HOUSE AMENDMENT

Bill No. SB 2514, 1st Eng. (2017)

Amendment No.

CHAMBER ACTION

Senate House

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Representative Brodeur offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. 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;~~

4.~~5.~~ 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 Transparency at the agency; or

5.~~6.~~ 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 2. Subsection (11) is added to section 409.904, Florida Statutes, 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.

(11) Subject to federal waiver approval, a person with acquired immune deficiency syndrome (AIDS) who has an AIDS-related opportunistic infection and is at risk of hospitalization as determined by the agency or its designee, and

whose income is at or below 300 percent of the federal benefit rate (FBR).

Section 3. Paragraph (b) of subsection (13) of section 409.906, Florida Statutes, is amended 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.—

~~(b) The agency may consolidate types of services offered in the Aged and Disabled Waiver, the Channeling Waiver, the Project AIDS Care Waiver, and the Traumatic Brain and Spinal Cord Injury Waiver programs in order to group similar services under a single service, or continue a service upon evidence of the need for including a particular service type in a particular waiver. The agency is authorized to seek a Medicaid state plan amendment or federal waiver approval to implement this policy.~~

Section 4. Subsections (6) through (26) of section 409.908, Florida Statutes, are renumbered as subsections (5) through (25), respectively, present subsections (5) and (24) are amended, and a new subsection (26) is added to that section, 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.

~~(5) An ambulatory surgical center shall be reimbursed the lesser of the amount billed by the provider or the Medicare-established allowable amount for the facility.~~

(23)~~(24)~~(a) The agency shall establish rates at a level that ensures no increase in statewide expenditures resulting from a change in unit costs effective July 1, 2011. Reimbursement rates shall be as provided in the General

Appropriations Act.

(b) Base rate reimbursement for inpatient services under a diagnosis-related group payment methodology shall be provided in the General Appropriations Act.

(c) Base rate reimbursement for outpatient services under an enhanced ambulatory payment group methodology shall be provided in the General Appropriations Act.

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

~~1. Inpatient hospitals.~~

~~2. Outpatient hospitals.~~

1. ~~3.~~ Nursing homes.

2. ~~4.~~ County health departments.

~~5. Prepaid health plans.~~

(e) ~~(d)~~ The agency shall apply the effect of this subsection to the reimbursement rates for nursing home diversion programs.

(26) The agency may receive funds from state entities, including, but not limited to, the Department of Health, local governments, and other local political subdivisions, for the purpose of making special exception payments, including federal matching funds. Funds received for this purpose shall be separately accounted for and may not be commingled with other state or local funds in any manner. The agency may certify all local governmental funds used as state match under Title XIX of

the Social Security Act to the extent and in the manner authorized under the General Appropriations Act and pursuant to an agreement between the agency and the local governmental entity. In order for the agency to certify such local governmental funds, a local governmental entity must submit a final, executed letter of agreement to the agency, which must be received by October 1 of each fiscal year and provide the total amount of local governmental funds authorized by the entity for that fiscal year under the General Appropriations Act. The local governmental entity shall use a certification form prescribed by the agency. At a minimum, the certification form must identify the amount being certified and describe the relationship between the certifying local governmental entity and the local health care provider. Local governmental funds outlined in the letters of agreement must be received by the agency no later than October 31 of each fiscal year in which such funds are pledged, unless an alternative plan is specifically approved by the agency.

Section 5. Paragraph (b) 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:

(b) "Medicaid payments" means the estimated total payments for reimbursing a hospital for direct inpatient services for the fiscal year in which the allocation fraction is calculated based on the hospital inpatient appropriation and the parameters for the inpatient diagnosis-related group base rate and the parameters for the outpatient enhanced ambulatory payment group rate, including applicable intergovernmental transfers, specified in the General Appropriations Act, as determined by the agency. Effective July 1, 2017, the term "Medicaid payments" means the estimated total payments for reimbursing a hospital for direct inpatient and outpatient services for the fiscal year in which the allocation fraction is calculated based on the hospital inpatient appropriation and outpatient appropriation and the parameters for the inpatient diagnosis-related group base rate and the parameters for the outpatient enhanced ambulatory payment group rate, including applicable intergovernmental transfers, specified in the General Appropriations Act, as determined by the agency.

Section 6. Paragraph (a) of subsection (2) of section

409.911, Florida Statutes, is amended to read:

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

(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 2009, 2010, and 2011 ~~2007, 2008, and 2009~~ audited disproportionate share data to determine each hospital's Medicaid days and charity care for the 2017-2018 ~~2015-2016~~ state fiscal year.

Section 7. Subsections (1) and (2) of section 409.979, Florida Statutes, are amended to read:

409.979 Eligibility.—

(1) PREREQUISITE CRITERIA FOR ELIGIBILITY.—Medicaid recipients who meet all of the following criteria are eligible to receive long-term care services and must receive long-term

care services by participating in the long-term care managed care program. The recipient must be:

(a) Sixty-five years of age or older, or age 18 or older and eligible for Medicaid by reason of a disability.

(b) Determined by the Comprehensive Assessment Review and Evaluation for Long-Term Care Services (CARES) preadmission screening program to require:

1. Nursing facility care as defined in s. 409.985(3); or

2. For individuals diagnosed as having cystic fibrosis, hospital level of care.

(2) ENROLLMENT OFFERS.—Subject to the availability of funds, the Department of Elderly Affairs shall make offers for enrollment to eligible individuals based on a wait-list prioritization. Before making enrollment offers, the agency and the Department of Elderly Affairs shall determine that sufficient funds exist to support additional enrollment into plans.

(a) A Medicaid recipient enrolled in one of the following home and community-based services Medicaid waiver programs who meets all of the eligibility criteria established in subsection (1) is eligible to participate in the long-term care managed care program and shall be transitioned into the long-term care managed care program by January 1, 2018:

1. Traumatic Brain and Spinal Cord Injury Waiver.

2. Adult Cystic Fibrosis Waiver.

3. Project AIDS Care Waiver.

(b) The agency shall seek federal approval to terminate the Traumatic Brain and Spinal Cord Injury Waiver, the Adult Cystic Fibrosis Waiver, and the Project AIDS Care Waiver once all eligible Medicaid recipients have transitioned into the long-term care managed care program.

Section 8. Subsection (3) of section 391.055, Florida Statutes, is amended to read:

391.055 Service delivery systems.—

(3) The Children's Medical Services network may contract with school districts participating in the certified school match program pursuant to ss. 409.908(21) ~~409.908(22)~~ and 1011.70 for the provision of school-based services, as provided for in s. 409.9071, for Medicaid-eligible children who are enrolled in the Children's Medical Services network.

Section 9. Subsection (7) of section 393.0661, Florida Statutes, is amended to read:

393.0661 Home and community-based services delivery system; comprehensive redesign.—The Legislature finds that the home and community-based services delivery system for persons with developmental disabilities and the availability of appropriated funds are two of the critical elements in making services available. Therefore, it is the intent of the Legislature that the Agency for Persons with Disabilities shall develop and implement a comprehensive redesign of the system.

(7) The agency shall collect premiums or cost sharing pursuant to s. 409.906(13)(c) ~~409.906(13)(d)~~.

Section 10. Paragraph (a) of subsection (4) of section 409.968, Florida Statutes, is amended to read:

409.968 Managed care plan payments.—

(4)(a) Subject to a specific appropriation and federal approval under s. 409.906(13)(d) ~~409.906(13)(c)~~, the agency shall establish a payment methodology to fund managed care plans for flexible services for persons with severe mental illness and substance use 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 use 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.

Section 11. Subsection (3) of section 427.0135, Florida Statutes, is amended to read:

427.0135 Purchasing agencies; duties and responsibilities.—Each purchasing agency, in carrying out the

policies and procedures of the commission, shall:

(3) Not procure transportation disadvantaged services without initially negotiating with the commission, as provided in s. 287.057(3)(e)12., or unless otherwise authorized by statute. If the purchasing agency, after consultation with the commission, determines that it cannot reach mutually acceptable contract terms with the commission, the purchasing agency may contract for the same transportation services provided in a more cost-effective manner and of comparable or higher quality and standards. The Medicaid agency shall implement this subsection in a manner consistent with s. 409.908(18) ~~409.908(19)~~ and as otherwise limited or directed by the General Appropriations Act.

Section 12. Subsections (1) and (5) of section 1011.70, Florida Statutes, are amended to read:

1011.70 Medicaid certified school funding maximization.—

(1) Each school district, subject to the provisions of ss. 409.9071 and 409.908(21) ~~409.908(22)~~ and this section, is authorized to certify funds provided for a category of required Medicaid services termed "school-based services," which are reimbursable under the federal Medicaid program. Such services shall include, but not be limited to, physical, occupational, and speech therapy services, behavioral health services, mental health services, transportation services, Early Periodic Screening, Diagnosis, and Treatment (EPSDT) administrative outreach for the purpose of determining eligibility for

exceptional student education, and any other such services, for the purpose of receiving federal Medicaid financial participation. Certified school funding shall not be available for the following services:

(a) Family planning.

(b) Immunizations.

(c) Prenatal care.

(5) Lab schools, as authorized under s. 1002.32, shall be authorized to participate in the Medicaid certified school match program on the same basis as school districts subject to the provisions of subsections (1)-(4) and ss. 409.9071 and 409.908(21) ~~409.908(22)~~.

Section 13. This act shall take effect July 1, 2017.

T I T L E A M E N D M E N T

Remove everything before the enacting clause and insert:

A bill to be entitled

An act relating to Medicaid services; amending s. 395.602, F.S.; revising the definition of the term "rural hospital" to delete sole community hospitals; amending s. 409.904, F.S.; providing that certain persons with AIDS are eligible for optional payments for medical assistance and related services; amending s. 409.906, F.S.; deleting a provision relating to

consolidation of waiver services to conform to changes made by the act; amending s. 409.908, F.S.; deleting a provision relating to reimbursement rate parameters for certain Medicaid providers; authorizing the agency to receive funds from certain governmental entities for specified purposes; providing requirements for letters of agreement executed by a local governmental entity; amending s. 409.909, F.S.; revising the definition of the term "Medicaid payments" to include the outpatient enhanced ambulatory payment group for purposes of the Statewide Medicaid Residency Program; amending s. 409.911, F.S.; updating references to data used for calculating disproportionate share program payments to certain hospitals for the 2017-2018 fiscal year; amending s. 409.979, F.S.; revising eligibility criteria for certain long-term care services; providing for certain home and community-based service waiver participants to transition into the long-term care managed care program; requiring the agency to seek federal approval to terminate certain waiver programs; amending ss. 391.055, 393.0661, 409.968, 427.0135, and 1011.70, F.S.; conforming cross-references; providing an effective date.