

By the Committee on Appropriations

576-02995-16

20162508__

1 A bill to be entitled
2 An act relating to health care services; amending s.
3 322.143, F.S.; providing an exception to the
4 prohibition against a private entity swiping an
5 individual's driver license or identification card for
6 certain entities for certain purposes; amending s.
7 395.602, F.S.; including specified hospitals in the
8 definition of "rural hospital"; amending s. 409.285,
9 F.S.; requiring appeals related to Medicaid programs
10 directly administered by the Agency for Health Care
11 Administration to be directed to the agency; providing
12 requirements for appeals directed to the agency;
13 providing an exemption from the uniform rules of
14 procedure and from a requirement that certain
15 proceedings be heard before an administrative law
16 judge for specified hearings; requiring the agency to
17 seek federal approval of its authority to oversee
18 appeals; providing that appeals related to Medicaid
19 programs administered by the Agency for Persons with
20 Disabilities are subject to that agency's hearing
21 rights process; amending s. 409.811, F.S.; defining
22 the term "lawfully residing child"; deleting the
23 definition of the term "qualified alien"; conforming
24 provisions to changes made by the act; amending s.
25 409.814, F.S.; revising eligibility for the Florida
26 Kidcare program to conform to changes made by the act;
27 clarifying that undocumented immigrants are excluded
28 from eligibility; amending s. 409.904, F.S.; providing
29 eligibility for optional payments for medical
30 assistance and related services for certain lawfully
31 residing children; clarifying that undocumented
32 immigrants are excluded from eligibility for optional

576-02995-16

20162508__

33 Medicaid payments or related services; amending s.
34 409.905, F.S.; deleting the limitation on the number
35 of hospital emergency department visits that may be
36 paid for by the Agency for Health Care Administration
37 for certain recipients; amending s. 409.906, F.S.;
38 directing the agency to seek federal approval to
39 provide temporary housing assistance for certain
40 persons; creating s. 409.9064, F.S.; directing the
41 agency to seek federal approval to provide home and
42 community-based services for individuals diagnosed
43 with Phelan-McDermid Syndrome; providing a method for
44 determining financial eligibility for Medicaid
45 benefits in certain circumstances; amending s.
46 409.907, F.S.; authorizing the agency to certify that
47 a Medicaid provider is out of business; creating s.
48 409.9072, F.S.; directing the agency to pay private
49 schools and charter schools that are Medicaid
50 providers for specified school-based services under
51 certain parameters; authorizing the agency to review a
52 school that has applied to the program for capability
53 requirements; providing a reimbursement schedule;
54 providing for a waiver of agency and school
55 confidentiality under certain circumstances; amending
56 s. 409.908, F.S.; revising the list of provider types
57 that are subject to certain statutory provisions
58 relating to the establishment of rates; amending s.
59 409.909; adding psychiatry to a list of primary care
60 specialties under the Statewide Medicaid Residency
61 Program; amending s. 409.911, F.S.; updating the

576-02995-16

20162508__

62 fiscal year for determining each hospital's Medicaid
63 days and charity care; providing an exception for the
64 distribution of moneys to certain hospitals for the
65 2016-2017 state fiscal year; amending ss. 409.9113,
66 409.9115, and 409.9119, F.S.; providing an exception
67 for the distribution of moneys to certain hospitals
68 for the 2016-2017 state fiscal year; amending s.
69 409.9128, F.S.; conforming provisions to changes made
70 by the act; amending s. 409.967, F.S.; defining the
71 term "Medicaid rate" for the purpose of determining
72 specified managed care plan payments for emergency
73 services in compliance with federal law; requiring
74 annual publication of fee schedules on the agency's
75 website; amending s. 409.968, F.S.; directing the
76 agency to establish a payment methodology for managed
77 care plans providing housing assistance to specified
78 persons; amending s. 409.975, F.S.; providing for the
79 determination of applicable Medicaid rates for
80 emergency services; defining the term "essential
81 provider"; deleting requirements relating to
82 contracted rates between managed care plans and
83 hospitals; conforming provisions to changes made by
84 the act; amending s. 624.91, F.S.; conforming
85 provisions to changes made by the act; amending s.
86 641.513, F.S.; specifying parameters for payments by a
87 health maintenance organization to a noncontracted
88 provider of emergency services under certain
89 circumstances; conforming provisions to changes made
90 by the act; authorizing a Program of All-Inclusive

576-02995-16

20162508__

91 Care for the Elderly organization granted certain
92 enrollee slots for frail elders residing in Broward
93 County to also use the slots for enrollees residing in
94 Miami-Dade County; authorizing the agency to contract
95 with an organization in Escambia County to provide
96 services under the federal Program of All-inclusive
97 Care for the Elderly in specified areas; exempting the
98 organization from ch. 641, F.S., relating to health
99 care service programs; authorizing enrollment slots
100 for the program in such areas, subject to
101 appropriation; providing effective dates.
102

103 Be It Enacted by the Legislature of the State of Florida:
104

105 Section 1. Subsection (2) of section 322.143, Florida
106 Statutes, is amended and subsection (10) is added to that
107 section, to read:

108 322.143 Use of a driver license or identification card.—

109 (2) Except as provided in subsections (6) and (10)
110 ~~subsection (6)~~, a private entity may not swipe an individual's
111 driver license or identification card, except for the following
112 purposes:

113 (a) To verify the authenticity of a driver license or
114 identification card or to verify the identity of the individual
115 if the individual pays for a good or service with a method other
116 than cash, returns an item, or requests a refund.

117 (b) To verify the individual's age when providing an age-
118 restricted good or service.

119 (c) To prevent fraud or other criminal activity if an

576-02995-16

20162508__

120 individual returns an item or requests a refund and the private
121 entity uses a fraud prevention service company or system.

122 (d) To transmit information to a check services company for
123 the purpose of approving negotiable instruments, electronic
124 funds transfers, or similar methods of payment.

125 (e) To comply with a legal requirement to record, retain,
126 or transmit the driver license information.

127 (10) To combat health care fraud, the Department of Highway
128 Safety and Motor Vehicles shall provide photographic access,
129 pursuant to a written agreement, with hospitals, insurance
130 companies, or their software providers, for the purpose of
131 verifying a patient's identity or Medicaid eligibility by
132 swiping an individual's driver license or identification card.

133 Section 2. Paragraph (e) of subsection (2) of section
134 395.602, Florida Statutes, is amended to read:

135 395.602 Rural hospitals.—

136 (2) DEFINITIONS.—As used in this part, the term:

137 (e) "Rural hospital" means an acute care hospital licensed
138 under this chapter, having 100 or fewer licensed beds and an
139 emergency room, which is:

140 1. The sole provider within a county with a population
141 density of up to 100 persons per square mile;

142 2. An acute care hospital, in a county with a population
143 density of up to 100 persons per square mile, which is at least
144 30 minutes of travel time, on normally traveled roads under
145 normal traffic conditions, from any other acute care hospital
146 within the same county;

147 3. A hospital supported by a tax district or subdistrict
148 whose boundaries encompass a population of up to 100 persons per

576-02995-16

20162508__

149 square mile;

150 4. A hospital classified as a sole community hospital under
151 42 C.F.R. s. 412.92 which has up to 175 licensed beds.

152 ~~5.4.~~ A hospital with a service area that has a population
153 of up to 100 persons per square mile. As used in this
154 subparagraph, the term "service area" means the fewest number of
155 zip codes that account for 75 percent of the hospital's
156 discharges for the most recent 5-year period, based on
157 information available from the hospital inpatient discharge
158 database in the Florida Center for Health Information and Policy
159 Analysis at the agency; or

160 ~~6.5.~~ A hospital designated as a critical access hospital,
161 as defined in s. 408.07.

162
163 Population densities used in this paragraph must be based upon
164 the most recently completed United States census. A hospital
165 that received funds under s. 409.9116 for a quarter beginning no
166 later than July 1, 2002, is deemed to have been and shall
167 continue to be a rural hospital from that date through June 30,
168 2021, if the hospital continues to have up to 100 licensed beds
169 and an emergency room. An acute care hospital that has not
170 previously been designated as a rural hospital and that meets
171 the criteria of this paragraph shall be granted such designation
172 upon application, including supporting documentation, to the
173 agency. A hospital that was licensed as a rural hospital during
174 the 2010-2011 or 2011-2012 fiscal year shall continue to be a
175 rural hospital from the date of designation through June 30,
176 2021, if the hospital continues to have up to 100 licensed beds
177 and an emergency room.

576-02995-16

20162508__

178 Section 3. Section 409.285, Florida Statutes, is amended to
179 read:

180 409.285 Opportunity for hearing and appeal.—

181 (1) If an application for public assistance is not acted
182 upon within a reasonable time after the filing of the
183 application, or is denied in whole or in part, or if an
184 assistance payment is modified or canceled, the applicant or
185 recipient may appeal the decision to the Department of Children
186 and Families in the manner and form prescribed by the
187 department.

188 (a) ~~(2)~~ The hearing authority may be the Secretary of
189 Children and Families, a panel of department officials, or a
190 hearing officer appointed for that purpose. The hearing
191 authority is responsible for a final administrative decision in
192 the name of the department on all issues that have been the
193 subject of a hearing. With regard to the department, the
194 decision of the hearing authority is final and binding. The
195 department is responsible for seeing that the decision is
196 carried out promptly.

197 (b) ~~(3)~~ The department may adopt rules to administer this
198 subsection ~~section~~. Rules for the Temporary Assistance for Needy
199 Families block grant programs must be similar to the federal
200 requirements for Medicaid programs.

201 (2) Appeals related to Medicaid programs directly
202 administered by the Agency for Health Care Administration,
203 including appeals related to Florida's Statewide Medicaid
204 Managed Care program and associated federal waivers, must be
205 directed to the Agency for Health Care Administration in the
206 manner and form prescribed by the agency.

576-02995-16

20162508__

207 (a) The hearing authority for appeals heard by the Agency
208 for Health Care Administration may be the secretary of the
209 agency, a panel of agency officials, or a hearing officer
210 appointed for that purpose. The hearing authority is responsible
211 for a final administrative decision in the name of the agency on
212 all issues that have been the subject of a hearing. A decision
213 of the hearing authority is final and binding on the agency. The
214 agency is responsible for seeing that the decision is promptly
215 carried out.

216 (b) Notwithstanding ss. 120.569 and 120.57, hearings
217 conducted by the Agency for Health Care Administration pursuant
218 to this subsection are exempt from the uniform rules of
219 procedure under s. 120.54(5) and do not need to be conducted by
220 an administrative law judge assigned by the Division of
221 Administrative Hearings.

222 (c) The Agency for Health Care Administration shall seek
223 federal approval necessary to implement this subsection and may
224 adopt rules necessary to administer this subsection.

225 (3) Appeals related to Medicaid programs administered by
226 the Agency for Persons with Disabilities are subject to s.
227 393.125.

228 Section 4. Present subsections (17) through (22) of section
229 409.811, Florida Statutes, are redesignated as subsections (18)
230 through (23), respectively, a new subsection (17) is added to
231 that section, and present subsections (23) and (24) of that
232 section are amended, to read:

233 409.811 Definitions relating to Florida Kidcare Act.—As
234 used in ss. 409.810-409.821, the term:

235 (17) "Lawfully residing child" means a child who is

576-02995-16

20162508__

236 lawfully present in the United States, meets Medicaid or
 237 Children's Health Insurance Program (CHIP) residency
 238 requirements, and may be eligible for medical assistance with
 239 federal financial participation as provided under s. 214 of the
 240 Children's Health Insurance Program Reauthorization Act of 2009,
 241 Pub. L. No. 111-3, and related federal regulations.

242 ~~(23) "Qualified alien" means an alien as defined in s. 431~~
 243 ~~of the Personal Responsibility and Work Opportunity~~
 244 ~~Reconciliation Act of 1996, as amended, Pub. L. No. 104-193.~~

245 (24) "Resident" means a United States citizen, or lawfully
 246 residing child ~~qualified alien,~~ who is domiciled in this state.

247 Section 5. Paragraph (c) of subsection (4) of section
 248 409.814, Florida Statutes, is amended to read:

249 409.814 Eligibility.—A child who has not reached 19 years
 250 of age whose family income is equal to or below 200 percent of
 251 the federal poverty level is eligible for the Florida Kidcare
 252 program as provided in this section. If an enrolled individual
 253 is determined to be ineligible for coverage, he or she must be
 254 immediately disenrolled from the respective Florida Kidcare
 255 program component.

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

261 (c) A child who is an alien, ~~but who does not meet the~~
 262 ~~definition of a lawfully residing child qualified alien, in the~~
 263 ~~United States. This paragraph does not extend eligibility for~~
 264 the Florida Kidcare program to an undocumented immigrant.

576-02995-16

20162508__

265 Section 6. Present subsections (8) and (9) of section
266 409.904, Florida Statutes, are redesignated as subsections (9)
267 and (10), respectively, and a new subsection (8) is added to
268 that section, to read:

269 409.904 Optional payments for eligible persons.—The agency
270 may make payments for medical assistance and related services on
271 behalf of the following persons who are determined to be
272 eligible subject to the income, assets, and categorical
273 eligibility tests set forth in federal and state law. Payment on
274 behalf of these Medicaid eligible persons is subject to the
275 availability of moneys and any limitations established by the
276 General Appropriations Act or chapter 216.

277 (8) A child who has not attained 19 years of age and who,
278 notwithstanding s. 414.095(3), would be eligible for Medicaid
279 under s. 409.903, except that the child is a lawfully residing
280 child as defined in s. 409.811. This subsection does not extend
281 eligibility for optional Medicaid payments or related services
282 to an undocumented immigrant.

283 Section 7. Subsection (5) of section 409.905, Florida
284 Statutes, is amended to read:

285 409.905 Mandatory Medicaid services.—The agency may make
286 payments for the following services, which are required of the
287 state by Title XIX of the Social Security Act, furnished by
288 Medicaid providers to recipients who are determined to be
289 eligible on the dates on which the services were provided. Any
290 service under this section shall be provided only when medically
291 necessary and in accordance with state and federal law.
292 Mandatory services rendered by providers in mobile units to
293 Medicaid recipients may be restricted by the agency. Nothing in

576-02995-16

20162508__

294 this section shall be construed to prevent or limit the agency
295 from adjusting fees, reimbursement rates, lengths of stay,
296 number of visits, number of services, or any other adjustments
297 necessary to comply with the availability of moneys and any
298 limitations or directions provided for in the General
299 Appropriations Act or chapter 216.

300 (5) HOSPITAL INPATIENT SERVICES.—The agency shall pay for
301 all covered services provided for the medical care and treatment
302 of a recipient who is admitted as an inpatient by a licensed
303 physician or dentist to a hospital licensed under part I of
304 chapter 395. However, the agency shall limit the payment for
305 inpatient hospital services for a Medicaid recipient 21 years of
306 age or older to 45 days or the number of days necessary to
307 comply with the General Appropriations Act. ~~Effective August 1,~~
308 ~~2012, the agency shall limit payment for hospital emergency~~
309 ~~department visits for a nonpregnant Medicaid recipient 21 years~~
310 ~~of age or older to six visits per fiscal year.~~

311 (a) The agency may implement reimbursement and utilization
312 management reforms in order to comply with any limitations or
313 directions in the General Appropriations Act, which may include,
314 but are not limited to: prior authorization for inpatient
315 psychiatric days; prior authorization for nonemergency hospital
316 inpatient admissions for individuals 21 years of age and older;
317 authorization of emergency and urgent-care admissions within 24
318 hours after admission; enhanced utilization and concurrent
319 review programs for highly utilized services; reduction or
320 elimination of covered days of service; adjusting reimbursement
321 ceilings for variable costs; adjusting reimbursement ceilings
322 for fixed and property costs; and implementing target rates of

576-02995-16

20162508__

323 increase. The agency may limit prior authorization for hospital
324 inpatient services to selected diagnosis-related groups, based
325 on an analysis of the cost and potential for unnecessary
326 hospitalizations represented by certain diagnoses. Admissions
327 for normal delivery and newborns are exempt from requirements
328 for prior authorization. In implementing the provisions of this
329 section related to prior authorization, the agency shall ensure
330 that the process for authorization is accessible 24 hours per
331 day, 7 days per week and authorization is automatically granted
332 when not denied within 4 hours after the request. Authorization
333 procedures must include steps for review of denials. Upon
334 implementing the prior authorization program for hospital
335 inpatient services, the agency shall discontinue its hospital
336 retrospective review program.

337 (b) A licensed hospital maintained primarily for the care
338 and treatment of patients having mental disorders or mental
339 diseases is not eligible to participate in the hospital
340 inpatient portion of the Medicaid program except as provided in
341 federal law. However, the department shall apply for a waiver,
342 within 9 months after June 5, 1991, designed to provide
343 hospitalization services for mental health reasons to children
344 and adults in the most cost-effective and lowest cost setting
345 possible. Such waiver shall include a request for the
346 opportunity to pay for care in hospitals known under federal law
347 as "institutions for mental disease" or "IMD's." The waiver
348 proposal shall propose no additional aggregate cost to the state
349 or Federal Government, and shall be conducted in Hillsborough
350 County, Highlands County, Hardee County, Manatee County, and
351 Polk County. The waiver proposal may incorporate competitive

576-02995-16

20162508__

352 bidding for hospital services, comprehensive brokering, prepaid
353 capitated arrangements, or other mechanisms deemed by the
354 department to show promise in reducing the cost of acute care
355 and increasing the effectiveness of preventive care. When
356 developing the waiver proposal, the department shall take into
357 account price, quality, accessibility, linkages of the hospital
358 to community services and family support programs, plans of the
359 hospital to ensure the earliest discharge possible, and the
360 comprehensiveness of the mental health and other health care
361 services offered by participating providers.

362 (c) The agency shall implement a prospective payment
363 methodology for establishing reimbursement rates for inpatient
364 hospital services. Rates shall be calculated annually and take
365 effect July 1 of each year. The methodology shall categorize
366 each inpatient admission into a diagnosis-related group and
367 assign a relative payment weight to the base rate according to
368 the average relative amount of hospital resources used to treat
369 a patient in a specific diagnosis-related group category. The
370 agency may adopt the most recent relative weights calculated and
371 made available by the Nationwide Inpatient Sample maintained by
372 the Agency for Healthcare Research and Quality or may adopt
373 alternative weights if the agency finds that Florida-specific
374 weights deviate with statistical significance from national
375 weights for high-volume diagnosis-related groups. The agency
376 shall establish a single, uniform base rate for all hospitals
377 unless specifically exempt pursuant to s. 409.908(1).

378 1. Adjustments may not be made to the rates after October
379 31 of the state fiscal year in which the rates take effect,
380 except for cases of insufficient collections of

576-02995-16

20162508__

381 intergovernmental transfers authorized under s. 409.908(1) or
382 the General Appropriations Act. In such cases, the agency shall
383 submit a budget amendment or amendments under chapter 216
384 requesting approval of rate reductions by amounts necessary for
385 the aggregate reduction to equal the dollar amount of
386 intergovernmental transfers not collected and the corresponding
387 federal match. Notwithstanding the \$1 million limitation on
388 increases to an approved operating budget contained in ss.
389 216.181(11) and 216.292(3), a budget amendment exceeding that
390 dollar amount is subject to notice and objection procedures set
391 forth in s. 216.177.

392 2. Errors in source data or calculations discovered after
393 October 31 must be reconciled in a subsequent rate period.
394 However, the agency may not make any adjustment to a hospital's
395 reimbursement more than 5 years after a hospital is notified of
396 an audited rate established by the agency. The prohibition
397 against adjustments more than 5 years after notification is
398 remedial and applies to actions by providers involving Medicaid
399 claims for hospital services. Hospital reimbursement is subject
400 to such limits or ceilings as may be established in law or
401 described in the agency's hospital reimbursement plan. Specific
402 exemptions to the limits or ceilings may be provided in the
403 General Appropriations Act.

404 (d) The agency shall implement a comprehensive utilization
405 management program for hospital neonatal intensive care stays in
406 certain high-volume participating hospitals, select counties, or
407 statewide, and replace existing hospital inpatient utilization
408 management programs for neonatal intensive care admissions. The
409 program shall be designed to manage appropriate admissions and

576-02995-16

20162508__

410 discharges for children being treated in neonatal intensive care
411 units and must seek medically appropriate discharge to the
412 child's home or other less costly treatment setting. The agency
413 may competitively bid a contract for the selection of a
414 qualified organization to provide neonatal intensive care
415 utilization management services. The agency may seek federal
416 waivers to implement this initiative.

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

420 Section 8. Paragraph (e) is added to subsection (13) of
421 section 409.906, Florida Statutes, to read:

422 409.906 Optional Medicaid services.—Subject to specific
423 appropriations, the agency may make payments for services which
424 are optional to the state under Title XIX of the Social Security
425 Act and are furnished by Medicaid providers to recipients who
426 are determined to be eligible on the dates on which the services
427 were provided. Any optional service that is provided shall be
428 provided only when medically necessary and in accordance with
429 state and federal law. Optional services rendered by providers
430 in mobile units to Medicaid recipients may be restricted or
431 prohibited by the agency. Nothing in this section shall be
432 construed to prevent or limit the agency from adjusting fees,
433 reimbursement rates, lengths of stay, number of visits, or
434 number of services, or making any other adjustments necessary to
435 comply with the availability of moneys and any limitations or
436 directions provided for in the General Appropriations Act or
437 chapter 216. If necessary to safeguard the state's systems of
438 providing services to elderly and disabled persons and subject

576-02995-16

20162508__

439 to the notice and review provisions of s. 216.177, the Governor
440 may direct the Agency for Health Care Administration to amend
441 the Medicaid state plan to delete the optional Medicaid service
442 known as "Intermediate Care Facilities for the Developmentally
443 Disabled." Optional services may include:

444 (13) HOME AND COMMUNITY-BASED SERVICES.—

445 (e) The agency shall seek federal approval to pay for
446 flexible services for persons with severe mental illness or
447 substance abuse disorders, including, but not limited to,
448 temporary housing assistance. Payments may be made as enhanced
449 capitation rates or incentive payments to managed care plans
450 that meet the requirements of s. 409.968(4).

451 Section 9. Section 409.9064, Florida Statutes, is created
452 to read:

453 409.9064 Medicaid Services for Individuals with Phelan-
454 McDermid Syndrome.—The agency shall seek federal approval of a
455 Section 1915(i) state plan option for home and community-based
456 services for individuals diagnosed with Phelan-McDermid
457 Syndrome. Financial eligibility for Medicaid benefits under this
458 plan option will be determined in the same manner as the home
459 and community-based services waiver for persons with
460 developmental disabilities.

461 Section 10. Present subsection (12) of section 409.907,
462 Florida Statutes, is redesignated as subsection (13), and a new
463 subsection (12) is added to that subsection, to read:

464 409.907 Medicaid provider agreements.—The agency may make
465 payments for medical assistance and related services rendered to
466 Medicaid recipients only to an individual or entity who has a
467 provider agreement in effect with the agency, who is performing

576-02995-16

20162508__

468 services or supplying goods in accordance with federal, state,
469 and local law, and who agrees that no person shall, on the
470 grounds of handicap, race, color, or national origin, or for any
471 other reason, be subjected to discrimination under any program
472 or activity for which the provider receives payment from the
473 agency.

474 (12) In accordance with 42 C.F.R. s. 433.318(d)(2)(ii), the
475 agency may certify that a provider is out of business and that
476 any overpayments made to the provider cannot be collected under
477 state law.

478 Section 11. Section 409.9072, Florida Statutes, is created
479 to read:

480 409.9072 Medicaid provider agreements for charter schools
481 and private schools.-

482 (1) Subject to a specific appropriation by the Legislature,
483 the agency shall reimburse private schools as defined in s.
484 1002.01 and schools designated as charter schools under s.
485 1002.33 which are Medicaid providers for school-based services
486 pursuant to the rehabilitative services option provided under 42
487 U.S.C. s. 1396d(a)(13) to children younger than 21 years of age
488 with specified disabilities who are eligible for both Medicaid
489 and part B or part H of the Individuals with Disabilities
490 Education Act (IDEA) or the exceptional student education
491 program, or who have an individualized educational plan.

492 (2) Schools that wish to enroll as Medicaid providers and
493 receive Medicaid reimbursement under this section must apply to
494 the agency for a provider agreement and must agree to:

495 (a) Verify Medicaid eligibility. The agency shall work
496 cooperatively with a private school or a charter school that is

576-02995-16

20162508__

497 a Medicaid provider to facilitate the school's verification of
498 Medicaid eligibility.

499 (b) Develop and maintain the financial and individual
500 education plan records needed to document the appropriate use of
501 state and federal Medicaid funds.

502 (c) Comply with all state and federal Medicaid laws, rules,
503 regulations, and policies, including, but not limited to, those
504 related to the confidentiality of records and freedom of choice
505 of providers.

506 (d) Be responsible for reimbursing the cost of any state or
507 federal disallowance that results from failure to comply with
508 state or federal Medicaid laws, rules, or regulations.

509 (3) The types of school-based services for which schools
510 may be reimbursed under this section are those included in s.
511 1011.70(1). Private schools and charter schools may not be
512 reimbursed by the agency for providing services that are
513 excluded by that subsection.

514 (4) Within 90 days after a private school or a charter
515 school applies to enroll as a Medicaid provider under this
516 section, the agency may conduct a review to ensure that the
517 school has the capability to comply with its responsibilities
518 under subsection (2). A finding by the agency that the school
519 has the capability to comply does not relieve the school of its
520 responsibility to correct any deficiencies or to reimburse the
521 cost of the state or federal disallowances identified pursuant
522 to any subsequent state or federal audits.

523 (5) For reimbursements to private schools and charter
524 schools under this section, the agency shall apply the
525 reimbursement schedule developed under s. 409.9071(5). Health

576-02995-16

20162508__

526 care practitioners engaged by a school to provide services under
527 this section must be enrolled as Medicaid providers and meet the
528 qualifications specified under 42 C.F.R. s. 440.110, as
529 applicable. Each school's continued participation in providing
530 Medicaid services under this section is contingent upon the
531 school providing to the agency an annual accounting of how the
532 Medicaid reimbursements are used.

533 (6) For Medicaid provider agreements issued under this
534 section, the agency's and the school's confidentiality is waived
535 in relation to the state's efforts to control Medicaid fraud.
536 The agency and the school shall provide any information or
537 documents relating to this section to the Medicaid Fraud Control
538 Unit in the Department of Legal Affairs, upon request, pursuant
539 to the Attorney General's authority under s. 409.920.

540 Section 12. Effective July 1, 2017, paragraph (c) of
541 subsection (23) of section 409.908, Florida Statutes, is amended
542 to read:

543 409.908 Reimbursement of Medicaid providers.—Subject to
544 specific appropriations, the agency shall reimburse Medicaid
545 providers, in accordance with state and federal law, according
546 to methodologies set forth in the rules of the agency and in
547 policy manuals and handbooks incorporated by reference therein.
548 These methodologies may include fee schedules, reimbursement
549 methods based on cost reporting, negotiated fees, competitive
550 bidding pursuant to s. 287.057, and other mechanisms the agency
551 considers efficient and effective for purchasing services or
552 goods on behalf of recipients. If a provider is reimbursed based
553 on cost reporting and submits a cost report late and that cost
554 report would have been used to set a lower reimbursement rate

576-02995-16

20162508__

555 for a rate semester, then the provider's rate for that semester
556 shall be retroactively calculated using the new cost report, and
557 full payment at the recalculated rate shall be effected
558 retroactively. Medicare-granted extensions for filing cost
559 reports, if applicable, shall also apply to Medicaid cost
560 reports. Payment for Medicaid compensable services made on
561 behalf of Medicaid eligible persons is subject to the
562 availability of moneys and any limitations or directions
563 provided for in the General Appropriations Act or chapter 216.
564 Further, nothing in this section shall be construed to prevent
565 or limit the agency from adjusting fees, reimbursement rates,
566 lengths of stay, number of visits, or number of services, or
567 making any other adjustments necessary to comply with the
568 availability of moneys and any limitations or directions
569 provided for in the General Appropriations Act, provided the
570 adjustment is consistent with legislative intent.

571 (23)

572 (c) This subsection applies to the following provider
573 types:

- 574 1. Inpatient hospitals.
- 575 2. Outpatient hospitals.
- 576 ~~3. Nursing homes.~~
- 577 3.4. County health departments.
- 578 4.5. Prepaid health plans.

579 Section 13. Paragraph (a) of subsection (2) of section
580 409.909, Florida Statutes, is amended to read:

581 409.909 Statewide Medicaid Residency Program.—

582 (2) On or before September 15 of each year, the agency
583 shall calculate an allocation fraction to be used for

576-02995-16

20162508__

584 distributing funds to participating hospitals. On or before the
585 final business day of each quarter of a state fiscal year, the
586 agency shall distribute to each participating hospital one-
587 fourth of that hospital's annual allocation calculated under
588 subsection (4). The allocation fraction for each participating
589 hospital is based on the hospital's number of full-time
590 equivalent residents and the amount of its Medicaid payments. As
591 used in this section, the term:

592 (a) "Full-time equivalent," or "FTE," means a resident who
593 is in his or her residency period, with the initial residency
594 period defined as the minimum number of years of training
595 required before the resident may become eligible for board
596 certification by the American Osteopathic Association Bureau of
597 Osteopathic Specialists or the American Board of Medical
598 Specialties in the specialty in which he or she first began
599 training, not to exceed 5 years. The residency specialty is
600 defined as reported using the current residency type codes in
601 the Intern and Resident Information System (IRIS), required by
602 Medicare. A resident training beyond the initial residency
603 period is counted as 0.5 FTE, unless his or her chosen specialty
604 is in primary care, in which case the resident is counted as 1.0
605 FTE. For the purposes of this section, primary care specialties
606 include:

- 607 1. Family medicine;
- 608 2. General internal medicine;
- 609 3. General pediatrics;
- 610 4. Preventive medicine;
- 611 5. Geriatric medicine;
- 612 6. Osteopathic general practice;

576-02995-16

20162508__

- 613 7. Obstetrics and gynecology;
614 8. Emergency medicine; ~~and~~
615 9. General surgery; and
616 10. Psychiatry.

617 Section 14. Paragraph (a) of subsection (2) of section
618 409.911, Florida Statutes, is amended, and subsection (10) is
619 added to that section, to read:

620 409.911 Disproportionate share program.—Subject to specific
621 allocations established within the General Appropriations Act
622 and any limitations established pursuant to chapter 216, the
623 agency shall distribute, pursuant to this section, moneys to
624 hospitals providing a disproportionate share of Medicaid or
625 charity care services by making quarterly Medicaid payments as
626 required. Notwithstanding the provisions of s. 409.915, counties
627 are exempt from contributing toward the cost of this special
628 reimbursement for hospitals serving a disproportionate share of
629 low-income patients.

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

634 (a) The average of the 2007, 2008, and 2009 audited
635 disproportionate share data to determine each hospital's
636 Medicaid days and charity care for the 2016-2017 ~~2015-2016~~ state
637 fiscal year.

638 (10) Notwithstanding the provisions of this section to the
639 contrary, for the 2016-2017 state fiscal year, the agency shall
640 distribute moneys to hospitals providing a disproportionate
641 share of Medicaid or charity care services as provided in the

576-02995-16

20162508__

642 2016-2017 General Appropriations Act.

643 Section 15. Subsection (3) is added to section 409.9113,
644 Florida Statutes, to read:

645 409.9113 Disproportionate share program for teaching
646 hospitals.—In addition to the payments made under s. 409.911,
647 the agency shall make disproportionate share payments to
648 teaching hospitals, as defined in s. 408.07, for their increased
649 costs associated with medical education programs and for
650 tertiary health care services provided to the indigent. This
651 system of payments must conform to federal requirements and
652 distribute funds in each fiscal year for which an appropriation
653 is made by making quarterly Medicaid payments. Notwithstanding
654 s. 409.915, counties are exempt from contributing toward the
655 cost of this special reimbursement for hospitals serving a
656 disproportionate share of low-income patients. The agency shall
657 distribute the moneys provided in the General Appropriations Act
658 to statutorily defined teaching hospitals and family practice
659 teaching hospitals, as defined in s. 395.805, pursuant to this
660 section. The funds provided for statutorily defined teaching
661 hospitals shall be distributed as provided in the General
662 Appropriations Act. The funds provided for family practice
663 teaching hospitals shall be distributed equally among family
664 practice teaching hospitals.

665 (3) Notwithstanding the provisions of this section to the
666 contrary, for the 2016-2017 state fiscal year, the agency shall
667 make disproportionate share payments to teaching hospitals, as
668 defined in s. 408.07, as provided in the 2016-2017 General
669 Appropriations Act.

670 Section 16. Subsection (3) is added to section 409.9115,

576-02995-16

20162508__

671 Florida Statutes, to read:

672 409.9115 Disproportionate share program for mental health
673 hospitals.—The Agency for Health Care Administration shall
674 design and implement a system of making mental health
675 disproportionate share payments to hospitals that qualify for
676 disproportionate share payments under s. 409.911. This system of
677 payments shall conform with federal requirements and shall
678 distribute funds in each fiscal year for which an appropriation
679 is made by making quarterly Medicaid payments. Notwithstanding
680 s. 409.915, counties are exempt from contributing toward the
681 cost of this special reimbursement for patients.

682 (3) Notwithstanding the provisions of this section to the
683 contrary, for the 2016-2017 state fiscal year, for hospitals
684 that qualify under subsection (2), the agency shall distribute
685 funds for the disproportionate share program for mental health
686 hospitals in the same manner as in the 2015-2016 state fiscal
687 year.

688 Section 17. Subsection (4) is added to section 409.9119,
689 Florida Statutes, to read:

690 409.9119 Disproportionate share program for specialty
691 hospitals for children.—In addition to the payments made under
692 s. 409.911, the Agency for Health Care Administration shall
693 develop and implement a system under which disproportionate
694 share payments are made to those hospitals that are licensed by
695 the state as specialty hospitals for children and were licensed
696 on January 1, 2000, as specialty hospitals for children. This
697 system of payments must conform to federal requirements and must
698 distribute funds in each fiscal year for which an appropriation
699 is made by making quarterly Medicaid payments. Notwithstanding

576-02995-16

20162508__

700 s. 409.915, counties are exempt from contributing toward the
701 cost of this special reimbursement for hospitals that serve a
702 disproportionate share of low-income patients. The agency may
703 make disproportionate share payments to specialty hospitals for
704 children as provided for in the General Appropriations Act.

705 (4) Notwithstanding the provisions of this section to the
706 contrary, for the 2016-2017 state fiscal year, for hospitals
707 achieving full compliance under subsection (3), the agency shall
708 make disproportionate share payments to specialty hospitals for
709 children as provided in the 2016-2017 General Appropriations
710 Act.

711 Section 18. Subsection (5) of section 409.9128, Florida
712 Statutes, is amended to read:

713 409.9128 Requirements for providing emergency services and
714 care.—

715 (5) Reimbursement for services provided to an enrollee of a
716 managed care plan under this section by a provider who does not
717 have a contract with the managed care plan shall be the lesser
718 of:

719 (a) The provider's charges;

720 (b) The usual and customary provider charges for similar
721 services in the community where the services were provided;

722 (c) The charge mutually agreed to by the entity and the
723 provider within 60 days after submittal of the claim; or

724 (d) The Medicaid rate, as provided in s. 409.967(2)(b).

725 Section 19. Paragraph (b) of subsection (2) of section
726 409.967, Florida Statutes, is amended to read:

727 409.967 Managed care plan accountability.—

728 (2) The agency shall establish such contract requirements

576-02995-16

20162508__

729 as are necessary for the operation of the statewide managed care
730 program. In addition to any other provisions the agency may deem
731 necessary, the contract must require:

732 (b) *Emergency services.*—Managed care plans shall pay for
733 services required by ss. 395.1041 and 401.45 and rendered by a
734 noncontracted provider. The plans must comply with s. 641.3155.
735 Reimbursement for services under this paragraph is the lesser
736 of:

737 1. The provider's charges;

738 2. The usual and customary provider charges for similar
739 services in the community where the services were provided;

740 3. The charge mutually agreed to by the entity and the
741 provider within 60 days after submittal of the claim; or

742 4. The Medicaid rate, which, for the purposes of this
743 paragraph, means the amount the provider would collect from the
744 agency on a fee-for-service basis, less any amounts for the
745 indirect costs of medical education and the direct costs of
746 graduate medical education that are otherwise included in the
747 agency's fee-for-service payment, as required under 42 U.S.C. s.
748 1396u-2(b)(2)(D) ~~The rate the agency would have paid on the most~~
749 ~~recent October 1st.~~

750

751 For the purpose of establishing the amounts specified in
752 subparagraph 4., the agency shall publish on its website
753 annually, or more frequently as needed, the applicable fee-for-
754 service fee schedules and their effective dates, less any
755 amounts for indirect costs of medical education and direct costs
756 of graduate medical education that are otherwise included in the
757 agency's fee-for-service payments.

576-02995-16

20162508__

758 Section 20. Present subsection (4) of section 409.968,
759 Florida Statutes, is redesignated as subsection (5) and a new
760 subsection (4) is added to that section, to read:

761 409.968 Managed care plan payments.—

762 (4) (a) Subject to a specific appropriation and federal
763 approval under s. 409.906(13) (e), the agency shall establish a
764 payment methodology to fund managed care plans for flexible
765 services for persons with severe mental illness and substance
766 abuse disorders, including, but not limited to, temporary
767 housing assistance. A managed care plan eligible for these
768 payments must do all of the following:

769 1. Participate as a specialty plan for severe mental
770 illness or substance abuse disorders or participate in counties
771 designated by the General Appropriations Act;

772 2. Include providers of behavioral health services pursuant
773 to chapters 394 and 397 in the managed care plan's provider
774 network; and

775 3. Document a capability to provide housing assistance
776 through agreements with housing providers, relationships with
777 local housing coalitions, and other appropriate arrangements.

778 (b) After receiving payments authorized by this section for
779 at least 1 year, a managed care plan must document the results
780 of its efforts to maintain the target population in stable
781 housing up to the maximum duration allowed under federal
782 approval.

783 Section 21. Subsections (1) and (6) of section 409.975,
784 Florida Statutes, are amended to read:

785 409.975 Managed care plan accountability.—In addition to
786 the requirements of s. 409.967, plans and providers

576-02995-16

20162508__

787 participating in the managed medical assistance program shall
788 comply with the requirements of this section.

789 (1) PROVIDER NETWORKS.—Managed care plans must develop and
790 maintain provider networks that meet the medical needs of their
791 enrollees in accordance with standards established pursuant to
792 s. 409.967(2)(c). Except as provided in this section, managed
793 care plans may limit the providers in their networks based on
794 credentials, quality indicators, and price.

795 (a) Plans must include all providers in the region that are
796 classified by the agency as essential Medicaid providers, unless
797 the agency approves, in writing, an alternative arrangement for
798 securing the types of services offered by the essential
799 providers. Providers are essential for serving Medicaid
800 enrollees if they offer services that are not available from any
801 other provider within a reasonable access standard, or if they
802 provided a substantial share of the total units of a particular
803 service used by Medicaid patients within the region during the
804 last 3 years and the combined capacity of other service
805 providers in the region is insufficient to meet the total needs
806 of the Medicaid patients. The agency may not classify physicians
807 and other practitioners as essential providers. The agency, at a
808 minimum, shall determine which providers in the following
809 categories are essential Medicaid providers:

810 1. Federally qualified health centers.

811 2. Statutory teaching hospitals as defined in s.
812 408.07(45).

813 3. Hospitals that are trauma centers as defined in s.
814 395.4001(14).

815 4. Hospitals located at least 25 miles from any other

576-02995-16

20162508__

816 hospital with similar services.

817

818 Managed care plans that have not contracted with all essential
819 providers in the region as of the first date of recipient
820 enrollment, or with whom an essential provider has terminated
821 its contract, must negotiate in good faith with such essential
822 providers for 1 year or until an agreement is reached, whichever
823 is first. Payments for services rendered by a nonparticipating
824 essential provider shall be made at the applicable Medicaid rate
825 as of the first day of the contract between the agency and the
826 plan. A rate schedule for all essential providers shall be
827 attached to the contract between the agency and the plan. After
828 1 year, managed care plans that are unable to contract with
829 essential providers shall notify the agency and propose an
830 alternative arrangement for securing the essential services for
831 Medicaid enrollees. The arrangement must rely on contracts with
832 other participating providers, regardless of whether those
833 providers are located within the same region as the
834 nonparticipating essential service provider. If the alternative
835 arrangement is approved by the agency, payments to
836 nonparticipating essential providers after the date of the
837 agency's approval shall equal 90 percent of the applicable
838 Medicaid rate. Except for payment for emergency services, if the
839 alternative arrangement is not approved by the agency, payment
840 to nonparticipating essential providers shall equal 110 percent
841 of the applicable Medicaid rate.

842 (b) Certain providers are statewide resources and essential
843 providers for all managed care plans in all regions. All managed
844 care plans must include these essential providers in their

576-02995-16

20162508__

845 networks. Statewide essential providers include:

846 1. Faculty plans of Florida medical schools.

847 2. Regional perinatal intensive care centers as defined in
848 s. 383.16(2).

849 3. Hospitals licensed as specialty children's hospitals as
850 defined in s. 395.002(28).

851 4. Accredited and integrated systems serving medically
852 complex children which comprise ~~that are comprised of~~ separately
853 licensed, but commonly owned, health care providers delivering
854 at least the following services: medical group home, in-home and
855 outpatient nursing care and therapies, pharmacy services,
856 durable medical equipment, and Prescribed Pediatric Extended
857 Care.

858
859 Managed care plans that have not contracted with all statewide
860 essential providers in all regions as of the first date of
861 recipient enrollment must continue to negotiate in good faith.
862 Payments to physicians on the faculty of nonparticipating
863 Florida medical schools shall be made at the applicable Medicaid
864 rate. Payments for services rendered by regional perinatal
865 intensive care centers shall be made at the applicable Medicaid
866 rate as of the first day of the contract between the agency and
867 the plan. Except for payments for emergency services, payments
868 to nonparticipating specialty children's hospitals shall equal
869 the highest rate established by contract between that provider
870 and any other Medicaid managed care plan.

871 (c) After 12 months of active participation in a plan's
872 network, the plan may exclude any essential provider from the
873 network for failure to meet quality or performance criteria. If

576-02995-16

20162508__

874 the plan excludes an essential provider from the plan, the plan
875 must provide written notice to all recipients who have chosen
876 that provider for care. The notice shall be provided at least 30
877 days before the effective date of the exclusion. For the
878 purposes of this paragraph, the term "essential provider"
879 includes providers determined by the agency to be essential
880 Medicaid providers under paragraph (a) and the statewide
881 essential providers specified in paragraph (b).

882 (d) The applicable Medicaid rates for emergency services
883 paid by a plan under this section to a provider with which the
884 plan does not have an active contract, shall be determined under
885 the requirements of s. 409.967(2)(b).

886 (e) Each managed care plan must offer a network contract to
887 each home medical equipment and supplies provider in the region
888 which meets quality and fraud prevention and detection standards
889 established by the plan and which agrees to accept the lowest
890 price previously negotiated between the plan and another such
891 provider.

892 (6) PROVIDER PAYMENT.—Managed care plans and hospitals
893 shall negotiate mutually acceptable rates, methods, and terms of
894 payment. ~~For rates, methods, and terms of payment negotiated~~
895 ~~after the contract between the agency and the plan is executed,~~
896 ~~plans shall pay hospitals, at a minimum, the rate the agency~~
897 ~~would have paid on the first day of the contract between the~~
898 ~~provider and the plan. Such payments to hospitals may not exceed~~
899 ~~120 percent of the rate the agency would have paid on the first~~
900 ~~day of the contract between the provider and the plan, unless~~
901 ~~specifically approved by the agency.~~ Payment rates may be
902 updated periodically.

576-02995-16

20162508__

903 Section 22. Paragraph (b) of subsection (3) of section
 904 624.91, Florida Statutes, is amended to read:

905 624.91 The Florida Healthy Kids Corporation Act.—

906 (3) ELIGIBILITY FOR STATE-FUNDED ASSISTANCE.—Only the
 907 following individuals are eligible for state-funded assistance
 908 in paying Florida Healthy Kids premiums:

909 (b) Notwithstanding s. 409.814, a legal alien ~~aliens~~ who is
 910 ~~are~~ enrolled in the Florida Healthy Kids program as of January
 911 31, 2004, who does ~~do~~ not qualify for Title XXI federal funds
 912 because he or she is ~~they are~~ not a lawfully residing child
 913 ~~qualified aliens~~ as defined in s. 409.811.

914 Section 23. Subsection (6) of section 641.513, Florida
 915 Statutes, is amended, and subsection (7) is added to that
 916 section, to read:

917 641.513 Requirements for providing emergency services and
 918 care.—

919 (6) Reimbursement for services under this section provided
 920 to subscribers who are Medicaid recipients by a provider for
 921 whom no contract exists between the provider and the health
 922 maintenance organization shall be determined under chapter 409
 923 ~~the lesser of:~~

- 924 ~~(a) The provider's charges;~~
- 925 ~~(b) The usual and customary provider charges for similar~~
 926 ~~services in the community where the services were provided;~~
- 927 ~~(c) The charge mutually agreed to by the entity and the~~
 928 ~~provider within 60 days after submittal of the claim; or~~
- 929 ~~(d) The Medicaid rate.~~

930 (7) Reimbursement for services under this section provided
 931 to subscribers who are enrolled in a health maintenance

576-02995-16

20162508__

932 organization pursuant to s. 624.91 by a provider for whom no
933 contract exists between the provider and the health maintenance
934 organization shall be the lesser of:

935 (a) The provider's charges;

936 (b) The usual and customary provider charges for similar
937 services in the community where the services were provided;

938 (c) The charge mutually agreed to by the entity and the
939 provider within 60 days after submittal of the claim; or

940 (d) The Medicaid rate.

941 Section 24. Subject to federal approval and adoption of a
942 contract amendment with the Agency for Health Care
943 Administration, an organization that is currently authorized to
944 provide Program of All-Inclusive Care for the Elderly (PACE)
945 services in southeast Florida and that is granted authority
946 under section 18 of chapter 2012-33, Laws of Florida, for up to
947 150 enrollee slots to serve frail elders residing in Broward
948 County may also use those PACE slots for frail elders residing
949 in Miami-Dade County.

950 Section 25. Subject to federal approval of the application
951 to be a site for the Program of All-inclusive Care for the
952 Elderly (PACE), the Agency for Health Care Administration shall
953 contract with one private, not-for-profit hospice organization
954 located in Escambia County that owns and manages health care
955 organizations licensed in Hospice Service Areas 1, 2A, and 2B
956 which provide comprehensive services, including, but not limited
957 to, hospice and palliative care, to frail elders who reside in
958 those Hospice Service Areas. The organization is exempt from the
959 requirements of chapter 641, Florida Statutes. The agency, in
960 consultation with the Department of Elderly Affairs and subject

576-02995-16

20162508__

961 to the appropriation of funds by the Legislature, shall approve
962 up to 100 initial enrollees in the Program of All-inclusive Care
963 for the Elderly established by the organization to serve frail
964 elders who reside in Hospice Service Areas 1, 2A, and 2B.

965 Section 26. Except as otherwise expressly provided in this
966 act and except for this section, which shall take effect upon
967 this act becoming a law, this act shall take effect July 1,
968 2016.