By the Committee on Appropriations

576-03477-17 20172514__

1 A bill to be entitled
2 An act relating to health care; amending s. 210.20,
3 F.S.; providing that a specified percentage of the
4 cigarette tax, up to a specified amount, be paid
5 annually to the Florida Consortium of National Cancer
6 Institute Centers Program, rather than the Sanford-
7 Burnham Medical Research Institute; requiring that the
8 funds be used to advance cures for cancers afflicting
9 pediatric populations through basic or applied
10 research; amending s. 381.922, F.S.; revising the
11 goals of the William G. “Bill” Bankhead, Jr., and
12 David Coley Cancer Research Program to include
13 identifying ways to increase pediatric enrollment in
14 cancer clinical trials; establishing the Live Like
15 Bella Initiative to advance progress toward curing
16 pediatric cancer, subject to an appropriation;
17 amending s. 394.9082, F.S.; creating the Substance
18 Abuse and Mental Health (SAMH) Safety Net Network;
19 providing legislative intent; requiring the Department
20 of Children and Families and the Agency for Health
21 Care Administration to determine the scope of services
22 to be offered through providers contracted with the
23 SAMH Safety Net Network; authorizing the SAMH Safety
24 Net Network to provide Medicaid reimbursable services
25 beyond the limits of the state Medicaid plan under
26 certain circumstances; providing that general revenue
27 matching funds for the services shall be derived from
28 the existing unmatched general revenue funds within
29 the substance abuse and mental health program and

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

576-03477-17 20172514__

30 documented through general revenue expenditure
31 submissions by the department; requiring the agency,
32 in consultation with the department, to seek federal
33 authorization for administrative claiming pursuant to
34 a specified federal program to fund certain
35 interventions, case managers, and facility services;
36 requiring the department, in collaboration with the
37 agency, to document local funding of behavioral health
38 services; requiring the agency to seek certain federal
39 matching funds; amending s. 395.602, F.S.; revising
40 the definition of the term "rural hospital" to include
41 a hospital classified as a sole community hospital,
42 regardless of the number of licensed beds; amending s.
43 409.904, F.S.; authorizing the agency to make payments
44 for medical assistance and related services on behalf
45 of a person diagnosed with acquired immune deficiency
46 syndrome who meets certain criteria, subject to the
47 availability of moneys and specified limitations;
48 amending s. 409.908, F.S.; revising requirements
49 related to the long-term care reimbursement plan and
50 cost reporting system; requiring the calculation of
51 separate prices for each patient care subcomponent
52 based on specified cost reports; providing that
53 certain ceilings and targets apply only to providers
54 being reimbursed on a cost-based system; expanding the
55 direct care subcomponent to include allowable therapy
56 and dietary costs; specifying that allowable ancillary
57 costs are included in the indirect care cost
58 subcomponent; requiring the agency to establish, by a

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

59 specified date, a technical advisory council to assist
60 in ongoing development and refining of quality
61 measures used in the nursing home prospective payment
62 system; providing for membership; requiring that
63 nursing home prospective payment rates be rebased at a
64 specified interval; authorizing the payment of a
65 direct care supplemental payment to certain providers;
66 specifying the amount providers will be reimbursed for
67 a specified period of time, which may be a cost-based
68 rate or a prospective payment rate; providing for
69 expiration of this reimbursement mechanism on a
70 specified date; requiring the agency to reimburse
71 providers on a cost-based rate or a rebased
72 prospective payment rate, beginning on a specified
73 date; requiring that Medicaid pay deductibles and
74 coinsurance for certain X-ray services provided in an
75 assisted living facility or in the patient's home;
76 amending s. 409.909, F.S.; providing that the agency
77 shall make payments and distribute funds to qualifying
78 institutions in addition to hospitals under the
79 Statewide Medicaid Residency Program; amending s.
80 409.9082; revising the uses of quality assessment and
81 federal matching funds to include the partial funding
82 of the quality incentive payment program for nursing
83 facilities that exceed quality benchmarks; amending s.
84 409.911, F.S.; updating obsolete language; amending s.
85 409.9119, F.S.; revising criteria for the
86 participation of hospitals in the disproportionate
87 share program for specialty hospitals for children;

576-03477-17 20172514__

88 amending s. 409.913, F.S.; removing a requirement that
89 the agency provide each Medicaid recipient with an
90 explanation of benefits; authorizing the agency to
91 provide an explanation of benefits to a sample of
92 Medicaid recipients or their representatives; amending
93 s. 409.975, F.S.; authorizing, rather than requiring,
94 a managed care plan to offer a network contract to
95 certain medical equipment and supplies providers in
96 the region; requiring the agency to contract with the
97 SAMH Safety Net Network; specifying that the contract
98 must require managing entities to provide specified
99 services to certain individuals; requiring the agency
100 to conduct a comprehensive readiness assessment before
101 contracting with the SAMH Safety Net Network;
102 requiring the agency and the department to develop
103 performance measures for the SAMH Safety Net Network;
104 requiring the agency and the department to develop
105 performance measures to evaluate the SAMH Safety Net
106 Network and its services; requiring the agency, in
107 consultation with the department and managing
108 entities, to determine the rates for services added to
109 the state Medicaid plan; amending s. 409.979, F.S.;
110 expanding eligibility for long-term care services to
111 include hospital level of care for certain individuals
112 diagnosed with cystic fibrosis; revising eligibility
113 for certain Medicaid recipients in the long-term care
114 managed care program; requiring the agency to contract
115 with an additional, not-for-profit organization that
116 meets certain conditions and offers specified services

117 to frail elders who reside in Miami-Dade County,
118 subject to federal approval; exempting the
119 organization from ch. 641, F.S., relating to health
120 care service programs; requiring the agency, in
121 consultation with the Department of Elderly Affairs,
122 to approve a certain number of initial enrollees in
123 the Program of All-inclusive Care for the Elderly
124 (PACE); requiring the agency to contract with a
125 specified not-for-profit organization, a not-for-
126 profit agency serving elders, and a not-for-profit
127 hospice in Leon County to be a site for PACE, subject
128 to federal approval; authorizing PACE to serve
129 eligible enrollees in Gadsden, Jefferson, Leon, and
130 Wakulla Counties; requiring the agency, in
131 consultation with the department, to approve a certain
132 number of initial enrollees in PACE at the new site,
133 subject to an appropriation; amending s. 17 of chapter
134 2011-61, Laws of Florida; requiring the agency, in
135 consultation with the department, to approve a certain
136 number of initial enrollees in PACE to serve frail
137 elders who reside in certain counties; amending s. 9
138 of chapter 2016-65, Laws of Florida; revising an
139 effective date; revising the date that rates for
140 hospital outpatient services must take effect;
141 amending s. 29 of chapter 2016-65, Laws of Florida;
142 requiring the agency, in consultation with the
143 department, to approve a certain number of enrollees
144 in the PACE established to serve frail elders who
145 reside in Hospice Service Area 7; requiring the agency

146 to contract with a not-for-profit organization that
147 meets certain criteria to offer specified services to
148 frail elders who reside in Alachua County, subject to
149 federal approval; exempting the organization from ch.
150 641, F.S., relating to health care service programs;
151 requiring the agency, in consultation with the
152 department, to approve a certain number of initial
153 enrollees in PACE at the new site, subject to certain
154 conditions; requiring the agency to contract with an
155 organization that meets certain criteria to offer
156 specified services to frail elders who reside in
157 certain counties, subject to federal approval;
158 exempting the organization from ch. 641, F.S.,
159 relating to health care service programs; requiring
160 the agency, in consultation with the department, to
161 approve a certain number of initial enrollees in PACE
162 at the new site, subject to certain conditions;
163 providing that the agency may seek any necessary
164 waiver or state plan amendments to serve a certain
165 purpose; providing effective dates.
166
167 Be It Enacted by the Legislature of the State of Florida:
168
169 Section 1. Paragraph (c) of subsection (2) of section
170 210.20, Florida Statutes, is amended to read:
171 210.20 Employees and assistants; distribution of funds.—
172 (2) As collections are received by the division from such
173 cigarette taxes, it shall pay the same into a trust fund in the
174 State Treasury designated “Cigarette Tax Collection Trust Fund”

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

175 which shall be paid and distributed as follows:
176 (c) Beginning July 1, 2017 ~~2013~~, and continuing through
177 June 30, 2033, the division shall from month to month certify to
178 the Chief Financial Officer the amount derived from the
179 cigarette tax imposed by s. 210.02, less the service charges
180 provided for in s. 215.20 and less 0.9 percent of the amount
181 derived from the cigarette tax imposed by s. 210.02, which shall
182 be deposited into the Alcoholic Beverage and Tobacco Trust Fund,
183 specifying an amount equal to 1 percent of the net collections,
184 not to exceed $3 million annually, and that amount shall be
185 deposited into the Biomedical Research Trust Fund in the
186 Department of Health. These funds are appropriated annually ~~in~~
187 ~~an amount not to exceed $3 million~~ from the Biomedical Research
188 Trust Fund for the advancement of cures for cancers afflicting
189 pediatric populations through basic or applied research,
190 including, but not limited to, clinical trials and nontoxic drug
191 discovery. These funds are not included in the calculation for
192 the distribution of funds pursuant to s. 381.915; however, these
193 funds shall be distributed to cancer centers participating in
194 the Florida Consortium of National Cancer Institute Centers
195 Program in the same proportion as is allocated to each cancer
196 center in accordance with s. 381.915 and are in addition to any
197 funds distributed pursuant to that section ~~Department of Health~~
198 ~~and the Sanford-Burnham Medical Research Institute to work in~~
199 ~~conjunction for the purpose of establishing activities and grant~~
200 ~~opportunities in relation to biomedical research~~.
201 Section 2. Subsection (2) of section 381.922, Florida
202 Statutes, is amended to read:
203 381.922 William G. "Bill" Bankhead, Jr., and David Coley

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

204 Cancer Research Program.—
205 (2) The program shall provide grants for cancer research to
206 further the search for cures for cancer.
207 (a) Emphasis shall be given to the following goals, as
208 those goals support the advancement of such cures:
209 1. Efforts to significantly expand cancer research capacity
210 in the state by:
211 a. Identifying ways to attract new research talent and
212 attendant national grant-producing researchers to cancer
213 research facilities in this state;
214 b. Implementing a peer-reviewed, competitive process to
215 identify and fund the best proposals to expand cancer research
216 institutes in this state;
217 c. Funding through available resources for those proposals
218 that demonstrate the greatest opportunity to attract federal
219 research grants and private financial support;
220 d. Encouraging the employment of bioinformatics in order to
221 create a cancer informatics infrastructure that enhances
222 information and resource exchange and integration through
223 researchers working in diverse disciplines, to facilitate the
224 full spectrum of cancer investigations;
225 e. Facilitating the technical coordination, business
226 development, and support of intellectual property as it relates
227 to the advancement of cancer research; and
228 f. Aiding in other multidisciplinary research-support
229 activities as they inure to the advancement of cancer research.
230 2. Efforts to improve both research and treatment through
231 greater participation in clinical trials networks by:
232 a. Identifying ways to increase pediatric and adult

233 enrollment in cancer clinical trials;
234 b. Supporting public and private professional education
235 programs designed to increase the awareness and knowledge about
236 cancer clinical trials;
237 c. Providing tools to cancer patients and community-based
238 oncologists to aid in the identification of cancer clinical
239 trials available in the state; and
240 d. Creating opportunities for the state’s academic cancer
241 centers to collaborate with community-based oncologists in
242 cancer clinical trials networks.
243 3. Efforts to reduce the impact of cancer on disparate
244 groups by:
245 a. Identifying those cancers that disproportionately impact
246 certain demographic groups; and
247 b. Building collaborations designed to reduce health
248 disparities as they relate to cancer.
249 (b) Preference may be given to grant proposals that foster
250 collaborations among institutions, researchers, and community
251 practitioners, as such proposals support the advancement of
252 cures through basic or applied research, including clinical
253 trials involving cancer patients and related networks.
254 (c) There is established within the program the Live Like
255 Bella Initiative. The purpose of the initiative is to advance
256 progress toward curing pediatric cancer by awarding grants
257 through the peer-reviewed, competitive process established under
258 subsection (3). This paragraph is subject to the annual
259 appropriation of funds by the Legislature.
260 Section 3. Subsection (11) is added to section 394.9082,
261 Florida Statutes, to read:

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

262 394.9082 Behavioral health managing entities.—
263 (11) SUBSTANCE ABUSE AND MENTAL HEALTH (SAMH) SAFETY NET
264 NETWORK.—
265 (a) It is the intent of the Legislature to create the
266 Substance Abuse and Mental Health (SAMH) Safety Net Network to
267 support and enhance the community mental health and substance
268 abuse services currently provided by managing entities. The SAMH
269 Safety Net Network as used in this section means the managing
270 entities and their contracted network of providers. Contracted
271 providers are considered vendors and not subrecipients, as
272 defined in s. 215.97. Managing entities and their contracted
273 providers are not public employees for purposes of chapter 112.
274 (b) The department and the agency shall establish the SAMH
275 Safety Net Network by adding specific behavioral health services
276 currently provided by managing entities to the state Medicaid
277 plan and adjusting the amount of units of services for specific
278 Medicaid services to better serve Medicaid-eligible individuals
279 with severe and persistent mental health or substance use
280 disorders, and their families, who are currently served by
281 managing entities. It is the intent of the Legislature to have
282 the department submit documentation of general revenue
283 expenditures to the agency for the state match for the services
284 and for the agency to pay managing entities the federal Medicaid
285 portion for services provided.
286 1. Behavioral health services currently funded by managing
287 entities through the substance abuse and mental health program
288 shall be added by the agency to the state Medicaid plan through
289 a state plan amendment. These services shall be provided
290 exclusively through the providers contracted with the SAMH

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

291 Safety Net Network. The department and the agency shall
292 determine which services are essential for individuals served by
293 managing entities through coordinated systems of care and which
294 services will most efficiently use state and federal resources.
295 2. The state Medicaid plan currently limits the amount of
296 behavioral health services that may be provided to a covered
297 individual. However, the SAMH Safety Net Network is authorized
298 to provide Medicaid reimbursable services beyond these limits
299 when providing services, including, but not limited to,
300 assessment, group therapy, individual therapy, psychosocial
301 rehabilitation, day treatment, medication management,
302 therapeutic onsite services, substance abuse inpatient or
303 residential detoxification, inpatient hospital services, and
304 crisis stabilization unit or as appropriate in lieu of services.
305 (c) The required general revenue matching funds for the
306 services shall be derived from the existing unmatched general
307 revenue funds within the substance abuse and mental health
308 program and documented through general revenue expenditure
309 submissions by the department. The Medicaid reimbursement for
310 services provided by the SAMH Safety Net Network shall be
311 limited to the availability of general revenue matching funds
312 within the substance abuse and mental health program for such
313 purpose.
314 (d) Except as otherwise provided in this part, the state
315 share of funds sufficient to implement the provisions of this
316 act shall be redirected from existing general revenue funds in
317 the department which are used for funding mental health and
318 substance abuse services, excluding funding for residential
319 services. The need for these state-only funds must be offset by

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

320 the infusion of federal funds made available to the SAMH Safety
321 Net Network under the provisions of this act.
322 Section 4. The Agency for Health Care Administration, in
323 consultation with the Department of Children and Families, shall
324 seek federal authorization for administrative claiming pursuant
325 to the Medicaid Administrative Claiming program to fund:
326 (1) The department's team-based interventions, including,
327 but not limited to, community action treatment teams and family
328 intervention treatment teams, which focus on the entire family
329 to prevent out-of-home placements in the child welfare,
330 behavioral health, and criminal justice systems.
331 (2) Case managers employed by the department's child
332 welfare community-based care lead agency who are responsible for
333 locating, coordinating, and monitoring necessary and appropriate
334 services extending beyond direct services for Medicaid-eligible
335 children, including, but not limited to, outreach, referral,
336 eligibility determination, and case management.
337 (3) Central receiving facility services for individuals
338 with mental health or substance use disorders.
339 Section 5. The Department of Children and Families, in
340 collaboration with the Agency for Health Care Administration,
341 shall document the extent to which behavioral health services
342 are funded with contributions from units of local government.
343 The agency shall seek federal authority to have these funds
344 qualify for federal matching funds as certified public
345 expenditures.
346 Section 6. Paragraph (e) of subsection (2) of section
347 395.602, Florida Statutes, is amended to read:
348 395.602 Rural hospitals.—

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

349 (2) DEFINITIONS.—As used in this part, the term:
350 (e) “Rural hospital” means an acute care hospital licensed
351 under this chapter, having 100 or fewer licensed beds and an
352 emergency room, which is:
353 1. The sole provider within a county with a population
354 density of up to 100 persons per square mile;
355 2. An acute care hospital, in a county with a population
356 density of up to 100 persons per square mile, which is at least
357 30 minutes of travel time, on normally traveled roads under
358 normal traffic conditions, from any other acute care hospital
359 within the same county;
360 3. A hospital supported by a tax district or subdistrict
361 whose boundaries encompass a population of up to 100 persons per
362 square mile;
363 4. A hospital classified as a sole community hospital under
364 42 C.F.R. s. 412.92, regardless of the number of ~~which has up to~~
365 ~~175~~ licensed beds;
366 5. A hospital with a service area that has a population of
367 up to 100 persons per square mile. As used in this subparagraph,
368 the term “service area” means the fewest number of zip codes
369 that account for 75 percent of the hospital’s discharges for the
370 most recent 5-year period, based on information available from
371 the hospital inpatient discharge database in the Florida Center
372 for Health Information and Transparency at the agency; or
373 6. A hospital designated as a critical access hospital, as
374 defined in s. 408.07.
375
376 Population densities used in this paragraph must be based upon
377 the most recently completed United States census. A hospital

378 that received funds under s. 409.9116 for a quarter beginning no
379 later than July 1, 2002, is deemed to have been and shall
380 continue to be a rural hospital from that date through June 30,
381 2021, if the hospital continues to have up to 100 licensed beds
382 and an emergency room. An acute care hospital that has not
383 previously been designated as a rural hospital and that meets
384 the criteria of this paragraph shall be granted such designation
385 upon application, including supporting documentation, to the
386 agency. A hospital that was licensed as a rural hospital during
387 the 2010-2011 or 2011-2012 fiscal year shall continue to be a
388 rural hospital from the date of designation through June 30,
389 2021, if the hospital continues to have up to 100 licensed beds
390 and an emergency room.
391 Section 7. Subsection (11) is added to section 409.904,
392 Florida Statutes, to read:
393 409.904 Optional payments for eligible persons.—The agency
394 may make payments for medical assistance and related services on
395 behalf of the following persons who are determined to be
396 eligible subject to the income, assets, and categorical
397 eligibility tests set forth in federal and state law. Payment on
398 behalf of these Medicaid eligible persons is subject to the
399 availability of moneys and any limitations established by the
400 General Appropriations Act or chapter 216.
401 (11) Subject to federal waiver approval, a person diagnosed
402 with acquired immune deficiency syndrome (AIDS) who has an AIDS-
403 related opportunistic infection and is at risk of
404 hospitalization as determined by the agency and whose income is
405 at or below 300 percent of the Federal Benefit Rate.
406 Section 8. Subsections (2) and (14) of section 409.908,

407 Florida Statutes, are amended to read:
408 409.908 Reimbursement of Medicaid providers.—Subject to
409 specific appropriations, the agency shall reimburse Medicaid
410 providers, in accordance with state and federal law, according
411 to methodologies set forth in the rules of the agency and in
412 policy manuals and handbooks incorporated by reference therein.
413 These methodologies may include fee schedules, reimbursement
414 methods based on cost reporting, negotiated fees, competitive
415 bidding pursuant to s. 287.057, and other mechanisms the agency
416 considers efficient and effective for purchasing services or
417 goods on behalf of recipients. If a provider is reimbursed based
418 on cost reporting and submits a cost report late and that cost
419 report would have been used to set a lower reimbursement rate
420 for a rate semester, then the provider's rate for that semester
421 shall be retroactively calculated using the new cost report, and
422 full payment at the recalculated rate shall be effected
423 retroactively. Medicare-granted extensions for filing cost
424 reports, if applicable, shall also apply to Medicaid cost
425 reports. Payment for Medicaid compensable services made on
426 behalf of Medicaid eligible persons is subject to the
427 availability of moneys and any limitations or directions
428 provided for in the General Appropriations Act or chapter 216.
429 Further, nothing in this section shall be construed to prevent
430 or limit the agency from adjusting fees, reimbursement rates,
431 lengths of stay, number of visits, or number of services, or
432 making any other adjustments necessary to comply with the
433 availability of moneys and any limitations or directions
434 provided for in the General Appropriations Act, provided the
435 adjustment is consistent with legislative intent.

436 (2)(a)1. Reimbursement to nursing homes licensed under part
437 II of chapter 400 and state-owned-and-operated intermediate care
438 facilities for the developmentally disabled licensed under part
439 VIII of chapter 400 must be made prospectively.
440 2. Unless otherwise limited or directed in the General
441 Appropriations Act, reimbursement to hospitals licensed under
442 part I of chapter 395 for the provision of swing-bed nursing
443 home services must be made on the basis of the average statewide
444 nursing home payment, and reimbursement to a hospital licensed
445 under part I of chapter 395 for the provision of skilled nursing
446 services must be made on the basis of the average nursing home
447 payment for those services in the county in which the hospital
448 is located. When a hospital is located in a county that does not
449 have any community nursing homes, reimbursement shall be
450 determined by averaging the nursing home payments in counties
451 that surround the county in which the hospital is located.
452 Reimbursement to hospitals, including Medicaid payment of
453 Medicare copayments, for skilled nursing services shall be
454 limited to 30 days, unless a prior authorization has been
455 obtained from the agency. Medicaid reimbursement may be extended
456 by the agency beyond 30 days, and approval must be based upon
457 verification by the patient's physician that the patient
458 requires short-term rehabilitative and recuperative services
459 only, in which case an extension of no more than 15 days may be
460 approved. Reimbursement to a hospital licensed under part I of
461 chapter 395 for the temporary provision of skilled nursing
462 services to nursing home residents who have been displaced as
463 the result of a natural disaster or other emergency may not
464 exceed the average county nursing home payment for those

465 services in the county in which the hospital is located and is
466 limited to the period of time which the agency considers
467 necessary for continued placement of the nursing home residents
468 in the hospital.
469 (b) Subject to any limitations or directions in the General
470 Appropriations Act, the agency shall establish and implement a
471 state Title XIX Long-Term Care Reimbursement Plan for nursing
472 home care in order to provide care and services in conformance
473 with the applicable state and federal laws, rules, regulations,
474 and quality and safety standards and to ensure that individuals
475 eligible for medical assistance have reasonable geographic
476 access to such care.
477 1. The agency shall amend the long-term care reimbursement
478 plan and cost reporting system to create direct care and
479 indirect care subcomponents of the patient care component of the
480 per diem rate. These two subcomponents together shall equal the
481 patient care component of the per diem rate. Separate prices
482 ~~cost-based ceilings~~ shall be calculated for each patient care
483 subcomponent, initially based on the September 2016 rate setting
484 cost reports and subsequently based on the most recently audited
485 cost report used during a rebasing year. The direct care
486 subcomponent of the per diem rate for any providers still being
487 reimbursed on a cost basis shall be limited by the cost-based
488 class ceiling, and the indirect care subcomponent may be limited
489 by the lower of the cost-based class ceiling, the target rate
490 class ceiling, or the individual provider target. The ceilings
491 and targets apply only to providers being reimbursed on a cost-
492 based system.
493 2. The direct care subcomponent shall include salaries and

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

494 benefits of direct care staff providing nursing services
495 including registered nurses, licensed practical nurses, and
496 certified nursing assistants who deliver care directly to
497 residents in the nursing home facility, allowable therapy costs,
498 and dietary costs. This excludes nursing administration, staff
499 development, the staffing coordinator, and the administrative
500 portion of the minimum data set and care plan coordinators. The
501 direct care subcomponent also includes medically necessary
502 dental care, vision care, hearing care, and podiatric care.
503 3. All other patient care costs shall be included in the
504 indirect care cost subcomponent of the patient care per diem
505 rate, including complex medical equipment, medical supplies, and
506 other allowable ancillary costs. Costs may not be allocated
507 directly or indirectly to the direct care subcomponent from a
508 home office or management company.
509 4. On July 1 of each year, the agency shall report to the
510 Legislature direct and indirect care costs, including average
511 direct and indirect care costs per resident per facility and
512 direct care and indirect care salaries and benefits per category
513 of staff member per facility.
514 5. Before December 31, 2017, the agency must establish a
515 technical advisory council to assist in ongoing development and
516 refining of the quality measures used in the nursing home
517 prospective payment system. The advisory council must include,
518 but need not be limited to, representatives of nursing home
519 providers and other interested stakeholders. In order to offset
520 the cost of general and professional liability insurance, the
521 agency shall amend the plan to allow for interim rate
522 adjustments to reflect increases in the cost of general or

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

523 ~~professional liability insurance for nursing homes. This~~
524 ~~provision shall be implemented to the extent existing~~
525 ~~appropriations are available.~~
526 6. Every fourth year, the agency shall rebase nursing home
527 prospective payment rates to reflect changes in cost based on
528 the most recently audited cost report for each participating
529 provider.
530 7. A direct care supplemental payment may be made to
531 providers whose direct care hours per patient day are above the
532 80th percentile and who provide Medicaid services to a larger
533 percentage of Medicaid patients than the state average.
534 8. For the period beginning on October 1, 2017, and ending
535 on September 30, 2020, the agency shall reimburse providers the
536 greater of their September 2016 cost-based rate or their
537 prospective payment rate. Effective October 1, 2020, the agency
538 shall reimburse providers the greater of 95 percent of their
539 cost-based rate or their rebased prospective payment rate, using
540 the most recently audited cost report for each facility. This
541 subsection shall expire September 30, 2022.
542 9. Pediatric, Florida Department of Veterans Affairs, and
543 government-owned facilities are exempt from the pricing model
544 established in this subsection and shall remain on a cost-based
545 prospective payment system. Effective October 1, 2018, the
546 agency shall set rates for all facilities remaining on a cost-
547 based prospective payment system using each facility’s most
548 recently audited cost report, eliminating retroactive
549 settlements.
550
551 It is the intent of the Legislature that the reimbursement plan

552 achieve the goal of providing access to health care for nursing
553 home residents who require large amounts of care while
554 encouraging diversion services as an alternative to nursing home
555 care for residents who can be served within the community. The
556 agency shall base the establishment of any maximum rate of
557 payment, whether overall or component, on the available moneys
558 as provided for in the General Appropriations Act. The agency
559 may base the maximum rate of payment on the results of
560 scientifically valid analysis and conclusions derived from
561 objective statistical data pertinent to the particular maximum
562 rate of payment.
563 (14) Medicare premiums for persons eligible for both
564 Medicare and Medicaid coverage shall be paid at the rates
565 established by Title XVIII of the Social Security Act. For
566 Medicare services rendered to Medicaid-eligible persons,
567 Medicaid shall pay Medicare deductibles and coinsurance as
568 follows:
569 (a) Medicaid’s financial obligation for deductibles and
570 coinsurance payments shall be based on Medicare allowable fees,
571 not on a provider’s billed charges.
572 (b) Medicaid will pay no portion of Medicare deductibles
573 and coinsurance when payment that Medicare has made for the
574 service equals or exceeds what Medicaid would have paid if it
575 had been the sole payor. The combined payment of Medicare and
576 Medicaid shall not exceed the amount Medicaid would have paid
577 had it been the sole payor. The Legislature finds that there has
578 been confusion regarding the reimbursement for services rendered
579 to dually eligible Medicare beneficiaries. Accordingly, the
580 Legislature clarifies that it has always been the intent of the

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

576-03477-17 20172514__

581 Legislature before and after 1991 that, in reimbursing in
582 accordance with fees established by Title XVIII for premiums,
583 deductibles, and coinsurance for Medicare services rendered by
584 physicians to Medicaid eligible persons, physicians be
585 reimbursed at the lesser of the amount billed by the physician
586 or the Medicaid maximum allowable fee established by the Agency
587 for Health Care Administration, as is permitted by federal law.
588 It has never been the intent of the Legislature with regard to
589 such services rendered by physicians that Medicaid be required
590 to provide any payment for deductibles, coinsurance, or
591 copayments for Medicare cost sharing, or any expenses incurred
592 relating thereto, in excess of the payment amount provided for
593 under the State Medicaid plan for such service. This payment
594 methodology is applicable even in those situations in which the
595 payment for Medicare cost sharing for a qualified Medicare
596 beneficiary with respect to an item or service is reduced or
597 eliminated. This expression of the Legislature is in
598 clarification of existing law and shall apply to payment for,
599 and with respect to provider agreements with respect to, items
600 or services furnished on or after the effective date of this
601 act. This paragraph applies to payment by Medicaid for items and
602 services furnished before the effective date of this act if such
603 payment is the subject of a lawsuit that is based on the
604 provisions of this section, and that is pending as of, or is
605 initiated after, the effective date of this act.
606 (c) Notwithstanding paragraphs (a) and (b):
607 1. Medicaid payments for Nursing Home Medicare part A
608 coinsurance are limited to the Medicaid nursing home per diem
609 rate less any amounts paid by Medicare, but only up to the

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

576-03477-17 20172514__

610 amount of Medicare coinsurance. The Medicaid per diem rate shall
611 be the rate in effect for the dates of service of the crossover
612 claims and may not be subsequently adjusted due to subsequent
613 per diem rate adjustments.
614 2. Medicaid shall pay all deductibles and coinsurance for
615 Medicare-eligible recipients receiving freestanding end stage
616 renal dialysis center services.
617 3. Medicaid payments for general and specialty hospital
618 inpatient services are limited to the Medicare deductible and
619 coinsurance per spell of illness. Medicaid payments for hospital
620 Medicare Part A coinsurance shall be limited to the Medicaid
621 hospital per diem rate less any amounts paid by Medicare, but
622 only up to the amount of Medicare coinsurance. Medicaid payments
623 for coinsurance shall be limited to the Medicaid per diem rate
624 in effect for the dates of service of the crossover claims and
625 may not be subsequently adjusted due to subsequent per diem
626 adjustments.
627 4. Medicaid shall pay all deductibles and coinsurance for
628 Medicare emergency transportation services provided by
629 ambulances licensed pursuant to chapter 401.
630 5. Medicaid shall pay all deductibles and coinsurance for
631 portable X-ray Medicare Part B services provided in a nursing
632 home, in an assisted living facility, or in the patient's home.
633 Section 9. Subsection (4) of section 409.9082, Florida
634 Statutes, is amended to read:
635 409.9082 Quality assessment on nursing home facility
636 providers; exemptions; purpose; federal approval required;
637 remedies.—
638 (4) The purpose of the nursing home facility quality

639 assessment is to ensure continued quality of care. Collected
640 assessment funds shall be used to obtain federal financial
641 participation through the Medicaid program to make Medicaid
642 payments for nursing home facility services up to the amount of
643 nursing home facility Medicaid rates as calculated in accordance
644 with the approved state Medicaid plan in effect on December 31,
645 2007. The quality assessment and federal matching funds shall be
646 used exclusively for the following purposes and in the following
647 order of priority:
648 (a) To reimburse the Medicaid share of the quality
649 assessment as a pass-through, Medicaid-allowable cost;
650 (b) To increase to each nursing home facility's Medicaid
651 rate, as needed, an amount that restores rate reductions
652 effective on or after January 1, 2008, as provided in the
653 General Appropriations Act; and
654 (c) To partially fund the quality incentive payment program
655 for nursing facilities that exceed quality benchmarks ~~increase~~
656 ~~each nursing home facility's Medicaid rate that accounts for the~~
657 ~~portion of the total assessment not included in paragraphs (a)~~
658 ~~and (b) which begins a phase-in to a pricing model for the~~
659 ~~operating cost component~~.
660 Section 10. Section 409.909, Florida Statutes, is amended
661 to read:
662 409.909 Statewide Medicaid Residency Program.—
663 (1) The Statewide Medicaid Residency Program is established
664 to improve the quality of care and access to care for Medicaid
665 recipients, expand graduate medical education on an equitable
666 basis, and increase the supply of highly trained physicians
667 statewide. The agency shall make payments to hospitals licensed

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

668 under part I of chapter 395 and to qualifying institutions as
669 defined in paragraph (2)(c) for graduate medical education
670 associated with the Medicaid program. This system of payments is
671 designed to generate federal matching funds under Medicaid and
672 distribute the resulting funds to participating hospitals on a
673 quarterly basis in each fiscal year for which an appropriation
674 is made.

675 (2) On or before September 15 of each year, the agency
676 shall calculate an allocation fraction to be used for
677 distributing funds to participating hospitals and to qualifying
678 institutions as defined in paragraph (2)(c). On or before the
679 final business day of each quarter of a state fiscal year, the
680 agency shall distribute to each participating hospital one-
681 fourth of that hospital's annual allocation calculated under
682 subsection (4). The allocation fraction for each participating
683 hospital is based on the hospital's number of full-time
684 equivalent residents and the amount of its Medicaid payments. As
685 used in this section, the term:

686 (a) "Full-time equivalent," or "FTE," means a resident who
687 is in his or her residency period, with the initial residency
688 period defined as the minimum number of years of training
689 required before the resident may become eligible for board
690 certification by the American Osteopathic Association Bureau of
691 Osteopathic Specialists or the American Board of Medical
692 Specialties in the specialty in which he or she first began
693 training, not to exceed 5 years. The residency specialty is
694 defined as reported using the current residency type codes in
695 the Intern and Resident Information System (IRIS), required by
696 Medicare. A resident training beyond the initial residency

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

697 period is counted as 0.5 FTE, unless his or her chosen specialty
698 is in primary care, in which case the resident is counted as 1.0
699 FTE. For the purposes of this section, primary care specialties
700 include:
701 1. Family medicine;
702 2. General internal medicine;
703 3. General pediatrics;
704 4. Preventive medicine;
705 5. Geriatric medicine;
706 6. Osteopathic general practice;
707 7. Obstetrics and gynecology;
708 8. Emergency medicine;
709 9. General surgery; and
710 10. Psychiatry.
711 (b) "Medicaid payments" means the estimated total payments
712 for reimbursing a hospital for direct inpatient services for the
713 fiscal year in which the allocation fraction is calculated based
714 on the hospital inpatient appropriation and the parameters for
715 the inpatient diagnosis-related group base rate, including
716 applicable intergovernmental transfers, specified in the General
717 Appropriations Act, as determined by the agency. Effective July
718 1, 2017, the term "Medicaid payments" means the estimated total
719 payments for reimbursing a hospital and qualifying institutions
720 as defined in paragraph (2)(c) for direct inpatient and
721 outpatient services for the fiscal year in which the allocation
722 fraction is calculated based on the hospital inpatient
723 appropriation and outpatient appropriation and the parameters
724 for the inpatient diagnosis-related group base rate, including
725 applicable intergovernmental transfers, specified in the General

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

726 Appropriations Act, as determined by the agency.
727 (c) “Qualifying institution” means a federally Qualified
728 Health Center holding an Accreditation Council for Graduate
729 Medical Education institutional accreditation.
730 (d) “Resident” means a medical intern, fellow, or resident
731 enrolled in a program accredited by the Accreditation Council
732 for Graduate Medical Education, the American Association of
733 Colleges of Osteopathic Medicine, or the American Osteopathic
734 Association at the beginning of the state fiscal year during
735 which the allocation fraction is calculated, as reported by the
736 hospital to the agency.
737 (3) The agency shall use the following formula to calculate
738 a participating hospital’s and qualifying institution’s
739 allocation fraction:
740
741 HAF=[0.9 x (HFTE/TFTE)] + [0.1 x (HMP/TMP)]
742
743 Where:
744 HAF=A hospital’s and qualifying institution’s allocation
745 fraction.
746 HFTE=A hospital’s and qualifying institution’s total number
747 of FTE residents.
748 TFTE=The total FTE residents for all participating
749 hospitals and qualifying institutions.
750 HMP=A hospital’s and qualifying institution’s Medicaid
751 payments.
752 TMP=The total Medicaid payments for all participating
753 hospitals and qualifying institutions.
754

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

755 (4) A hospital's and qualifying institution's annual
756 allocation shall be calculated by multiplying the funds
757 appropriated for the Statewide Medicaid Residency Program in the
758 General Appropriations Act by that hospital's and qualifying
759 institution's allocation fraction. If the calculation results in
760 an annual allocation that exceeds two times the average per FTE
761 resident amount for all hospitals and qualifying institutions,
762 the hospital's and qualifying institution's annual allocation
763 shall be reduced to a sum equaling no more than two times the
764 average per FTE resident. The funds calculated for that hospital
765 and qualifying institution in excess of two times the average
766 per FTE resident amount for all hospitals and qualifying
767 institutions shall be redistributed to participating hospitals
768 and qualifying institutions whose annual allocation does not
769 exceed two times the average per FTE resident amount for all
770 hospitals and qualifying institutions, using the same
771 methodology and payment schedule specified in this section.
772 (5) The Graduate Medical Education Startup Bonus Program is
773 established to provide resources for the education and training
774 of physicians in specialties which are in a statewide supply-
775 and-demand deficit. Hospitals and qualifying institutions as
776 defined in paragraph (2)(c) eligible for participation in
777 subsection (1) are eligible to participate in the Graduate
778 Medical Education Startup Bonus Program established under this
779 subsection. Notwithstanding subsection (4) or an FTE's residency
780 period, and in any state fiscal year in which funds are
781 appropriated for the startup bonus program, the agency shall
782 allocate a $100,000 startup bonus for each newly created
783 resident position that is authorized by the Accreditation

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

784 Council for Graduate Medical Education or Osteopathic
785 Postdoctoral Training Institution in an initial or established
786 accredited training program that is in a physician specialty in
787 statewide supply-and-demand deficit. In any year in which
788 funding is not sufficient to provide $100,000 for each newly
789 created resident position, funding shall be reduced pro rata
790 across all newly created resident positions in physician
791 specialties in statewide supply-and-demand deficit.
792 (a) Hospitals and qualifying institutions as defined in
793 paragraph (2)(c) applying for a startup bonus must submit to the
794 agency by March 1 their Accreditation Council for Graduate
795 Medical Education or Osteopathic Postdoctoral Training
796 Institution approval validating the new resident positions
797 approved on or after March 2 of the prior fiscal year through
798 March 1 of the current fiscal year for the physician specialties
799 identified in a statewide supply-and-demand deficit as provided
800 in the current fiscal year's General Appropriations Act. An
801 applicant hospital or qualifying institution as defined in
802 paragraph (2)(c) may validate a change in the number of
803 residents by comparing the number in the prior period
804 Accreditation Council for Graduate Medical Education or
805 Osteopathic Postdoctoral Training Institution approval to the
806 number in the current year.
807 (b) Any unobligated startup bonus funds on April 15 of each
808 fiscal year shall be proportionally allocated to hospitals and
809 to qualifying institutions as defined in paragraph (2)(c)
810 participating under subsection (3) for existing FTE residents in
811 the physician specialties in statewide supply-and-demand
812 deficit. This nonrecurring allocation shall be in addition to

813 the funds allocated in subsection (4). Notwithstanding
814 subsection (4), the allocation under this subsection may not
815 exceed $100,000 per FTE resident.
816 (c) For purposes of this subsection, physician specialties
817 and subspecialties, both adult and pediatric, in statewide
818 supply-and-demand deficit are those identified in the General
819 Appropriations Act.
820 (d) The agency shall distribute all funds authorized under
821 the Graduate Medical Education Startup Bonus Program on or
822 before the final business day of the fourth quarter of a state
823 fiscal year.
824 (6) Beginning in the 2015-2016 state fiscal year, the
825 agency shall reconcile each participating hospital's total
826 number of FTE residents calculated for the state fiscal year 2
827 years before with its most recently available Medicare cost
828 reports covering the same time period. Reconciled FTE counts
829 shall be prorated according to the portion of the state fiscal
830 year covered by a Medicare cost report. Using the same
831 definitions, methodology, and payment schedule specified in this
832 section, the reconciliation shall apply any differences in
833 annual allocations calculated under subsection (4) to the
834 current year's annual allocations.
835 (7) The agency may adopt rules to administer this section.
836 Section 11. Paragraph (a) of subsection (2) of section
837 409.911, Florida Statutes, is amended, and paragraph (b) of that
838 subsection is republished, to read:
839 409.911 Disproportionate share program.—Subject to specific
840 allocations established within the General Appropriations Act
841 and any limitations established pursuant to chapter 216, the

842 agency shall distribute, pursuant to this section, moneys to
843 hospitals providing a disproportionate share of Medicaid or
844 charity care services by making quarterly Medicaid payments as
845 required. Notwithstanding the provisions of s. 409.915, counties
846 are exempt from contributing toward the cost of this special
847 reimbursement for hospitals serving a disproportionate share of
848 low-income patients.
849 (2) The Agency for Health Care Administration shall use the
850 following actual audited data to determine the Medicaid days and
851 charity care to be used in calculating the disproportionate
852 share payment:
853 (a) The average of the 2009, 2010, and 2011 ~~2007, 2008, and~~
854 ~~2009~~ audited disproportionate share data to determine each
855 hospital's Medicaid days and charity care for the 2017-2018
856 ~~2015-2016~~ state fiscal year.
857 (b) If the Agency for Health Care Administration does not
858 have the prescribed 3 years of audited disproportionate share
859 data as noted in paragraph (a) for a hospital, the agency shall
860 use the average of the years of the audited disproportionate
861 share data as noted in paragraph (a) which is available.
862 Section 12. Section 409.9119, Florida Statutes, is amended
863 to read:
864 409.9119 Disproportionate share program for specialty
865 hospitals for children.—In addition to the payments made under
866 s. 409.911, the Agency for Health Care Administration shall
867 develop and implement a system under which disproportionate
868 share payments are made to those hospitals that are separately
869 licensed by the state as specialty hospitals for children, have
870 a federal Centers for Medicare and Medicaid Services

576-03477-17 20172514__

871 certification number in the 3300-3399 range, have Medicaid days
872 that exceed 55 percent of their total days and Medicare days
873 that are less than 5 percent of their total days, and were
874 licensed on January 1, 2012 ~~January 1, 2000~~, as specialty
875 hospitals for children. This system of payments must conform to
876 federal requirements and must distribute funds in each fiscal
877 year for which an appropriation is made by making quarterly
878 Medicaid payments. Notwithstanding s. 409.915, counties are
879 exempt from contributing toward the cost of this special
880 reimbursement for hospitals that serve a disproportionate share
881 of low-income patients. The agency may make disproportionate
882 share payments to specialty hospitals for children as provided
883 for in the General Appropriations Act.
884 (1) Unless specified in the General Appropriations Act, the
885 agency shall use the following formula to calculate the total
886 amount earned for hospitals that participate in the specialty
887 hospital for children disproportionate share program:
888
889 TAE = DSR x BMPD x MD
890
891 Where:
892 TAE = total amount earned by a specialty hospital for
893 children.
894 DSR = disproportionate share rate.
895 BMPD = base Medicaid per diem.
896 MD = Medicaid days.
897
898 (2) The agency shall calculate the total additional payment
899 for hospitals that participate in the specialty hospital for

900 children disproportionate share program as follows:
901
902 TAP = (TAE x TA) ÷ STAE
903
904 Where:
905 TAP = total additional payment for a specialty hospital for
906 children.
907 TAE = total amount earned by a specialty hospital for
908 children.
909 TA = total appropriation for the specialty hospital for
910 children disproportionate share program.
911 STAE = sum of total amount earned by each hospital that
912 participates in the specialty hospital for children
913 disproportionate share program.
914
915 (3) A hospital may not receive any payments under this
916 section until it achieves full compliance with the applicable
917 rules of the agency. A hospital that is not in compliance for
918 two or more consecutive quarters may not receive its share of
919 the funds. Any forfeited funds must be distributed to the
920 remaining participating specialty hospitals for children that
921 are in compliance.
922 (4) Notwithstanding any provision of this section to the
923 contrary, for the 2017-2018 ~~2016-2017~~ state fiscal year, for
924 hospitals achieving full compliance under subsection (3), the
925 agency shall make disproportionate share payments to specialty
926 hospitals for children as provided in the 2017-2018 ~~2016-2017~~
927 General Appropriations Act. This subsection expires July 1, 2018
928 ~~2017~~.

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

929 Section 13. Subsection (36) of section 409.913, Florida
930 Statutes, is amended to read:
931 409.913 Oversight of the integrity of the Medicaid
932 program.—The agency shall operate a program to oversee the
933 activities of Florida Medicaid recipients, and providers and
934 their representatives, to ensure that fraudulent and abusive
935 behavior and neglect of recipients occur to the minimum extent
936 possible, and to recover overpayments and impose sanctions as
937 appropriate. Beginning January 1, 2003, and each year
938 thereafter, the agency and the Medicaid Fraud Control Unit of
939 the Department of Legal Affairs shall submit a joint report to
940 the Legislature documenting the effectiveness of the state's
941 efforts to control Medicaid fraud and abuse and to recover
942 Medicaid overpayments during the previous fiscal year. The
943 report must describe the number of cases opened and investigated
944 each year; the sources of the cases opened; the disposition of
945 the cases closed each year; the amount of overpayments alleged
946 in preliminary and final audit letters; the number and amount of
947 fines or penalties imposed; any reductions in overpayment
948 amounts negotiated in settlement agreements or by other means;
949 the amount of final agency determinations of overpayments; the
950 amount deducted from federal claiming as a result of
951 overpayments; the amount of overpayments recovered each year;
952 the amount of cost of investigation recovered each year; the
953 average length of time to collect from the time the case was
954 opened until the overpayment is paid in full; the amount
955 determined as uncollectible and the portion of the uncollectible
956 amount subsequently reclaimed from the Federal Government; the
957 number of providers, by type, that are terminated from

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

958 participation in the Medicaid program as a result of fraud and
959 abuse; and all costs associated with discovering and prosecuting
960 cases of Medicaid overpayments and making recoveries in such
961 cases. The report must also document actions taken to prevent
962 overpayments and the number of providers prevented from
963 enrolling in or reenrolling in the Medicaid program as a result
964 of documented Medicaid fraud and abuse and must include policy
965 recommendations necessary to prevent or recover overpayments and
966 changes necessary to prevent and detect Medicaid fraud. All
967 policy recommendations in the report must include a detailed
968 fiscal analysis, including, but not limited to, implementation
969 costs, estimated savings to the Medicaid program, and the return
970 on investment. The agency must submit the policy recommendations
971 and fiscal analyses in the report to the appropriate estimating
972 conference, pursuant to s. 216.137, by February 15 of each year.
973 The agency and the Medicaid Fraud Control Unit of the Department
974 of Legal Affairs each must include detailed unit-specific
975 performance standards, benchmarks, and metrics in the report,
976 including projected cost savings to the state Medicaid program
977 during the following fiscal year.
978 (36) ~~At least three times a year,~~ The agency may ~~shall~~
979 provide to a sample of ~~each~~ Medicaid recipients ~~recipient~~ or
980 their representatives through the distribution of explanations
981 ~~his or her representative an explanation~~ of benefits information
982 about services reimbursed by the Medicaid program for goods and
983 services to such recipients, including ~~in the form of a letter~~
984 ~~that is mailed to the most recent address of the recipient on~~
985 ~~the record with the Department of Children and Families. The~~
986 ~~explanation of benefits must include the patient’s name, the~~

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

987 ~~name of the health care provider and the address of the location~~
988 ~~where the service was provided, a description of all services~~
989 ~~billed to Medicaid in terminology that should be understood by a~~
990 ~~reasonable person, and~~ information on how to report
991 inappropriate or incorrect billing to the agency or other law
992 enforcement entities for review or investigation~~. At least once~~
993 ~~a year~~, ~~the letter also must include~~ information on how to
994 report criminal Medicaid fraud <u>to</u>~~,~~ the Medicaid Fraud Control
995 Unit's toll-free hotline number, and information about the
996 rewards available under s. 409.9203. The explanation of benefits
997 may not be mailed for Medicaid independent laboratory services
998 as described in s. 409.905(7) or for Medicaid certified match
999 services as described in ss. 409.9071 and 1011.70.
1000 Section 14. Paragraph (e) of subsection (1) of section
1001 409.975, Florida Statutes, is amended, and subsection (7) is
1002 added to that section, to read:
1003 409.975 Managed care plan accountability.—In addition to
1004 the requirements of s. 409.967, plans and providers
1005 participating in the managed medical assistance program shall
1006 comply with the requirements of this section.
1007 (1) PROVIDER NETWORKS.—Managed care plans must develop and
1008 maintain provider networks that meet the medical needs of their
1009 enrollees in accordance with standards established pursuant to
1010 s. 409.967(2)(c). Except as provided in this section, managed
1011 care plans may limit the providers in their networks based on
1012 credentials, quality indicators, and price.
1013 (e) Each managed care plan <u>may</u> ~~must~~ offer a network
1014 contract to each home medical equipment and supplies provider in
1015 the region which meets quality and fraud prevention and

1016 detection standards established by the plan and which agrees to
1017 accept the lowest price previously negotiated between the plan
1018 and another such provider.
1019 (7) SUBSTANCE ABUSE AND MENTAL HEALTH (SAMH) SAFETY NET
1020 NETWORK.—
1021 (a) The agency shall contract with the Substance Abuse and
1022 Mental Health (SAMH) Safety Net Network, established under s.
1023 394.9082(11), to plan, coordinate, and contract for delivering
1024 certain community mental health and substance abuse services,
1025 thereby improving access to behavioral health care, promoting
1026 the continuity of such services, and supporting efficient and
1027 effective delivery of such services under this section. The
1028 contract must require managing entities to provide specified
1029 services to Medicaid-eligible individuals with specified
1030 behaviors, diagnoses, or addictions.
1031 (b) Before contracting, the agency must conduct a
1032 comprehensive readiness assessment to ensure that the SAMH
1033 Safety Net Network has the necessary infrastructure, financial
1034 resources, and relevant experience to implement the contract.
1035 The agency and the department shall develop performance measures
1036 to evaluate the impact of the SAMH Safety Net Network and to
1037 determine the adequacy, timeliness, and quality of the services
1038 provided for specified target populations and the efficiency of
1039 the services in addressing mental health and substance use
1040 disorders within a community.
1041 (c) The agency, in consultation with the department and
1042 managing entities, shall determine the rates for services added
1043 to the state Medicaid plan. The rates shall be developed based
1044 on the full cost of the services and reasonable administrative

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

1045 costs for providers and managing entities.
1046 Section 15. Subsection (1) and (2) of section 409.979,
1047 Florida Statutes, are amended to read:
1048 409.979 Eligibility.—
1049 (1) PREREQUISITE CRITERIA FOR ELIGIBILITY.—Medicaid
1050 recipients who meet all of the following criteria are eligible
1051 to receive long-term care services and must receive long-term
1052 care services by participating in the long-term care managed
1053 care program. The recipient must be:
1054 (a) Sixty-five years of age or older, or age 18 or older
1055 and eligible for Medicaid by reason of a disability.
1056 (b) Determined by the Comprehensive Assessment Review and
1057 Evaluation for Long-Term Care Services (CARES) preadmission
1058 screening program to require:
1059 1. Nursing facility care as defined in s. 409.985(3); or
1060 2. Hospital level of care for individuals diagnosed with
1061 cystic fibrosis.
1062 (2) ENROLLMENT OFFERS.—Subject to the availability of
1063 funds, the Department of Elderly Affairs shall make offers for
1064 enrollment to eligible individuals based on a wait-list
1065 prioritization. Before making enrollment offers, the agency and
1066 the Department of Elderly Affairs shall determine that
1067 sufficient funds exist to support additional enrollment into
1068 plans.
1069 (a) A Medicaid recipient enrolled in one of the following
1070 Medicaid home and community-based services waiver programs who
1071 meets the eligibility criteria established in subsection (1) is
1072 eligible to participate in the long-term care managed care
1073 program and must be transitioned into the long-term care managed

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

1074 care program by January 1, 2018:
1075 1. Traumatic Brain and Spinal Cord Injury Waiver.
1076 2. Adult Cystic Fibrosis Waiver.
1077 3. Project AIDS Care Waiver.
1078 (b) The agency shall seek federal approval to terminate the
1079 Traumatic Brain and Spinal Cord Injury Waiver, the Adult Cystic
1080 Fibrosis Waiver, and the Project AIDS Care Waiver once all
1081 eligible Medicaid recipients have transitioned into the long-
1082 term care managed care program.
1083 Section 16. Subject to federal approval of the application
1084 to be a site for the Program of All-inclusive Care for the
1085 Elderly (PACE), the Agency for Health Care Administration shall
1086 contract with an additional not-for-profit organization to serve
1087 individuals and families in Miami-Dade County. The not-for-
1088 profit organization must have a history of serving primarily the
1089 Hispanic population by providing primary care services,
1090 nutrition, meals, and adult day care to senior citizens. The
1091 not-for-profit organization shall leverage existing community-
1092 based care providers and health care organizations to provide
1093 PACE services to frail elders who reside in Miami-Dade County.
1094 The organization is exempt from the requirements of chapter 641,
1095 Florida Statutes. The agency, in consultation with the
1096 Department of Elderly Affairs and subject to an appropriation,
1097 shall approve up to 250 initial enrollees in the additional PACE
1098 site established by this organization to serve frail elders who
1099 reside in Miami-Dade County.
1100 Section 17. Notwithstanding section 27 of chapter 2016-65,
1101 Laws of Florida, and subject to federal approval of the
1102 application to be a site for the Program of All-inclusive Care

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

1103 for the Elderly (PACE), the Agency for Health Care
1104 Administration shall contract with a not-for-profit
1105 organization, formed by a partnership with a not-for-profit
1106 hospital, a not-for-profit agency serving elders, and a not-for-
1107 profit hospice in Leon County. The not-for-profit PACE shall
1108 serve eligible PACE enrollees in Gadsden, Jefferson, Leon, and
1109 Wakulla Counties. The Agency for Health Care Administration, in
1110 consultation with the Department of Elderly Affairs and subject
1111 to an appropriation, shall approve up to 300 initial enrollees
1112 for the additional PACE site.
1113 Section 18. Section 17 of chapter 2011-61, Laws of Florida,
1114 is amended to read:
1115 Section 17. Notwithstanding s. 430.707, Florida Statutes,
1116 and subject to federal approval of the application to be a site
1117 for the Program of All-inclusive Care for the Elderly, the
1118 Agency for Health Care Administration shall contract with one
1119 private health care organization, the sole member of which is a
1120 private, not-for-profit corporation that owns and manages health
1121 care organizations which provide comprehensive long-term care
1122 services, including nursing home, assisted living, independent
1123 housing, home care, adult day care, and care management, with a
1124 board-certified, trained geriatrician as the medical director.
1125 This organization shall provide these services to frail and
1126 elderly persons who reside in Indian River, Martin, Okeechobee,
1127 Palm Beach, and St. Lucie Counties ~~County~~. The organization is
1128 exempt from the requirements of chapter 641, Florida Statutes.
1129 The agency, in consultation with the Department of Elderly
1130 Affairs and subject to an appropriation, shall approve up to 150
1131 initial enrollees who reside in Palm Beach County and up to 150

1132 initial enrollees who reside in Martin County in the Program of
1133 All-inclusive Care for the Elderly established by this
1134 organization to serve elderly persons ~~who reside in Palm Beach~~
1135 ~~County~~.
1136 Section 19. Effective June 30, 2017, section 9 of chapter
1137 2016-65, Laws of Florida, is amended to read:
1138 Section 9. Effective July 1, 2018 ~~2017~~, paragraph (b) of
1139 subsection (6) of section 409.905, Florida Statutes, is amended
1140 to read:
1141 409.905 Mandatory Medicaid services.—The agency may make
1142 payments for the following services, which are required of the
1143 state by Title XIX of the Social Security Act, furnished by
1144 Medicaid providers to recipients who are determined to be
1145 eligible on the dates on which the services were provided. Any
1146 service under this section shall be provided only when medically
1147 necessary and in accordance with state and federal law.
1148 Mandatory services rendered by providers in mobile units to
1149 Medicaid recipients may be restricted by the agency. Nothing in
1150 this section shall be construed to prevent or limit the agency
1151 from adjusting fees, reimbursement rates, lengths of stay,
1152 number of visits, number of services, or any other adjustments
1153 necessary to comply with the availability of moneys and any
1154 limitations or directions provided for in the General
1155 Appropriations Act or chapter 216.
1156 (6) HOSPITAL OUTPATIENT SERVICES.—
1157 (b) The agency shall implement a prospective payment
1158 methodology for establishing reimbursement rates for outpatient
1159 hospital services. Rates shall be calculated annually and take
1160 effect July 1, 2018 ~~2017~~, and July 1 of each year thereafter.

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

1161 The methodology shall categorize the amount and type of services
1162 used in various ambulatory visits which group together
1163 procedures and medical visits that share similar characteristics
1164 and resource utilization.
1165 1. Adjustments may not be made to the rates after July 31
1166 of the state fiscal year in which the rates take effect.
1167 2. Errors in source data or calculations discovered after
1168 July 31 of each state fiscal year must be reconciled in a
1169 subsequent rate period. However, the agency may not make any
1170 adjustment to a hospital's reimbursement more than 5 years after
1171 a hospital is notified of an audited rate established by the
1172 agency. The prohibition against adjustments more than 5 years
1173 after notification is remedial and applies to actions by
1174 providers involving Medicaid claims for hospital services.
1175 Hospital reimbursement is subject to such limits or ceilings as
1176 may be established in law or described in the agency's hospital
1177 reimbursement plan. Specific exemptions to the limits or
1178 ceilings may be provided in the General Appropriations Act.
1179 Section 20. Section 29 of chapter 2016-65, Laws of Florida,
1180 is amended to read:
1181 Section 29. Subject to federal approval of the application
1182 to be a site for the Program of All-inclusive Care for the
1183 Elderly (PACE), the Agency for Health Care Administration shall
1184 contract with one private, not-for-profit hospice organization
1185 located in Lake County which operates health care organizations
1186 licensed in Hospice Areas 7B and 3E and which provides
1187 comprehensive services, including hospice and palliative care,
1188 to frail elders who reside in these service areas. The
1189 organization is exempt from the requirements of chapter 641,

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

1190 Florida Statutes. The agency, in consultation with the
1191 Department of Elderly Affairs and subject to the appropriation
1192 of funds by the Legislature, shall approve up to 150 initial
1193 enrollees in the Program of All-inclusive Care for the Elderly
1194 established by the organization to serve frail elders who reside
1195 in Hospice Service Areas 7B and 3E. The agency, in consultation
1196 with the department and subject to an appropriation, shall
1197 approve up to 150 enrollees in the Program of All-inclusive Care
1198 for the Elderly established by this organization to serve frail
1199 elders who reside in Hospice Service Area 7C.
1200 Section 21. Subject to federal approval of the application
1201 to be a site for the Program of All-inclusive Care for the
1202 Elderly (PACE), the Agency for Health Care Administration shall
1203 contract with one not-for-profit organization that satisfies
1204 each of the following conditions:
1205 (1) The organization is exempt from federal income taxation
1206 as an entity described in s. 501(c)(3) of the Internal Revenue
1207 Code of 1986, as amended;
1208 (2) The organization is licensed pursuant to part IV of
1209 chapter 400, Florida Statutes, to provide hospice services in
1210 the Agency for Health Care Administration Areas 3 and 4 and
1211 operates inpatient hospice care centers in each of the following
1212 counties within those regions: Alachua, Citrus, Clay, Columbia,
1213 and Putnam;
1214 (3) The organization has more than 30 years of experience
1215 as a licensed hospice provider in this state; and
1216 (4) The organization is affiliated, through common
1217 ownership or control, with other not-for-profit organizations
1218 licensed by the agency to provide home health services, to

1219 operate a nursing home, and to operate an assisted living
1220 facility.
1221
1222 The approved not-for-profit organization shall provide PACE
1223 services to frail and elderly persons who reside in Alachua
1224 County. The organization is exempt from the requirements of
1225 chapter 641, Florida Statutes. The agency, in consultation with
1226 the Department of Elder Affairs and subject to an appropriation,
1227 shall approve up to 150 initial enrollees in the PACE site
1228 established by this organization to serve frail and elderly
1229 persons who reside in Alachua County.
1230 Section 22. Subject to federal approval of the application
1231 to be a site for the Program of All-inclusive Care for the
1232 Elderly (PACE), the Agency for Health Care Administration shall
1233 contract with an organization located in Miami-Dade County that
1234 owns and operates primary care medical centers in South Florida.
1235 The organization shall leverage its existing community-based
1236 care providers to provide PACE services to frail elders who
1237 reside in Broward, Miami-Dade, and Palm Beach Counties. The
1238 organization is exempt from the requirements of chapter 641,
1239 Florida Statutes. The agency, in consultation with the
1240 Department of Elderly Affairs and subject to an appropriation of
1241 funds by the Legislature, shall approve up to 300 initial
1242 enrollees in the PACE site established by the organization for
1243 frail elders who reside in Broward, Miami-Dade, and Palm Beach
1244 Counties. The agency may seek any necessary waiver or state plan
1245 amendments to implement this section.
1246 Section 23. Except as otherwise expressly provided in this
1247 act and except for this section, which shall take effect upon

576-03477-17 20172514__

1248 becoming a law, this act shall take effect July 1, 2017.

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