
 615 program to persons who are not eligible for the Medicaid  
 616 program, and who reside within the area.

617 (g) Provide inpatient services to residents within the  
 618 area who are not eligible for Medicaid or Medicare, and who do  
 619 not have private health insurance, regardless of ability to pay,  
 620 on the basis of available space, except that hospitals may not  
 621 be prevented from establishing bill collection programs based on  
 622 ability to pay.

623 (h) Work with the Florida Healthy Kids Corporation, the  
 624 Florida Health Care Purchasing Cooperative, and business health  
 625 coalitions, as appropriate, to develop a feasibility study and  
 626 plan to provide a low-cost comprehensive health insurance plan  
 627 to persons who reside within the area and who do not have access  
 628 to such a plan.

629 (i) Work with public health officials and other experts to  
 630 provide community health education and prevention activities  
 631 designed to promote healthy lifestyles and appropriate use of  
 632 health services.

633 (j) Work with the local health council to develop a plan  
 634 for promoting access to affordable health care services for all  
 635 persons who reside within the area, including, but not limited  
 636 to, public health services, primary care services, inpatient  
 637 services, and affordable health insurance generally.

638  
 639 Any hospital that fails to comply with any of the provisions of  
 640 this subsection, or any other contractual condition, may not  
 641 receive payments under this section until full compliance is  
 642 achieved.

643 Section 8. Subsection (2) of section 409.979, Florida  
 644 Statutes, is amended to read:

645 409.979 Eligibility.—

646 (2) Medicaid recipients who, on the date long-term care  
 647 managed care plans become available in their region, reside in a  
 648 nursing home facility or are enrolled in one of the following  
 649 long-term care Medicaid waiver programs are eligible to  
 650 participate in the long-term care managed care program for up to  
 651 12 months without being reevaluated for their need for nursing  
 652 facility care as defined in s. 409.985(3):

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

654 (b) The Aged and Disabled Adult Waiver.

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

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

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

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

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

662 Section 9. Subsection (15) of section 430.04, Florida  
 663 Statutes, is amended to read:

664 430.04 Duties and responsibilities of the Department of  
 665 Elderly Affairs.—The Department of Elderly Affairs shall:

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

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

670 (b) The Aged and Disabled Adult Waiver.

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

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



673 | in s. 409.221.

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

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

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

678 |

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

685 |       Section 10. Section 31 of chapter 2009-223, Laws of  
686 | Florida, as amended by section 44 of chapter 2010-151, Laws of  
687 | Florida, is redesignated as section 409.9132, Florida Statutes,  
688 | and amended to read:

689 |       409.9132 ~~Section 31.~~ Pilot project to monitor home health  
690 | services.—The Agency for Health Care Administration may expand  
691 | the shall develop and implement a home health agency monitoring  
692 | pilot project in Miami-Dade County to include Broward, Escambia,  
693 | Martin, and Palm Beach Counties, effective July 1, 2012 ~~by~~  
694 | ~~January 1, 2010.~~ The agency shall contract with a vendor to  
695 | verify the utilization and delivery of home health services and  
696 | provide an electronic billing interface for home health  
697 | services. The contract must require the creation of a program to  
698 | submit claims electronically for the delivery of home health  
699 | services. The program must verify telephonically visits for the  
700 | delivery of home health services using voice biometrics. The

701 agency may seek amendments to the Medicaid state plan and  
 702 waivers of federal laws, as necessary, to implement or expand  
 703 the pilot project. Notwithstanding s. 287.057(3)(f), ~~Florida~~  
 704 ~~Statutes~~, the agency must award the contract through the  
 705 competitive solicitation process and may use the current  
 706 contract to expand the home health agency monitoring pilot  
 707 project to include additional counties as authorized under this  
 708 section. ~~The agency shall submit a report to the Governor, the~~  
 709 ~~President of the Senate, and the Speaker of the House of~~  
 710 ~~Representatives evaluating the pilot project by February 1,~~  
 711 ~~2011.~~

712 Section 11. Section 32 of chapter 2009-223, Laws of  
 713 Florida, is redesignated as section 409.9133, Florida Statutes,  
 714 and amended to read:

715 409.9133 ~~Section 32.~~ Pilot project for home health care  
 716 management.—The Agency for Health Care Administration may expand  
 717 the ~~shall implement~~ a comprehensive care management pilot  
 718 project for home health services to include private duty nursing  
 719 and personal care services effective July 1, 2012 ~~by January 1,~~  
 720 ~~2010~~, which includes face-to-face assessments by a nurse  
 721 licensed pursuant to chapter 464, Florida Statutes, consultation  
 722 with physicians ordering services to substantiate the medical  
 723 necessity for services, and on-site or desk reviews of  
 724 recipients' medical records, in Miami-Dade, Broward, Orange, and  
 725 Palm Beach Counties ~~County~~. The agency may enter into a contract  
 726 with a qualified organization to implement or expand the pilot  
 727 project. The agency may use the current contract to expand the  
 728 comprehensive care management pilot project to include the

729 additional services and counties as authorized under this  
 730 section. The agency may seek amendments to the Medicaid state  
 731 plan and waivers of federal laws, as necessary, to implement or  
 732 expand the pilot project.

733 Section 12. Notwithstanding s. 430.707, Florida Statutes,  
 734 and subject to federal approval of the application to be a site  
 735 for the Program of All-inclusive Care for the Elderly (PACE),  
 736 the Agency for Health Care Administration shall contract with  
 737 one not-for-profit organization with more than 30 years'  
 738 experience as a licensed hospice provider and currently licensed  
 739 as a hospice provider to serve individuals and families in  
 740 Duval, Clay, and Alachua Counties. This not-for-profit  
 741 organization shall provide PACE services to frail elders who  
 742 reside in Duval, Clay, and Alachua Counties. The organization  
 743 shall be exempt from the requirements of chapter 641, Florida  
 744 Statutes. The agency, in consultation with the Department of  
 745 Elderly Affairs and subject to an appropriation, shall approve  
 746 up to 150 initial enrollees in the Program of All-inclusive Care  
 747 for the Elderly established by this organization to serve frail  
 748 elders who reside in Duval, Clay, and Alachua Counties.

749 Section 13. Notwithstanding s. 430.707, Florida Statutes,  
 750 and subject to federal approval of the application to be a site  
 751 for the Program of All-inclusive Care for the Elderly (PACE),  
 752 the Agency for Health Care Administration shall contract with  
 753 one private health care organization, the sole member of which  
 754 is a private, not-for-profit corporation that owns and manages  
 755 health care organizations licensed in Manatee, Sarasota, and  
 756 DeSoto Counties which provide comprehensive services, including

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757 hospice and palliative care, to frail elders who reside in these  
758 counties. The organization shall be exempt from the requirements  
759 of chapter 641, Florida Statutes. The agency, in consultation  
760 with the Department of Elderly Affairs and subject to an  
761 appropriation, shall approve up to 150 initial enrollees in the  
762 Program of All-inclusive Care for the Elderly established by  
763 this organization to serve frail elders who reside in Manatee,  
764 Sarasota, and DeSoto Counties.

765 Section 14. This act shall take effect July 1, 2012.