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LEGISLATIVE ACTION

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The Conference Committee on SB 2508-A recommended the following:

Senate Conference Committee Amendment (with title amendment)

Delete 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 340 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 Policy Analysis 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 ~~2015~~, 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 ~~2015~~, if the hospital continues to have up to 100 licensed beds and an emergency room.

Section 2. Effective upon this act becoming a law, paragraphs (c) and (d) of subsection (1) of section 409.908, Florida Statutes, are redesignated as paragraphs (d) and (e), respectively, and new paragraphs (c) and (f) are added to that subsection, 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.

(1) Reimbursement to hospitals licensed under part I of chapter 395 must be made prospectively or on the basis of negotiation.

(c) The agency may receive intergovernmental transfers of funds from governmental entities, including, but not limited to, the Department of Health, local governments, and other local political subdivisions, for the advancement of the Medicaid program and for enhancing or supplementing provider reimbursement under this part and part IV. The agency shall seek and maintain a low-income pool in a manner authorized by federal waiver and implemented under spending authority granted in the General Appropriations Act. The low-income pool must be used to support enhanced access to services by offsetting shortfalls in Medicaid reimbursement or paying for otherwise uncompensated care, and the agency shall seek waiver authority to encourage

the donation of intergovernmental transfers and to utilize intergovernmental transfers as the state's share of Medicaid funding within the low-income pool.

(f)1. Pursuant to chapter 120, the agency shall furnish to providers written notice of the audited hospital cost-based per diem reimbursement rate for inpatient and outpatient care established by the agency. The written notice constitutes final agency action. A substantially affected provider seeking to correct or adjust the calculation of the audited hospital cost-based per diem reimbursement rate for inpatient and outpatient care, other than a challenge to the methodologies set forth in the rules of the agency and in reimbursement plans incorporated by reference therein used to calculate the reimbursement rate for inpatient and outpatient care, may request an administrative hearing to challenge the final agency action by filing a petition with the agency within 180 days after receipt of the written notice by the provider. The petition must include all documentation supporting the challenge upon which the provider intends to rely at the administrative hearing and may not be amended or supplemented except as authorized under uniform rules adopted pursuant to s. 120.54(5). The failure to timely file a petition in compliance with this subparagraph is deemed conclusive acceptance of the audited hospital cost-based per diem reimbursement rate for inpatient and outpatient care established by the agency.

2. Any challenge to the methodologies set forth in the rules of the agency and in reimbursement plans incorporated by reference therein used to calculate the reimbursement rate for inpatient and outpatient care may not result in a correction or

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an adjustment of a reimbursement rate for a rate period that occurred more than 5 years before the date the petition initiating the proceeding was filed.

3. This paragraph applies to any challenge to final agency action which seeks the correction or adjustment of a provider's audited hospital cost-based per diem reimbursement rate for inpatient and outpatient care and to any challenge to the methodologies set forth in the rules of the agency and in reimbursement plans incorporated by reference therein used to calculate the reimbursement rate for inpatient and outpatient care, including any right to challenge which arose before July 1, 2015. A correction or adjustment of an audited hospital cost-based per diem reimbursement rate for inpatient and outpatient care which is required by an administrative order or appellate decision:

a. Must be reconciled in the first rate period after the order or decision becomes final;

b. May not be the basis for any challenge to correct or adjust hospital rates required to be paid by any Medicaid managed care provider pursuant to part IV of chapter 409.

4. The agency may not be compelled by an administrative body or a court to pay additional compensation to a hospital relating to the establishment of audited hospital cost-based per diem reimbursement rates by the agency or for remedies relating to such rates, unless an appropriation has been made by law for the exclusive, specific purpose of paying such additional compensation. As used in this subparagraph, the term "appropriation made by law" has the same meaning as provided in s. 11.066.

5. Any period of time specified in this paragraph is not tolled by the pendency of any administrative or appellate proceeding.

6. The exclusive means to challenge a written notice of an audited hospital cost-based per diem reimbursement rate for inpatient and outpatient care for the purpose of correcting or adjusting such rate before, on, or after July 1, 2015, or to challenge the methodologies set forth in the rules of the agency and in reimbursement plans incorporated by reference therein used to calculate the reimbursement rate for inpatient and outpatient care is through an administrative proceeding pursuant to chapter 120.

Section 3. For the purpose of incorporating paragraph (f) of subsection (1) of section 409.908, Florida Statutes, as created by this act, in a reference thereto, section 383.18, Florida Statutes, is reenacted to read:

383.18 Contracts; conditions.—Participation in the regional perinatal intensive care centers program under ss. 383.15-383.19 is contingent upon the department entering into a contract with a provider. The contract shall provide that patients will receive services from the center and that parents or guardians of patients who participate in the program and who are in compliance with Medicaid eligibility requirements as determined by the department are not additionally charged for treatment and care which has been contracted for by the department. Financial eligibility for the program is based on the Medicaid income guidelines for pregnant women and for children under 1 year of age. Funding shall be provided in accordance with ss. 383.19 and 409.908.

Section 4. For the purpose of incorporating paragraph (f) of subsection (1) of section 409.908, Florida Statutes, as created by this act, in a reference thereto, subsection (4) of section 409.8132, Florida Statutes, is reenacted to read:

409.8132 Medikids program component.—

(4) APPLICABILITY OF LAWS RELATING TO MEDICAID.—The provisions of ss. 409.902, 409.905, 409.906, 409.907, 409.908, 409.912, 409.9121, 409.9122, 409.9123, 409.9124, 409.9127, 409.9128, 409.913, 409.916, 409.919, 409.920, and 409.9205 apply to the administration of the Medikids program component of the Florida Kidcare program, except that s. 409.9122 applies to Medikids as modified by the provisions of subsection (7).

Section 5. For the purpose of incorporating paragraph (f) of subsection (1) of section 409.908, Florida Statutes, as created by this act, in references thereto, paragraph (c) of subsection (5) and paragraph (b) of subsection (6) of section 409.905, Florida Statutes, are reenacted to read:

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

necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216.

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

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

unless specifically exempt pursuant to s. 409.908(1).

1. Adjustments may not be made to the rates after October 31 of the state fiscal year in which the rates take effect, except for cases of insufficient collections of intergovernmental transfers authorized under s. 409.908(1) or the General Appropriations Act. In such cases, the agency shall submit a budget amendment or amendments under chapter 216 requesting approval of rate reductions by amounts necessary for the aggregate reduction to equal the dollar amount of intergovernmental transfers not collected and the corresponding federal match. Notwithstanding the $1 million limitation on increases to an approved operating budget contained in ss. 216.181(11) and 216.292(3), a budget amendment exceeding that dollar amount is subject to notice and objection procedures set forth in s. 216.177.

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

(6) HOSPITAL OUTPATIENT SERVICES.—

(b) The agency shall implement a methodology for

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establishing base reimbursement rates for outpatient services for each hospital based on allowable costs, as defined by the agency. Rates shall be calculated annually and take effect July 1 of each year based on the most recent complete and accurate cost report submitted by each hospital.

1. Adjustments may not be made to the rates after October 31 of the state fiscal year in which the rates take effect, except for cases of insufficient collections of intergovernmental transfers authorized under s. 409.908(1) or the General Appropriations Act. In such cases, the agency shall submit a budget amendment or amendments under chapter 216 requesting approval of rate reductions by amounts necessary for the aggregate reduction to equal the dollar amount of intergovernmental transfers not collected and the corresponding federal match. Notwithstanding the $1 million limitation on increases to an approved operating budget under ss. 216.181(11) and 216.292(3), a budget amendment exceeding that dollar amount is subject to notice and objection procedures set forth in s. 216.177.

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

exemptions to the limits or ceilings may be provided in the General Appropriations Act.

Section 6. Paragraph (c) of subsection (23) of section 409.908, Florida Statutes, is amended to read:

409.908 Reimbursement of Medicaid providers.—Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. If a provider is reimbursed based on cost reporting and submits a cost report late and that cost report would have been used to set a lower reimbursement rate for a rate semester, then the provider's rate for that semester shall be retroactively calculated using the new cost report, and full payment at the recalculated rate shall be effected retroactively. Medicare-granted extensions for filing cost reports, if applicable, shall also apply to Medicaid cost reports. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the

availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(23)

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

1. Inpatient hospitals.

2. Outpatient hospitals.

3. Nursing homes.

4. County health departments.

~~5. Community intermediate care facilities for the developmentally disabled.~~

5.~~6.~~ Prepaid health plans.

Section 7. Subsection (2) of section 409.9082, Florida Statutes, is amended to read:

409.9082 Quality assessment on nursing home facility providers; exemptions; purpose; federal approval required; remedies.—

(2) A quality assessment is imposed upon each nursing home facility. The aggregated amount of assessments for all nursing home facilities in a given year shall be an amount not exceeding the maximum percentage allowed under federal law of the total aggregate net patient service revenue of assessed facilities. The agency shall calculate the quality assessment rate annually on a per-resident-day basis, exclusive of those resident days funded by the Medicare program, as reported by the facilities. The per-resident-day assessment rate must be uniform except as prescribed in subsection (3). Each facility shall report monthly to the agency its total number of resident days, exclusive of

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Medicare Part A resident days, and remit an amount equal to the assessment rate times the reported number of days. The agency shall collect, and each facility shall pay, the quality assessment each month. The agency shall collect the assessment from nursing home facility providers by the 20th ~~15th~~ day of the next succeeding calendar month. The agency shall notify providers of the quality assessment and provide a standardized form to complete and submit with payments. The collection of the nursing home facility quality assessment shall commence no sooner than 5 days after the agency's initial payment of the Medicaid rates containing the elements prescribed in subsection (4). Nursing home facilities may not create a separate line-item charge for the purpose of passing the assessment through to residents.

Section 8. Section 409.909, Florida Statutes, is amended to read:

409.909 Statewide Medicaid Residency Program.—

(1) The Statewide Medicaid Residency Program is established to improve the quality of care and access to care for Medicaid recipients, expand graduate medical education on an equitable basis, and increase the supply of highly trained physicians statewide. The agency shall make payments to hospitals licensed under part I of chapter 395 for graduate medical education associated with the Medicaid program. This system of payments is designed to generate federal matching funds under Medicaid and distribute the resulting funds to participating hospitals on a quarterly basis in each fiscal year for which an appropriation is made.

(2) On or before September 15 of each year, the agency

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

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

1. Family medicine;
2. General internal medicine;
3. General pediatrics;
4. Preventive medicine;
5. Geriatric medicine;

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6. Osteopathic general practice;

7. Obstetrics and gynecology; ~~and~~

8. Emergency medicine; and

9. General surgery.

(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, including applicable intergovernmental transfers, specified in the General Appropriations Act, as determined by the agency.

(c) "Resident" means a medical intern, fellow, or resident enrolled in a program accredited by the Accreditation Council for Graduate Medical Education, the American Association of Colleges of Osteopathic Medicine, or the American Osteopathic Association at the beginning of the state fiscal year during which the allocation fraction is calculated, as reported by the hospital to the agency.

(3) The agency shall use the following formula to calculate a participating hospital's allocation fraction:

$$HAF=[0.9 \times (HFTE/TFTE)] + [0.1 \times (HMP/TMP)]$$

Where:

HAF=A hospital's allocation fraction.

HFTE=A hospital's total number of FTE residents.

TFTE=The total FTE residents for all participating hospitals.

HMP=A hospital's Medicaid payments.


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TMP=The total Medicaid payments for all participating hospitals.

(4) A hospital's annual allocation shall be calculated by multiplying the funds appropriated for the Statewide Medicaid Residency Program in the General Appropriations Act by that hospital's allocation fraction. If the calculation results in an annual allocation that exceeds two times the average ~~$50,000~~ per FTE resident amount for all hospitals, the hospital's annual allocation shall be reduced to a sum equaling no more than two times the average ~~$50,000~~ per FTE resident. The funds calculated for that hospital in excess of two times the average ~~$50,000~~ per FTE resident amount for all hospitals shall be redistributed to participating hospitals whose annual allocation does not exceed two times the average ~~$50,000~~ per FTE resident amount for all hospitals, using the same methodology and payment schedule specified in this section.

(5) The Graduate Medical Education Startup Bonus Program is established to provide resources for the education and training of physicians in specialties which are in a statewide supply-and-demand deficit. Hospitals eligible for participation in subsection (1) are eligible to participate in the Graduate Medical Education Startup Bonus Program established under this subsection. Notwithstanding subsection (4) or an FTE's residency period, and in any state fiscal year in which funds are appropriated for the startup bonus program, the agency shall allocate a $100,000 startup bonus for each newly created resident position that is authorized by the Accreditation Council for Graduate Medical Education or Osteopathic

Postdoctoral Training Institution in an initial or established accredited training program that is in a physician specialty in statewide supply-and-demand deficit. In any year in which funding is not sufficient to provide $100,000 for each newly created resident position, funding shall be reduced pro rata across all newly created resident positions in physician specialties in statewide supply-and-demand deficit.

(a) Hospitals applying for a startup bonus must submit to the agency by March 1 their Accreditation Council for Graduate Medical Education or Osteopathic Postdoctoral Training Institution approval validating the new resident positions approved in physician specialties in statewide supply-and-demand deficit in the current fiscal year. An applicant hospital may validate a change in the number of residents by comparing the number in the prior period Accreditation Council for Graduate Medical Education or Osteopathic Postdoctoral Training Institution approval to the number in the current year.

(b) Any unobligated startup bonus funds on April 15 of each fiscal year shall be proportionally allocated to hospitals participating under subsection (3) for existing FTE residents in the physician specialties in statewide supply-and-demand deficit. This nonrecurring allocation shall be in addition to the funds allocated in subsection (4). Notwithstanding subsection (4), the allocation under this subsection may not exceed $100,000 per FTE resident.

(c) For purposes of this subsection, physician specialties and subspecialties, both adult and pediatric, in statewide supply-and-demand deficit are those identified in the General Appropriations Act.


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(d) The agency shall distribute all funds authorized under the Graduate Medical Education Startup Bonus Program on or before the final business day of the fourth quarter of a state fiscal year.

(6) ~~(5)~~ Beginning in the 2015-2016 state fiscal year, the agency shall reconcile each participating hospital's total number of FTE residents calculated for the state fiscal year 2 years before ~~prior~~ with its most recently available Medicare cost reports covering the same time period. Reconciled FTE counts shall be prorated according to the portion of the state fiscal year covered by a Medicare cost report. Using the same definitions, methodology, and payment schedule specified in this section, the reconciliation shall apply any differences in annual allocations calculated under subsection (4) to the current year's annual allocations.

(7) ~~(6)~~ The agency may adopt rules to administer this section.

Section 9. Paragraph (a) of subsection (2) and paragraph (d) of subsection (4) of section 409.911, Florida Statutes, are 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


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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 ~~2005, 2006, and~~ 2007, 2008, and 2009 audited disproportionate share data to determine each hospital's Medicaid days and charity care for the 2015-2016 ~~2014-2015~~ state fiscal year.

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

(d) Any nonstate government owned or operated hospital eligible for payments under this section on July 1, 2011, remains eligible for payments during the 2015-2016 ~~2014-2015~~ state fiscal year.

Section 10. Paragraph (f) of subsection (3) and paragraph (c) of subsection (4) of section 409.967, Florida Statutes, are amended to read:

409.967 Managed care plan accountability.—

(3) ACHIEVED SAVINGS REBATE.—

(f) Achieved savings rebates validated by the certified public accountant are due within 30 days after the report is submitted. Except as provided in paragraph (h), the achieved savings rebate is established by determining pretax income as a percentage of revenues and applying the following income sharing ratios:

1. One hundred percent of income up to and including 5 percent of revenue shall be retained by the plan.

2. Fifty percent of income above 5 percent and up to 10

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percent shall be retained by the plan, and the other 50 percent refunded to the state and transferred to the General Revenue Fund, unallocated.

3. One hundred percent of income above 10 percent of revenue shall be refunded to the state and transferred to the General Revenue Fund, unallocated.

(4) MEDICAL LOSS RATIO.—If required as a condition of a waiver, the agency may calculate a medical loss ratio for managed care plans. The calculation shall use uniform financial data collected from all plans and shall be computed for each plan on a statewide basis. The method for calculating the medical loss ratio shall meet the following criteria:

(c) Before ~~Prior to~~ final determination of the medical loss ratio for any period, a plan may contribute to a designated state trust fund for the purpose of supporting Medicaid and indigent care and have the contribution counted as a medical expenditure for the period. Funds contributed for this purpose shall be deposited into the Grants and Donations Trust Fund.

Section 11. Section 409.97, Florida Statutes, is repealed.

Section 12. Paragraph (a) of subsection (4) of section 409.975, Florida Statutes, is amended to read:

409.975 Managed care plan accountability.—In addition to the requirements of s. 409.967, plans and providers participating in the managed medical assistance program shall comply with the requirements of this section.

(4) MOMCARE NETWORK.—

(a) The agency shall contract with an administrative services organization representing all Healthy Start Coalitions providing risk appropriate care coordination and other services

in accordance with a federal waiver and pursuant to s. 409.906. The contract shall require the network of coalitions to provide counseling, education, risk-reduction and case management services, and quality assurance for all enrollees of the waiver. The agency shall evaluate the impact of the MomCare network by monitoring each plan's performance on specific measures to determine the adequacy, timeliness, and quality of services for pregnant women and infants. ~~The agency shall support this contract with certified public expenditures of general revenue appropriated for Healthy Start services and any earned federal matching funds.~~

Section 13. Subsection (6) of section 409.983, Florida Statutes, is amended to read:

409.983 Long-term care managed care plan payment.—In addition to the payment provisions of s. 409.968, the agency shall provide payment to plans in the long-term care managed care program pursuant to this section.

(6) The agency shall establish nursing-facility-specific payment rates for each licensed nursing home based on facility costs adjusted for inflation and other factors as authorized in the General Appropriations Act. Payments to long-term care managed care plans shall be reconciled to reimburse actual payments to nursing facilities <u>resulting from changes in nursing home per diem rates, but may not be reconciled to actual days experienced by the long-term care managed care plans</u>.

Section 14. <u>Effective upon this act becoming a law, the Agency for Health Care Administration may partner with any other state or territory for the purposes of providing Medicaid fiscal agent operations only if any resulting agreement or contract</u>

provides for termination when the State of Florida decides it is not in the best interest of the state. Any such agreement or contract may not impact Florida's current Medicaid Management Information System and each state or territory shall deal directly with the federal Centers for Medicare and Medicaid Services independently regarding any billing or matching requirements.

Section 15. Subsection (43) of section 408.07, Florida Statutes, is amended to read:

408.07 Definitions.—As used in this chapter, with the exception of ss. 408.031-408.045, the term:

(43) "Rural hospital" means an acute care hospital licensed under chapter 395, having 100 or fewer licensed beds and an emergency room, and which is:

(a) The sole provider within a county with a population density of no greater than 100 persons per square mile;

(b) An acute care hospital, in a county with a population density of no greater than 100 persons per square mile, which is at least 30 minutes of travel time, on normally traveled roads under normal traffic conditions, from another acute care hospital within the same county;

(c) A hospital supported by a tax district or subdistrict whose boundaries encompass a population of 100 persons or fewer per square mile;

(d) A hospital with a service area that has a population of 100 persons or fewer per square mile. As used in this paragraph, 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


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the hospital inpatient discharge database in the Florida Center for Health Information and Policy Analysis at the Agency for Health Care Administration; or

(e) A critical access hospital.

Population densities used in this subsection 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, 2015, if the hospital continues to have 100 or fewer licensed beds and an emergency room~~, or meets the criteria of s. 395.602(2)(e)4~~. An acute care hospital that has not previously been designated as a rural hospital and that meets the criteria of this subsection shall be granted such designation upon application, including supporting documentation, to the Agency for Health Care Administration.

Section 16. The model, methodology, and framework for hospital funding programs contained in the document titled "Medicaid Hospital Funding Programs," dated June 16, 2015, and filed with the Secretary of the Senate, are incorporated by reference for the purpose of displaying, demonstrating, and explaining the calculations used by the Legislature, consistent with the requirements of state law, when making appropriations in the General Appropriations Act for the 2015-2016 fiscal year for the Rural Hospital Financial Assistance Program, Hospital Inpatient Services, Hospital Outpatient Services, Low-Income Pool, the Disproportionate Share Hospital Program, Graduate Medical Education, and Prepaid Health Plans. The document titled


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"Medicaid Hospital Funding Programs" does not allocate or appropriate any funds. The Agency for Health Care Administration shall rely solely on the model, methodology, and framework displayed, demonstrated, and explained in the document titled "Medicaid Hospital Funding Programs" and the proviso applicable to appropriations for Medicaid funding when setting hospital rates, calculating the hospital components of prepaid health plan capitation rates, and making payments to hospitals and other providers. This section expires July 1, 2016.

Section 17. The Legislature has determined that this act, including the document titled "Medicaid Hospital Funding Programs," together with the specific appropriations contained in the fiscal year 2015-2016 General Appropriations Act for the Rural Hospital Financial Assistance Program, Hospital Inpatient Services, Hospital Outpatient Services, Low-Income Pool, the Disproportionate Share Hospital Program, Graduate Medical Education, and Prepaid Health Plans, are interdependent and interrelated, are directly and rationally related to the overall purposes of the state's Medicaid program, and are advisable only if considered together and balanced when allocating the state's resources, especially considering the complexities of Florida's Statewide Medicaid Managed Care program; how hospital rates are determined in the marketplace, including Medicaid; how the individual component Medicaid appropriations impact the rates Florida's Medicaid managed care entities pay for services; and the large amounts of uncompensated care provided by Florida's Medicaid hospital service providers and the relative potential impact of that uncompensated care on the overall economic viability of those institutions. If this act, or any portion of

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this act, including the document titled "Medicaid Hospital Funding Programs," or any portion thereof, is determined to be unconstitutional or the applicability thereof to any person or circumstance is held invalid, then: (1) such determination shall render all other provisions or applications of this act invalid; (2) the provisions of this act are not severable; and (3) this entire act shall be deemed never to have become law. This section expires July 1, 2016.

Section 18. Section 409.908(1)(f), Florida Statutes, as created by this act, is remedial in nature, confirms and clarifies existing law, and applies to all proceedings pending on or commenced after this act takes effect.

Section 19. If any law amended by this act was also amended by a law enacted during the 2015 Regular Session of the Legislature, such laws shall be construed as if enacted during the same session of the Legislature, and full effect shall be given to each if possible.

Section 20. Except as otherwise expressly provided in this act and except for this section, which shall take effect upon this act becoming a law, this act shall take effect July 1, 2015, or, if this act fails to become a law until after that date, it shall take effect upon becoming a law and operate retroactively to July 1, 2015.

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

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

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An act relating to Medicaid; amending s. 395.602, F.S.; revising the term "rural hospital"; amending s. 409.908, F.S.; authorizing the Agency for Health Care Administration to receive intergovernmental transfers of funds from governmental entities for specified purposes; requiring the agency to seek and maintain a low-income pool under certain parameters; requiring the agency to seek Medicaid waiver authority for the use of local intergovernmental transfers under certain parameters; requiring the Agency for Health Care Administration to provide written notice, pursuant to ch. 120, F.S., of reimbursement rates to providers; specifying procedures and requirements to challenge the calculation of or the methodology used to calculate such rates; providing that the failure to timely file a certain challenge constitutes acceptance of the rates; specifying limits on and procedures for the correction or adjustment of the rates; providing applicability; prohibiting the agency from being compelled by an administrative body or a court to pay additional compensation that exceeds a certain amount to a hospital for specified matters unless an appropriation is made by law; prohibiting certain periods of time from being tolled under specified circumstances; specifying that an administrative proceeding is the exclusive means for challenging certain issues; reenacting ss. 383.18, 409.8132(4), and 409.905(5)(c) and (6)(b), F.S., relating to contracts for the regional perinatal intensive care


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centers program, the Medikids program component, and mandatory Medicaid services, respectively, to incorporate the amendment made to s. 409.908, F.S., in references thereto; amending s. 409.908, F.S.; revising the list of provider types that are subject to certain statutory provisions relating to the establishment of rates; amending s. 409.9082, F.S.; revising the date in each calendar month on which the agency shall collect an assessment from nursing home facility providers; amending s. 409.909, F.S.; revising a term; revising the annual allocation cap for hospitals participating in the Statewide Medicaid Residency Program; establishing the Graduate Medical Education Startup Bonus Program; providing allocations for the program; amending s. 409.911, F.S.; updating references to data used for calculating disproportionate share program payments to certain hospitals for the 2015-2016 fiscal year; amending s. 409.967, F.S.; requiring that certain achieved savings rebates be placed in the General Revenue Fund, unallocated; requiring that certain funds to support Medicaid and indigent care be deposited into the Grants and Donations Trust Fund; repealing s. 409.97, F.S, relating to state and local Medicaid partnerships; amending s. 409.975, F.S.; deleting a requirement that the agency support Healthy Start services with public expenditures and federal matching funds; amending s. 409.983, F.S.; providing parameters for the reconciliation of managed care plan payments

in the long-term care managed care program; authorizing the agency to partner with other states or territories to provide Medicaid fiscal agent operations under certain conditions and limitations; amending s. 408.07, F.S.; conforming a cross-reference; providing an incorporation by reference, the purposes and legislative intent of the incorporation, and for the expiration of the section; providing a legislative determination of the interdependence and interrelatedness of the act, the incorporation by reference and certain specific appropriations; providing that, if the act or any portion of the act is determined to be unconstitutional or held invalid, then all other provisions or applications of the act are invalid and not severable; providing for the expiration of the section; providing that the act is remedial, intended to confirm and clarify law, and applies to proceedings pending on or commenced after the effective date; providing for construction of the act in pari materia with laws enacted during the 2015 Regular Session of the Legislature; providing for contingent retroactive operation; providing effective dates.