FOR CONSIDERATION By the Committee on Appropriations

576-02765-16 20162508pb

A bill to be entitled

An act relating to health care services; amending s. 322.143, F.S.; providing an exception to the prohibition against a private entity swiping an individual's driver license or identification card for certain entities for certain purposes; amending s. 395.602, F.S.; including specified hospitals in the definition of "rural hospital"; amending s. 409.285, F.S.; requiring appeals related to Medicaid programs directly administered by the Agency for Health Care Administration to be directed to the agency; providing requirements for appeals directed to the agency; providing an exemption from the uniform rules of procedure and from a requirement that certain proceedings be heard before an administrative law judge for specified hearings; requiring the agency to seek federal approval of its authority to oversee appeals; providing that appeals related to Medicaid programs administered by the Agency for Persons with Disabilities are subject to that agency's hearing rights process; amending s. 409.811, F.S.; defining the term "lawfully residing child"; deleting the definition of the term "qualified alien"; conforming provisions to changes made by the act; amending s. 409.814, F.S.; revising eligibility for the Florida Kidcare program to conform to changes made by the act; clarifying that undocumented immigrants are excluded from eligibility; amending s. 409.904, F.S.; providing eligibility for optional payments for medical assistance and related services for certain lawfully residing children; clarifying that undocumented immigrants are excluded from eligibility for optional

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

fiscal year for determining each hospital's Medicaid days and charity care; providing an exception for the distribution of moneys to certain hospitals for the 2016-2017 state fiscal year; amending ss. 409.9113, 409.9115, and 409.9119, F.S.; providing an exception for the distribution of moneys to certain hospitals for the 2016-2017 state fiscal year; amending s. 409.9128, F.S.; conforming provisions to changes made by the act; amending s. 409.967, F.S.; defining the term "Medicaid rate" for the purpose of determining specified managed care plan payments for emergency services in compliance with federal law; requiring annual publication of fee schedules on the agency's website; amending s. 409.968, F.S.; directing the agency to establish a payment methodology for managed care plans providing housing assistance to specified persons; amending s. 409.975, F.S.; providing for the determination of applicable Medicaid rates for emergency services; defining the term "essential provider"; deleting requirements relating to contracted rates between managed care plans and hospitals; conforming provisions to changes made by the act; amending s. 624.91, F.S.; conforming provisions to changes made by the act; amending s. 641.513, F.S.; specifying parameters for payments by a health maintenance organization to a noncontracted provider of emergency services under certain circumstances; conforming provisions to changes made by the act; authorizing a Program of All-Inclusive

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

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

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

322.143 Use of a driver license or identification card.—

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

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

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

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

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

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

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

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

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

395.602 Rural hospitals.—

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

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

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

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

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

square mile;

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

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

6.~~5.~~ A hospital designated as a critical access hospital, as defined in s. 408.07.

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

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

409.285 Opportunity for hearing and appeal.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(13) HOME AND COMMUNITY-BASED SERVICES.—

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

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

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

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

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

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

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

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

409.9072 Medicaid provider agreements for charter schools and private schools.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(23)

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

1. Inpatient hospitals.

2. Outpatient hospitals.

~~3. Nursing homes.~~

3.~~4.~~ County health departments.

4.~~5.~~ Prepaid health plans.

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

409.909 Statewide Medicaid Residency Program.—

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

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

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

1. Family medicine;
2. General internal medicine;
3. General pediatrics;
4. Preventive medicine;
5. Geriatric medicine;
6. Osteopathic general practice;

7. Obstetrics and gynecology;

8. Emergency medicine; ~~and~~

9. General surgery; and

10. Psychiatry.

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

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

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

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

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

2016-2017 General Appropriations Act.

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

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

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

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

Florida Statutes, to read:

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

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

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

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

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

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

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

409.9128 Requirements for providing emergency services and care.—

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

(a) The provider's charges;

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

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

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

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

409.967 Managed care plan accountability.—

(2) The agency shall establish such contract requirements

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

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

1. The provider's charges;

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

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

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

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

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

409.968 Managed care plan payments.—

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

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

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

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

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

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

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

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

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

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

1. Federally qualified health centers.

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

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

4. Hospitals located at least 25 miles from any other

hospital with similar services.

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

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

networks. Statewide essential providers include:

1. Faculty plans of Florida medical schools.

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

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

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

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

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

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

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

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

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

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

624.91 The Florida Healthy Kids Corporation Act.—

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

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

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

641.513 Requirements for providing emergency services and care.—

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

~~(a) The provider's charges;~~

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

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

~~(d) The Medicaid rate~~.

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

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

(a) The provider's charges;

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

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

(d) The Medicaid rate.

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

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

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

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