CHAMBER ACTION

Senate		House
	.	

1 The Conference Committee on HB 5101 offered the following:
2
3 **Conference Committee Amendment (with title amendment)**
4 Remove everything after the enacting clause and insert:
5 Section 1. Effective upon this act becoming a law,
6 paragraphs (k) and (l) of subsection (4) of section 322.142,
7 Florida Statutes, are amended, and paragraph (m) is added to
8 that section, to read:
9 322.142 Color photographic or digital imaged licenses.—
10 (4) The department may maintain a film negative or print
11 file. The department shall maintain a record of the digital
12 image and signature of the licensees, together with other data
13 required by the department for identification and retrieval.
14 Reproductions from the file or digital record are exempt from

15 the provisions of s. 119.07(1) and may be made and issued only:
16 (k) To district medical examiners pursuant to an
17 interagency agreement for the purpose of identifying a deceased
18 individual, determining cause of death, and notifying next of
19 kin of any investigations, including autopsies and other
20 laboratory examinations, authorized in s. 406.11; ~~or~~
21 (l) To the following persons for the purpose of
22 identifying a person as part of the official work of a court:
23 1. A justice or judge of this state;
24 2. An employee of the state courts system who works in a
25 position that is designated in writing for access by the Chief
26 Justice of the Supreme Court or a chief judge of a district or
27 circuit court, or by his or her designee; or
28 3. A government employee who performs functions on behalf
29 of the state courts system in a position that is designated in
30 writing for access by the Chief Justice or a chief judge, or by
31 his or her designee; or
32 (m) To the Agency for Health Care Administration pursuant
33 to an interagency agreement to prevent health care fraud. If the
34 Agency for Health Care Administration enters into an agreement
35 with a private entity to carry out duties relating to health
36 care fraud prevention, such contracts shall include, but need
37 not be limited to:
38 1. Provisions requiring internal controls and audit
39 processes to identify access, use, and unauthorized access of
40 information.

41 2. A requirement to report unauthorized access or use to
42 the Agency for Health Care Administration within 1 business day
43 after the discovery of the unauthorized access or use.
44 3. Provisions for liquidated damages for unauthorized
45 access or use of no less than $5,000 per occurrence.
46 Section 2. Subsection (5) of section 409.9128, Florida
47 Statutes, is amended to read:
48 409.9128 Requirements for providing emergency services and
49 care.—
50 (5) Reimbursement for services provided to an enrollee of
51 a managed care plan under this section by a provider who does
52 not have a contract with the managed care plan shall be the
53 lesser of:
54 (a) The provider's charges;
55 (b) The usual and customary provider charges for similar
56 services in the community where the services were provided;
57 (c) The charge mutually agreed to by the entity and the
58 provider within 60 days after submittal of the claim; or
59 (d) The Medicaid rate, as provided in s. 409.967(2)(b).
60 Section 3. Paragraph (e) of subsection (2) of section
61 395.602, Florida Statutes, is amended to read:
62 395.602 Rural hospitals.—
63 (2) DEFINITIONS.—As used in this part, the term:
64 (e) "Rural hospital" means an acute care hospital licensed
65 under this chapter, having 100 or fewer licensed beds and an
66 emergency room, which is:

67 1. The sole provider within a county with a population
68 density of up to 100 persons per square mile;
69 2. An acute care hospital, in a county with a population
70 density of up to 100 persons per square mile, which is at least
71 30 minutes of travel time, on normally traveled roads under
72 normal traffic conditions, from any other acute care hospital
73 within the same county;
74 3. A hospital supported by a tax district or subdistrict
75 whose boundaries encompass a population of up to 100 persons per
76 square mile;
77 4. A hospital classified as a sole community hospital
78 under 42 C.F.R. s. 412.92 which has up to 175 licensed beds;
79 5.~~4.~~ A hospital with a service area that has a population
80 of up to 100 persons per square mile. As used in this
81 subparagraph, the term "service area" means the fewest number of
82 zip codes that account for 75 percent of the hospital's
83 discharges for the most recent 5-year period, based on
84 information available from the hospital inpatient discharge
85 database in the Florida Center for Health Information and Policy
86 Analysis at the agency; or
87 6.~~5.~~ A hospital designated as a critical access hospital,
88 as defined in s. 408.07.
89
90 Population densities used in this paragraph must be based upon
91 the most recently completed United States census. A hospital
92 that received funds under s. 409.9116 for a quarter beginning no

93 later than July 1, 2002, is deemed to have been and shall
94 continue to be a rural hospital from that date through June 30,
95 2021, if the hospital continues to have up to 100 licensed beds
96 and an emergency room. An acute care hospital that has not
97 previously been designated as a rural hospital and that meets
98 the criteria of this paragraph shall be granted such designation
99 upon application, including supporting documentation, to the
100 agency. A hospital that was licensed as a rural hospital during
101 the 2010-2011 or 2011-2012 fiscal year shall continue to be a
102 rural hospital from the date of designation through June 30,
103 2021, if the hospital continues to have up to 100 licensed beds
104 and an emergency room.
105 Section 4. Section 409.285, Florida Statutes, is amended
106 to read:
107 409.285 Opportunity for hearing and appeal.—
108 (1) If an application for public assistance is not acted
109 upon within a reasonable time after the filing of the
110 application, or is denied in whole or in part, or if an
111 assistance payment is modified or canceled, the applicant or
112 recipient may appeal the decision to the Department of Children
113 and Families in the manner and form prescribed by the
114 department.
115 (a)~~(2)~~ The hearing authority may be the Secretary of
116 Children and Families, a panel of department officials, or a
117 hearing officer appointed for that purpose. The hearing
118 authority is responsible for a final administrative decision in

119 the name of the department on all issues that have been the
120 subject of a hearing. With regard to the department, the
121 decision of the hearing authority is final and binding. The
122 department is responsible for seeing that the decision is
123 carried out promptly.
124 (b) ~~(3)~~ The department may adopt rules to administer this
125 subsection ~~section~~. Rules for the Temporary Assistance for Needy
126 Families block grant programs must be similar to the federal
127 requirements for Medicaid programs.
128 (2) Appeals related to Medicaid programs directly
129 administered by the Agency for Health Care Administration,
130 including appeals related to Florida's Statewide Medicaid
131 Managed Care program and associated federal waivers, filed on or
132 after March 1, 2017, must be directed to the agency in the
133 manner and form prescribed by the agency. The department and the
134 agency shall establish a transition process to transfer
135 administration of these appeals from the department to the
136 agency by March 1, 2017.
137 (a) The hearing authority for appeals heard by the Agency
138 for Health Care Administration may be the Secretary of Health
139 Care Administration, a panel of agency officials, or a hearing
140 officer appointed for that purpose. The hearing authority is
141 responsible for a final administrative decision in the name of
142 the agency on all issues that have been the subject of a
143 hearing. A decision of the hearing authority is final and
144 binding on the agency. The agency is responsible for ensuring

145 that the decision is promptly carried out.
146 (b) Notwithstanding ss. 120.569 and 120.57, hearings
147 conducted by the Agency for Health Care Administration pursuant
148 to this subsection are subject to federal regulations and
149 requirements relating to Medicaid appeals, are exempt from the
150 uniform rules of procedure under s. 120.54(5), and are not
151 required to be conducted by an administrative law judge assigned
152 by the Division of Administrative Hearings.
153 (c) The Agency for Health Care Administration shall seek
154 federal approval necessary to implement this subsection and may
155 adopt rules necessary to administer this subsection. Before such
156 rules are adopted, the agency shall follow the rules applicable
157 to the Medicaid hearings pursuant to s. 409.285(1).
158 (3) Appeals related to Medicaid programs administered by
159 the Agency for Persons with Disabilities are subject to s.
160 393.125.
161 Section 5. Subsections (17) through (22) of section
162 409.811, Florida Statutes, are renumbered as subsections (18)
163 through (23), respectively, a new subsection (17) is added to
164 that section, and present subsections (23) and (24) of that
165 section are amended, to read:
166 409.811 Definitions relating to Florida Kidcare Act.—As
167 used in ss. 409.810-409.821, the term:
168 (17) "Lawfully residing child" means a child who is
169 lawfully present in the United States, meets Medicaid or
170 Children's Health Insurance Program (CHIP) residency

171 requirements, and may be eligible for medical assistance with
172 federal financial participation as provided under s. 214 of the
173 Children's Health Insurance Program Reauthorization Act of 2009,
174 Pub. L. No. 111-3, and related federal regulations.
175 ~~(23) "Qualified alien" means an alien as defined in s. 431~~
176 ~~of the Personal Responsibility and Work Opportunity~~
177 ~~Reconciliation Act of 1996, as amended, Pub. L. No. 104-193.~~
178 (24) "Resident" means a United States citizen~~,~~ or lawfully
179 residing child ~~qualified alien,~~ who is domiciled in this state.
180 Section 6. Paragraph (c) of subsection (4) of section
181 409.814, Florida Statutes, is amended to read:
182 409.814 Eligibility.—A child who has not reached 19 years
183 of age whose family income is equal to or below 200 percent of
184 the federal poverty level is eligible for the Florida Kidcare
185 program as provided in this section. If an enrolled individual
186 is determined to be ineligible for coverage, he or she must be
187 immediately disenrolled from the respective Florida Kidcare
188 program component.
189 (4) The following children are not eligible to receive
190 Title XXI-funded premium assistance for health benefits coverage
191 under the Florida Kidcare program, except under Medicaid if the
192 child would have been eligible for Medicaid under s. 409.903 or
193 s. 409.904 as of June 1, 1997:
194 (c) A child who is an alien~~,~~ but who does not meet the
195 definition of a lawfully residing child ~~qualified alien, in the~~
196 ~~United States~~. This paragraph does not extend eligibility for

197 the Florida Kidcare program to an undocumented immigrant.
198 Section 7. Subsections (8) and (9) of section 409.904,
199 Florida Statutes, are renumbered as subsections (9) and (10),
200 respectively, and a new subsection (8) is added to that section
201 to read:
202 409.904 Optional payments for eligible persons.—The agency
203 may make payments for medical assistance and related services on
204 behalf of the following persons who are determined to be
205 eligible subject to the income, assets, and categorical
206 eligibility tests set forth in federal and state law. Payment on
207 behalf of these Medicaid eligible persons is subject to the
208 availability of moneys and any limitations established by the
209 General Appropriations Act or chapter 216.
210 (8) A child who has not attained 19 years of age and who,
211 notwithstanding s. 414.095(3), would be eligible for Medicaid
212 under s. 409.903, except that the child is a lawfully residing
213 child as defined in s. 409.811. This subsection does not extend
214 eligibility for optional Medicaid payments or related services
215 to an undocumented immigrant.
216 Section 8. Subsection (5) of section 409.905, Florida
217 Statutes, is amended to read:
218 409.905 Mandatory Medicaid services.—The agency may make
219 payments for the following services, which are required of the
220 state by Title XIX of the Social Security Act, furnished by
221 Medicaid providers to recipients who are determined to be
222 eligible on the dates on which the services were provided. Any

223 service under this section shall be provided only when medically
224 necessary and in accordance with state and federal law.
225 Mandatory services rendered by providers in mobile units to
226 Medicaid recipients may be restricted by the agency. Nothing in
227 this section shall be construed to prevent or limit the agency
228 from adjusting fees, reimbursement rates, lengths of stay,
229 number of visits, number of services, or any other adjustments
230 necessary to comply with the availability of moneys and any
231 limitations or directions provided for in the General
232 Appropriations Act or chapter 216.
233 (5) HOSPITAL INPATIENT SERVICES.—The agency shall pay for
234 all covered services provided for the medical care and treatment
235 of a recipient who is admitted as an inpatient by a licensed
236 physician or dentist to a hospital licensed under part I of
237 chapter 395. However, the agency shall limit the payment for
238 inpatient hospital services for a Medicaid recipient 21 years of
239 age or older to 45 days or the number of days necessary to
240 comply with the General Appropriations Act. ~~Effective August 1,~~
241 ~~2012, the agency shall limit payment for hospital emergency~~
242 ~~department visits for a nonpregnant Medicaid recipient 21 years~~
243 ~~of age or older to six visits per fiscal year.~~
244 (a) The agency may implement reimbursement and utilization
245 management reforms in order to comply with any limitations or
246 directions in the General Appropriations Act, which may include,
247 but are not limited to: prior authorization for inpatient
248 psychiatric days; prior authorization for nonemergency hospital

249 inpatient admissions for individuals 21 years of age and older;
250 authorization of emergency and urgent-care admissions within 24
251 hours after admission; enhanced utilization and concurrent
252 review programs for highly utilized services; reduction or
253 elimination of covered days of service; adjusting reimbursement
254 ceilings for variable costs; adjusting reimbursement ceilings
255 for fixed and property costs; and implementing target rates of
256 increase. The agency may limit prior authorization for hospital
257 inpatient services to selected diagnosis-related groups, based
258 on an analysis of the cost and potential for unnecessary
259 hospitalizations represented by certain diagnoses. Admissions
260 for normal delivery and newborns are exempt from requirements
261 for prior authorization. In implementing the provisions of this
262 section related to prior authorization, the agency shall ensure
263 that the process for authorization is accessible 24 hours per
264 day, 7 days per week and authorization is automatically granted
265 when not denied within 4 hours after the request. Authorization
266 procedures must include steps for review of denials. Upon
267 implementing the prior authorization program for hospital
268 inpatient services, the agency shall discontinue its hospital
269 retrospective review program.
270 (b) A licensed hospital maintained primarily for the care
271 and treatment of patients having mental disorders or mental
272 diseases is not eligible to participate in the hospital
273 inpatient portion of the Medicaid program except as provided in
274 federal law. However, the department shall apply for a waiver,

275 within 9 months after June 5, 1991, designed to provide
276 hospitalization services for mental health reasons to children
277 and adults in the most cost-effective and lowest cost setting
278 possible. Such waiver shall include a request for the
279 opportunity to pay for care in hospitals known under federal law
280 as "institutions for mental disease" or "IMD's." The waiver
281 proposal shall propose no additional aggregate cost to the state
282 or Federal Government, and shall be conducted in Hillsborough
283 County, Highlands County, Hardee County, Manatee County, and
284 Polk County. The waiver proposal may incorporate competitive
285 bidding for hospital services, comprehensive brokering, prepaid
286 capitated arrangements, or other mechanisms deemed by the
287 department to show promise in reducing the cost of acute care
288 and increasing the effectiveness of preventive care. When
289 developing the waiver proposal, the department shall take into
290 account price, quality, accessibility, linkages of the hospital
291 to community services and family support programs, plans of the
292 hospital to ensure the earliest discharge possible, and the
293 comprehensiveness of the mental health and other health care
294 services offered by participating providers.
295 (c) The agency shall implement a prospective payment
296 methodology for establishing reimbursement rates for inpatient
297 hospital services. Rates shall be calculated annually and take
298 effect July 1 of each year. The methodology shall categorize
299 each inpatient admission into a diagnosis-related group and
300 assign a relative payment weight to the base rate according to

301 the average relative amount of hospital resources used to treat
302 a patient in a specific diagnosis-related group category. The
303 agency may adopt the most recent relative weights calculated and
304 made available by the Nationwide Inpatient Sample maintained by
305 the Agency for Healthcare Research and Quality or may adopt
306 alternative weights if the agency finds that Florida-specific
307 weights deviate with statistical significance from national
308 weights for high-volume diagnosis-related groups. The agency
309 shall establish a single, uniform base rate for all hospitals
310 unless specifically exempt pursuant to s. 409.908(1).
311 1. Adjustments may not be made to the rates after October
312 31 of the state fiscal year in which the rates take effect,
313 except for cases of insufficient collections of
314 intergovernmental transfers authorized under s. 409.908(1) or
315 the General Appropriations Act. In such cases, the agency shall
316 submit a budget amendment or amendments under chapter 216
317 requesting approval of rate reductions by amounts necessary for
318 the aggregate reduction to equal the dollar amount of
319 intergovernmental transfers not collected and the corresponding
320 federal match. Notwithstanding the $1 million limitation on
321 increases to an approved operating budget contained in ss.
322 216.181(11) and 216.292(3), a budget amendment exceeding that
323 dollar amount is subject to notice and objection procedures set
324 forth in s. 216.177.
325 2. Errors in source data or calculations discovered after
326 October 31 must be reconciled in a subsequent rate period.

327 However, the agency may not make any adjustment to a hospital's
328 reimbursement more than 5 years after a hospital is notified of
329 an audited rate established by the agency. The prohibition
330 against adjustments more than 5 years after notification is
331 remedial and applies to actions by providers involving Medicaid
332 claims for hospital services. Hospital reimbursement is subject
333 to such limits or ceilings as may be established in law or
334 described in the agency's hospital reimbursement plan. Specific
335 exemptions to the limits or ceilings may be provided in the
336 General Appropriations Act.
337 (d) The agency shall implement a comprehensive utilization
338 management program for hospital neonatal intensive care stays in
339 certain high-volume participating hospitals, select counties, or
340 statewide, and replace existing hospital inpatient utilization
341 management programs for neonatal intensive care admissions. The
342 program shall be designed to manage appropriate admissions and
343 discharges for children being treated in neonatal intensive care
344 units and must seek medically appropriate discharge to the
345 child's home or other less costly treatment setting. The agency
346 may competitively bid a contract for the selection of a
347 qualified organization to provide neonatal intensive care
348 utilization management services. The agency may seek federal
349 waivers to implement this initiative.
350 (e) The agency may develop and implement a program to
351 reduce the number of hospital readmissions among the non-
352 Medicare population eligible in areas 9, 10, and 11.

353 Section 9. Effective July 1, 2017, paragraph (b) of
354 subsection (6) of section 409.905, Florida Statutes, is amended
355 to read:
356 409.905 Mandatory Medicaid services.—The agency may make
357 payments for the following services, which are required of the
358 state by Title XIX of the Social Security Act, furnished by
359 Medicaid providers to recipients who are determined to be
360 eligible on the dates on which the services were provided. Any
361 service under this section shall be provided only when medically
362 necessary and in accordance with state and federal law.
363 Mandatory services rendered by providers in mobile units to
364 Medicaid recipients may be restricted by the agency. Nothing in
365 this section shall be construed to prevent or limit the agency
366 from adjusting fees, reimbursement rates, lengths of stay,
367 number of visits, number of services, or any other adjustments
368 necessary to comply with the availability of moneys and any
369 limitations or directions provided for in the General
370 Appropriations Act or chapter 216.
371 (6) HOSPITAL OUTPATIENT SERVICES.—
372 (b) The agency shall implement a prospective payment
373 methodology for establishing ~~base~~ reimbursement rates for
374 outpatient hospital services ~~for each hospital based on~~
375 ~~allowable costs, as defined by the agency~~. Rates shall be
376 calculated annually and take effect July 1, 2017, and July 1 of
377 each year thereafter. The methodology shall categorize the
378 amount and type of services used in various ambulatory visits

379 which group together procedures and medical visits that share
380 similar characteristics and resource utilization ~~based on the~~
381 ~~most recent complete and accurate cost report submitted by each~~
382 ~~hospital~~.
383 1. Adjustments may not be made to the rates after July 31
384 ~~October 31~~ of the state fiscal year in which the rates take
385 effect~~, except for cases of insufficient collections of~~
386 ~~intergovernmental transfers authorized under s. 409.908(1) or~~
387 ~~the General Appropriations Act. In such cases, the agency shall~~
388 ~~submit a budget amendment or amendments under chapter 216~~
389 ~~requesting approval of rate reductions by amounts necessary for~~
390 ~~the aggregate reduction to equal the dollar amount of~~
391 ~~intergovernmental transfers not collected and the corresponding~~
392 ~~federal match. Notwithstanding the $1 million limitation on~~
393 ~~increases to an approved operating budget under ss. 216.181(11)~~
394 ~~and 216.292(3), a budget amendment exceeding that dollar amount~~
395 ~~is subject to notice and objection procedures set forth in s.~~
396 ~~216.177~~.
397 2. Errors in source data or calculations discovered after
398 July 31 of each state fiscal year ~~October 31~~ must be reconciled
399 in a subsequent rate period. However, the agency may not make
400 any adjustment to a hospital's reimbursement more than 5 years
401 after a hospital is notified of an audited rate established by
402 the agency. The prohibition against adjustments more than 5
403 years after notification is remedial and applies to actions by
404 providers involving Medicaid claims for hospital services.

405 Hospital reimbursement is subject to such limits or ceilings as
406 may be established in law or described in the agency's hospital
407 reimbursement plan. Specific exemptions to the limits or
408 ceilings may be provided in the General Appropriations Act.
409 Section 10. Paragraph (e) is added to subsection (13) of
410 section 409.906, Florida Statutes, to read:
411 409.906 Optional Medicaid services.—Subject to specific
412 appropriations, the agency may make payments for services which
413 are optional to the state under Title XIX of the Social Security
414 Act and are furnished by Medicaid providers to recipients who
415 are determined to be eligible on the dates on which the services
416 were provided. Any optional service that is provided shall be
417 provided only when medically necessary and in accordance with
418 state and federal law. Optional services rendered by providers
419 in mobile units to Medicaid recipients may be restricted or
420 prohibited by the agency. Nothing in this section shall be
421 construed to prevent or limit the agency from adjusting fees,
422 reimbursement rates, lengths of stay, number of visits, or
423 number of services, or making any other adjustments necessary to
424 comply with the availability of moneys and any limitations or
425 directions provided for in the General Appropriations Act or
426 chapter 216. If necessary to safeguard the state's systems of
427 providing services to elderly and disabled persons and subject
428 to the notice and review provisions of s. 216.177, the Governor
429 may direct the Agency for Health Care Administration to amend
430 the Medicaid state plan to delete the optional Medicaid service

431 known as "Intermediate Care Facilities for the Developmentally
432 Disabled." Optional services may include:
433 (13) HOME AND COMMUNITY-BASED SERVICES.—
434 (e) The agency shall seek federal approval to pay for
435 flexible services for persons with severe mental illness or
436 substance use disorders, including, but not limited to,
437 temporary housing assistance. Payments may be made as enhanced
438 capitation rates or incentive payments to managed care plans
439 that meet the requirements of s. 409.968(4).
440 Section 11. Subsection (9) of section 393.063, Florida
441 Statutes, is amended to read:
442 393.063 Definitions.—For the purposes of this chapter, the
443 term:
444 (9) "Developmental disability" means a disorder or
445 syndrome that is attributable to intellectual disability,
446 cerebral palsy, autism, spina bifida, Down syndrome, Phelan-
447 McDermid syndrome, or Prader-Willi syndrome; that manifests
448 before the age of 18; and that constitutes a substantial
449 handicap that can reasonably be expected to continue
450 indefinitely.
451 Section 12. Subsections (25) through (41) of section
452 393.063, Florida Statutes, are renumbered as subsections (26)
453 through (42), respectively, and a new subsection (25) is added
454 to that section to read:
455 393.063 Definitions.—For the purposes of this chapter, the
456 term:

457 (25) "Phelan-McDermid syndrome" means a disorder caused by
458 the loss of the terminal segment of the long arm of chromosome
459 22, which occurs near the end of the chromosome at a location
460 designated q13.3, typically leading to developmental delay,
461 intellectual disability, dolicocephaly, hypotonia, or absent or
462 delayed speech.
463 Section 13. Paragraphs (a) and (b) of subsection (5) of
464 section 393.065, Florida Statutes, are amended, subsections (6)
465 and (7) are renumbered as subsections (9) and (10),
466 respectively, present subsection (7) is amended, and new
467 subsections (6), (7), and (8) are added to that section, to
468 read:
469 393.065 Application and eligibility determination.—
470 (5) Except as otherwise directed by law, beginning July 1,
471 2010, The agency shall assign and provide priority to clients
472 waiting for waiver services in the following order:
473 (a) Category 1, which includes clients deemed to be in
474 crisis as described in rule, shall be given first priority in
475 moving from the waiting list to the waiver.
476 (b) Category 2, which includes individuals on the waiting
477 ~~children on the wait~~ list who are:
478 1. From the child welfare system with an open case in the
479 Department of Children and Families' statewide automated child
480 welfare information system and who are either:
481 a. Transitioning out of the child welfare system at the
482 finalization of an adoption, a reunification with family

483 members, a permanent placement with a relative, or a
484 guardianship with a nonrelative; or
485 b. At least 18 years but not yet 22 years of age and who
486 need both waiver services and extended foster care services; or
487 2. At least 18 years but not yet 22 years of age and who
488 withdrew consent pursuant to s. 39.6251(5)(c) to remain in the
489 extended foster care system.
490
491 For individuals who are at least 18 years but not yet 22 years
492 of age and who are eligible under sub-subparagraph 1.b., the
493 agency shall provide waiver services, including residential
494 habilitation, and the community-based care lead agency shall
495 fund room and board at the rate established in s. 409.145(4) and
496 provide case management and related services as defined in s.
497 409.986(3)(e). Individuals may receive both waiver services and
498 services under s. 39.6251. Services may not duplicate services
499 available through the Medicaid state plan.
500
501 Within categories 3, 4, 5, 6, and 7, the agency shall maintain a
502 wait list of clients placed in the order of the date that the
503 client is determined eligible for waiver services.
504 (6) The agency shall allow an individual who meets the
505 eligibility requirements of subsection (1) to receive home and
506 community-based services in this state if the individual's
507 parent or legal guardian is an active-duty military
508 servicemember and if, at the time of the servicemember's

509 transfer to this state, the individual was receiving home and
510 community-based services in another state.
511 (7) The agency shall allow an individual with a diagnosis
512 of Phelan-McDermid syndrome who meets the eligibility
513 requirements of subsection (1) to receive home and community-
514 based services.
515 (8) Agency action that selects individuals to receive
516 waiver services pursuant to this section does not establish a
517 right to a hearing or an administrative proceeding under chapter
518 120 for individuals remaining on the waiting list.
519 (9) ~~(7)~~ The agency and the Agency for Health Care
520 Administration may adopt rules specifying application
521 procedures, criteria associated with the waiting list ~~wait-list~~
522 categories, procedures for administering the waiting ~~wait~~ list,
523 including tools for prioritizing waiver enrollment within
524 categories, and eligibility criteria as needed to administer
525 this section.
526 Section 14. If CS/CS/HB 1083 or similar legislation
527 adopted at the 2016 Regular Session of the Legislature or an
528 extension thereof amending paragraph (b) of subsection (1) of
529 section 393.0662, Florida Statutes, fails to become law,
530 paragraph (b) of subsection (1) of section 393.0662, Florida
531 Statutes, is amended to read:
532 393.0662 Individual budgets for delivery of home and
533 community-based services; iBudget system established.—The
534 Legislature finds that improved financial management of the

535 existing home and community-based Medicaid waiver program is
536 necessary to avoid deficits that impede the provision of
537 services to individuals who are on the waiting list for
538 enrollment in the program. The Legislature further finds that
539 clients and their families should have greater flexibility to
540 choose the services that best allow them to live in their
541 community within the limits of an established budget. Therefore,
542 the Legislature intends that the agency, in consultation with
543 the Agency for Health Care Administration, develop and implement
544 a comprehensive redesign of the service delivery system using
545 individual budgets as the basis for allocating the funds
546 appropriated for the home and community-based services Medicaid
547 waiver program among eligible enrolled clients. The service
548 delivery system that uses individual budgets shall be called the
549 iBudget system.
550 (1) The agency shall establish an individual budget,
551 referred to as an iBudget, for each individual served by the
552 home and community-based services Medicaid waiver program. The
553 funds appropriated to the agency shall be allocated through the
554 iBudget system to eligible, Medicaid-enrolled clients. For the
555 iBudget system, eligible clients shall include individuals with
556 a diagnosis of Down syndrome or a developmental disability as
557 defined in s. 393.063. The iBudget system shall be designed to
558 provide for: enhanced client choice within a specified service
559 package; appropriate assessment strategies; an efficient
560 consumer budgeting and billing process that includes

561 reconciliation and monitoring components; a redefined role for
562 support coordinators that avoids potential conflicts of
563 interest; a flexible and streamlined service review process; and
564 a methodology and process that ensures the equitable allocation
565 of available funds to each client based on the client's level of
566 need, as determined by the variables in the allocation
567 algorithm.
568 (b) The allocation methodology shall provide the algorithm
569 that determines the amount of funds allocated to a client's
570 iBudget. The agency may approve an increase in the amount of
571 funds allocated, as determined by the algorithm, based on the
572 client having one or more of the following needs that cannot be
573 accommodated within the funding as determined by the algorithm
574 and having no other resources, supports, or services available
575 to meet the need:
576 1. An extraordinary need that would place the health and
577 safety of the client, the client's caregiver, or the public in
578 immediate, serious jeopardy unless the increase is approved. An
579 extraordinary need may include, but is not limited to:
580 a. A documented history of significant, potentially life-
581 threatening behaviors, such as recent attempts at suicide,
582 arson, nonconsensual sexual behavior, or self-injurious behavior
583 requiring medical attention;
584 b. A complex medical condition that requires active
585 intervention by a licensed nurse on an ongoing basis that cannot
586 be taught or delegated to a nonlicensed person;

587 c. A chronic comorbid condition. As used in this
588 subparagraph, the term "comorbid condition" means a medical
589 condition existing simultaneously but independently with another
590 medical condition in a patient; or
591 d. A need for total physical assistance with activities
592 such as eating, bathing, toileting, grooming, and personal
593 hygiene.
594
595 However, the presence of an extraordinary need alone does not
596 warrant an increase in the amount of funds allocated to a
597 client's iBudget as determined by the algorithm.
598 2. A significant need for one-time or temporary support or
599 services that, if not provided, would place the health and
600 safety of the client, the client's caregiver, or the public in
601 serious jeopardy, unless the increase is approved. A significant
602 need may include, but is not limited to, the provision of
603 environmental modifications, durable medical equipment, services
604 to address the temporary loss of support from a caregiver, or
605 special services or treatment for a serious temporary condition
606 when the service or treatment is expected to ameliorate the
607 underlying condition. As used in this subparagraph, the term
608 "temporary" means a period of fewer than 12 continuous months.
609 However, the presence of such significant need for one-time or
610 temporary supports or services alone does not warrant an
611 increase in the amount of funds allocated to a client's iBudget
612 as determined by the algorithm.

613 3. A significant increase in the need for services after
614 the beginning of the service plan year that would place the
615 health and safety of the client, the client's caregiver, or the
616 public in serious jeopardy because of substantial changes in the
617 client's circumstances, including, but not limited to, permanent
618 or long-term loss or incapacity of a caregiver, loss of services
619 authorized under the state Medicaid plan due to a change in age,
620 or a significant change in medical or functional status which
621 requires the provision of additional services on a permanent or
622 long-term basis that cannot be accommodated within the client's
623 current iBudget. As used in this subparagraph, the term "long-
624 term" means a period of 12 or more continuous months. However,
625 such significant increase in need for services of a permanent or
626 long-term nature alone does not warrant an increase in the
627 amount of funds allocated to a client's iBudget as determined by
628 the algorithm.
629 4. A significant need for transportation services to a
630 waiver-funded adult day training program or to waiver-funded
631 employment services when such need cannot be accommodated within
632 a client's iBudget as determined by the algorithm without
633 affecting the health and safety of the client, if public
634 transportation is not an option due to the unique needs of the
635 client or other transportation resources are not reasonably
636 available.
637
638 The agency shall reserve portions of the appropriation for the

639 home and community-based services Medicaid waiver program for
640 adjustments required pursuant to this paragraph and may use the
641 services of an independent actuary in determining the amount of
642 the portions to be reserved.
643 Section 15. If CS/CS/HB 1083 or similar legislation
644 adopted at the 2016 Regular Session of the Legislature or an
645 extension thereof amending subsection (15) of section 393.067,
646 Florida Statutes, fails to become law, notwithstanding the
647 expiration date in section 24 of chapter 2015-222, Laws of
648 Florida, subsection (15) of section 393.067, Florida Statutes,
649 is reenacted to read:
650 393.067 Facility licensure.—
651 (15) The agency is not required to contract with
652 facilities licensed pursuant to this chapter.
653 Section 16. If CS/CS/HB 1083 or similar legislation
654 adopted at the 2016 Regular Session of the Legislature or an
655 extension thereof amending section 393.18, Florida Statutes,
656 fails to become law, notwithstanding the expiration date in
657 section 26 of chapter 2015-222, Laws of Florida, section 393.18,
658 Florida Statutes, is reenacted to read:
659 393.18 Comprehensive transitional education program.—A
660 comprehensive transitional education program is a group of
661 jointly operating centers or units, the collective purpose of
662 which is to provide a sequential series of educational care,
663 training, treatment, habilitation, and rehabilitation services
664 to persons who have developmental disabilities and who have

665 severe or moderate maladaptive behaviors. However, this section
666 does not require such programs to provide services only to
667 persons with developmental disabilities. All such services shall
668 be temporary in nature and delivered in a structured residential
669 setting, having the primary goal of incorporating the principle
670 of self-determination in establishing permanent residence for
671 persons with maladaptive behaviors in facilities that are not
672 associated with the comprehensive transitional education
673 program. The staff shall include behavior analysts and teachers,
674 as appropriate, who shall be available to provide services in
675 each component center or unit of the program. A behavior analyst
676 must be certified pursuant to s. 393.17.
677 (1) Comprehensive transitional education programs shall
678 include a minimum of two component centers or units, one of
679 which shall be an intensive treatment and educational center or
680 a transitional training and educational center, which provides
681 services to persons with maladaptive behaviors in the following
682 sequential order:
683 (a) Intensive treatment and educational center.—This
684 component is a self-contained residential unit providing
685 intensive behavioral and educational programming for persons
686 with severe maladaptive behaviors whose behaviors preclude
687 placement in a less restrictive environment due to the threat of
688 danger or injury to themselves or others. Continuous-shift staff
689 shall be required for this component.
690 (b) Transitional training and educational center.—This

691 component is a residential unit for persons with moderate
692 maladaptive behaviors providing concentrated psychological and
693 educational programming that emphasizes a transition toward a
694 less restrictive environment. Continuous-shift staff shall be
695 required for this component.
696 (c) Community transition residence.—This component is a
697 residential center providing educational programs and any
698 support services, training, and care that are needed to assist
699 persons with maladaptive behaviors to avoid regression to more
700 restrictive environments while preparing them for more
701 independent living. Continuous-shift staff shall be required for
702 this component.
703 (d) Alternative living center.—This component is a
704 residential unit providing an educational and family living
705 environment for persons with maladaptive behaviors in a
706 moderately unrestricted setting. Residential staff shall be
707 required for this component.
708 (e) Independent living education center.—This component is
709 a facility providing a family living environment for persons
710 with maladaptive behaviors in a largely unrestricted setting and
711 includes education and monitoring that is appropriate to support
712 the development of independent living skills.
713 (2) Components of a comprehensive transitional education
714 program are subject to the license issued under s. 393.067 to a
715 comprehensive transitional education program and may be located
716 on a single site or multiple sites.

717 (3) Comprehensive transitional education programs shall
718 develop individual education plans for each person with
719 maladaptive behaviors who receives services from the program.
720 Each individual education plan shall be developed in accordance
721 with the criteria specified in 20 U.S.C. ss. 401 et seq., and 34
722 C.F.R. part 300.
723 (4) For comprehensive transitional education programs, the
724 total number of residents who are being provided with services
725 may not in any instance exceed the licensed capacity of 120
726 residents and each residential unit within the component centers
727 of the program authorized under this section may not in any
728 instance exceed 15 residents. However, a program that was
729 authorized to operate residential units with more than 15
730 residents before July 1, 2015, may continue to operate such
731 units.
732 Section 17. Subsection (12) of section 409.907, Florida
733 Statutes, is renumbered as subsection (13), and a new subsection
734 (12) is added to that subsection to read:
735 409.907 Medicaid provider agreements.—The agency may make
736 payments for medical assistance and related services rendered to
737 Medicaid recipients only to an individual or entity who has a
738 provider agreement in effect with the agency, who is performing
739 services or supplying goods in accordance with federal, state,
740 and local law, and who agrees that no person shall, on the
741 grounds of handicap, race, color, or national origin, or for any
742 other reason, be subjected to discrimination under any program

743 or activity for which the provider receives payment from the
744 agency.
745 (12) In accordance with 42 C.F.R. s. 433.318(d)(2)(ii),
746 the agency may certify that a provider is out of business and
747 that any overpayments made to the provider cannot be collected
748 under state law.
749 Section 18. Section 409.9072, Florida Statutes, is created
750 to read:
751 409.9072 Medicaid provider agreements for charter schools
752 and private schools.—
753 (1) Subject to a specific appropriation by the
754 Legislature, the agency shall reimburse private schools as
755 defined in s. 1002.01 and schools designated as charter schools
756 under s. 1002.33 which are Medicaid providers for school-based
757 services pursuant to the rehabilitative services option provided
758 under 42 U.S.C. s. 1396d(a)(13) to children younger than 21
759 years of age with specified disabilities who are eligible for
760 both Medicaid and part B or part H of the Individuals with
761 Disabilities Education Act (IDEA) or the exceptional student
762 education program, or who have an individualized educational
763 plan.
764 (2) Schools that wish to enroll as Medicaid providers and
765 receive Medicaid reimbursement under this section must apply to
766 the agency for a provider agreement and must agree to:
767 (a) Verify Medicaid eligibility. The agency shall work
768 cooperatively with a private school or a charter school that is

769 a Medicaid provider to facilitate the school's verification of
770 Medicaid eligibility.
771 (b) Develop and maintain the financial and individual
772 education plan records needed to document the appropriate use of
773 state and federal Medicaid funds.
774 (c) Comply with all state and federal Medicaid laws,
775 rules, regulations, and policies, including, but not limited to,
776 those related to the confidentiality of records and freedom of
777 choice of providers.
778 (d) Be responsible for reimbursing the cost of any state
779 or federal disallowance that results from failure to comply with
780 state or federal Medicaid laws, rules, or regulations.
781 (3) The types of school-based services for which schools
782 may be reimbursed under this section are those included in s.
783 1011.70(1). Private schools and charter schools may not be
784 reimbursed by the agency for providing services that are
785 excluded by that subsection.
786 (4) Within 90 days after a private school or a charter
787 school applies to enroll as a Medicaid provider under this
788 section, the agency may conduct a review to ensure that the
789 school has the capability to comply with its responsibilities
790 under subsection (2). A finding by the agency that the school
791 has the capability to comply does not relieve the school of its
792 responsibility to correct any deficiencies or to reimburse the
793 cost of the state or federal disallowances identified pursuant
794 to any subsequent state or federal audits.

795 (5) For reimbursements to private schools and charter
796 schools under this section, the agency shall apply the
797 reimbursement schedule developed under s. 409.9071(5). Health
798 care practitioners engaged by a school to provide services under
799 this section must be enrolled as Medicaid providers and meet the
800 qualifications specified under 42 C.F.R. s. 440.110, as
801 applicable. Each school's continued participation in providing
802 Medicaid services under this section is contingent upon the
803 school providing to the agency an annual accounting of how the
804 Medicaid reimbursements are used.
805 (6) For Medicaid provider agreements issued under this
806 section, the agency's and the school's confidentiality is waived
807 in relation to the state's efforts to control Medicaid fraud.
808 The agency and the school shall provide any information or
809 documents relating to this section to the Medicaid Fraud Control
810 Unit in the Department of Legal Affairs, upon request, pursuant
811 to the Attorney General's authority under s. 409.920.
812 Section 19. Paragraph (a) of subsection (1) of section
813 409.908, Florida Statutes, is amended, subsections (6) through
814 (24) are renumbered as subsections (7) through (25),
815 respectively, and a new subsection (6) is added to that section
816 to read:
817 409.908 Reimbursement of Medicaid providers.—Subject to
818 specific appropriations, the agency shall reimburse Medicaid
819 providers, in accordance with state and federal law, according
820 to methodologies set forth in the rules of the agency and in

821 policy manuals and handbooks incorporated by reference therein.
822 These methodologies may include fee schedules, reimbursement
823 methods based on cost reporting, negotiated fees, competitive
824 bidding pursuant to s. 287.057, and other mechanisms the agency
825 considers efficient and effective for purchasing services or
826 goods on behalf of recipients. If a provider is reimbursed based
827 on cost reporting and submits a cost report late and that cost
828 report would have been used to set a lower reimbursement rate
829 for a rate semester, then the provider's rate for that semester
830 shall be retroactively calculated using the new cost report, and
831 full payment at the recalculated rate shall be effected
832 retroactively. Medicare-granted extensions for filing cost
833 reports, if applicable, shall also apply to Medicaid cost
834 reports. Payment for Medicaid compensable services made on
835 behalf of Medicaid eligible persons is subject to the
836 availability of moneys and any limitations or directions
837 provided for in the General Appropriations Act or chapter 216.
838 Further, nothing in this section shall be construed to prevent
839 or limit the agency from adjusting fees, reimbursement rates,
840 lengths of stay, number of visits, or number of services, or
841 making any other adjustments necessary to comply with the
842 availability of moneys and any limitations or directions
843 provided for in the General Appropriations Act, provided the
844 adjustment is consistent with legislative intent.
845 (1) Reimbursement to hospitals licensed under part I of
846 chapter 395 must be made prospectively or on the basis of

847 negotiation.
848 (a) Reimbursement for inpatient care is limited as
849 provided in s. 409.905(5), except as otherwise provided in this
850 subsection.
851 1. If authorized by the General Appropriations Act, the
852 agency may modify reimbursement for specific types of services
853 or diagnoses, recipient ages, and hospital provider types.
854 2. The agency may establish an alternative methodology to
855 the DRG-based prospective payment system to set reimbursement
856 rates for:
857 a. State-owned psychiatric hospitals.
858 b. Newborn hearing screening services.
859 c. Transplant services for which the agency has
860 established a global fee.
861 d. Recipients who have tuberculosis that is resistant to
862 therapy who are in need of long-term, hospital-based treatment
863 pursuant to s. 392.62.
864 e. Class III psychiatric hospitals.
865 3. The agency shall modify reimbursement according to
866 other methodologies recognized in the General Appropriations
867 Act.
868
869 The agency may receive funds from state entities, including, but
870 not limited to, the Department of Health, local governments, and
871 other local political subdivisions, for the purpose of making
872 special exception payments, including federal matching funds,

873 through the Medicaid inpatient reimbursement methodologies.
874 Funds received for this purpose shall be separately accounted
875 for and may not be commingled with other state or local funds in
876 any manner. The agency may certify all local governmental funds
877 used as state match under Title XIX of the Social Security Act,
878 to the extent and in the manner authorized under the General
879 Appropriations Act and pursuant to an agreement between the
880 agency and the local governmental entity. In order for the
881 agency to certify such local governmental funds, a local
882 governmental entity must submit a final, executed letter of
883 agreement to the agency, which must be received by October 1 of
884 each fiscal year and provide the total amount of local
885 governmental funds authorized by the entity for that fiscal year
886 under this paragraph, paragraph (b), or the General
887 Appropriations Act. The local governmental entity shall use a
888 certification form prescribed by the agency. At a minimum, the
889 certification form must identify the amount being certified and
890 describe the relationship between the certifying local
891 governmental entity and the local health care provider. The
892 agency shall prepare an annual statement of impact which
893 documents the specific activities undertaken during the previous
894 fiscal year pursuant to this paragraph, to be submitted to the
895 Legislature annually by January 1.
896 (6) Effective July 1, 2017, an ambulatory surgical center
897 shall be reimbursed pursuant to a prospective payment
898 methodology. The agency shall implement a prospective payment

899 methodology for establishing reimbursement rates for ambulatory
900 surgical centers. Rates shall be calculated annually and take
901 effect July 1, 2017, and on July 1 each year thereafter. The
902 methodology shall categorize the amount and type of services
903 used in various ambulatory visits which group together
904 procedures and medical visits that share similar characteristics
905 and resource utilization.
906 Section 20. Paragraphs (a) and (b) of subsection (2),
907 subsections (3) and (4), and paragraph (a) of subsection (5) of
908 section 409.909, Florida Statutes, are amended, paragraph (c) of
909 subsection (2) is redesignated as paragraph (d), and a new
910 paragraph (c) is added to that subsection, to read:
911 409.909 Statewide Medicaid Residency Program.—
912 (2) On or before September 15 of each year, the agency
913 shall calculate an allocation fraction to be used for
914 distributing funds to participating hospitals. On or before the
915 final business day of each quarter of a state fiscal year, the
916 agency shall distribute to each participating hospital one-
917 fourth of that hospital's annual allocation calculated under
918 subsection (4). The allocation fraction for each participating
919 hospital is based on the hospital's number of full-time
920 equivalent residents and the amount of its Medicaid payments. As
921 used in this section, the term:
922 (a) "Full-time equivalent," or "FTE," means a resident who
923 is in his or her residency period, with the initial residency
924 period defined as the minimum number of years of training

925 required before the resident may become eligible for board
926 certification by the American Osteopathic Association Bureau of
927 Osteopathic Specialists or the American Board of Medical
928 Specialties in the specialty in which he or she first began
929 training, not to exceed 5 years. The residency specialty is
930 defined as reported using the current residency type codes in
931 the Intern and Resident Information System (IRIS), required by
932 Medicare. A resident training beyond the initial residency
933 period is counted as 0.5 FTE, unless his or her chosen specialty
934 is in primary care, in which case the resident is counted as 1.0
935 FTE. For the purposes of this section, primary care specialties
936 include:

937 1. Family medicine;

938 2. General internal medicine;

939 3. General pediatrics;

940 4. Preventive medicine;

941 5. Geriatric medicine;

942 6. Osteopathic general practice;

943 7. Obstetrics and gynecology;

944 8. Emergency medicine; ~~and~~

945 9. General surgery; and

946 10. Psychiatry.

947 (b) "Medicaid payments" means the estimated total payments
948 for reimbursing a hospital for direct inpatient services for the
949 fiscal year in which the allocation fraction is calculated based
950 on the hospital inpatient appropriation and the parameters for

951 the inpatient diagnosis-related group base rate, including
952 applicable intergovernmental transfers, specified in the General
953 Appropriations Act, as determined by the agency. Effective July
954 1, 2017, the term "Medicaid payments" means the estimated total
955 payments for reimbursing a hospital for direct inpatient and
956 outpatient services for the fiscal year in which the allocation
957 fraction is calculated based on the hospital inpatient
958 appropriation and outpatient appropriation and the parameters
959 for the inpatient diagnosis-related group base rate, including
960 applicable intergovernmental transfers, specified in the General
961 Appropriations Act, as determined by the agency.
962 (c) "Qualifying institution" means a federally Qualified
963 Health Center holding an Accreditation Council for Graduate
964 Medical Education institutional accreditation.
965 (3) The agency shall use the following formula to
966 calculate a participating hospital's and qualifying
967 institution's allocation fraction:
968 HAF=[0.9 x (HFTE/TFTE)] + [0.1 x (HMP/TMP)]
969 Where:
970 HAF=A hospital's and qualifying institution's allocation
971 fraction.
972 HFTE=A hospital's and qualifying institution's total number
973 of FTE residents.
974 TFTE=The total FTE residents for all participating
975 hospitals and qualifying institutions.
976 HMP=A hospital's and qualifying institution's Medicaid

977 payments.
978 TMP=The total Medicaid payments for all participating
979 hospitals and qualifying institutions.
980 (4) A hospital's and qualifying institution's annual
981 allocation shall be calculated by multiplying the funds
982 appropriated for the Statewide Medicaid Residency Program in the
983 General Appropriations Act by that hospital's and qualifying
984 institution's allocation fraction. If the calculation results in
985 an annual allocation that exceeds two times the average per FTE
986 resident amount for all hospitals and qualifying institutions,
987 the hospital's and qualifying institution's annual allocation
988 shall be reduced to a sum equaling no more than two times the
989 average per FTE resident. The funds calculated for that hospital
990 and qualifying institution in excess of two times the average
991 per FTE resident amount for all hospitals and qualifying
992 institutions shall be redistributed to participating hospitals
993 and qualifying institutions whose annual allocation does not
994 exceed two times the average per FTE resident amount for all
995 hospitals and qualifying institutions, using the same
996 methodology and payment schedule specified in this section.
997 (5) The Graduate Medical Education Startup Bonus Program
998 is established to provide resources for the education and
999 training of physicians in specialties which are in a statewide
1000 supply-and-demand deficit. Hospitals eligible for participation
1001 in subsection (1) are eligible to participate in the Graduate
1002 Medical Education Startup Bonus Program established under this

1003 subsection. Notwithstanding subsection (4) or an FTE's residency
1004 period, and in any state fiscal year in which funds are
1005 appropriated for the startup bonus program, the agency shall
1006 allocate a $100,000 startup bonus for each newly created
1007 resident position that is authorized by the Accreditation
1008 Council for Graduate Medical Education or Osteopathic
1009 Postdoctoral Training Institution in an initial or established
1010 accredited training program that is in a physician specialty in
1011 statewide supply-and-demand deficit. In any year in which
1012 funding is not sufficient to provide $100,000 for each newly
1013 created resident position, funding shall be reduced pro rata
1014 across all newly created resident positions in physician
1015 specialties in statewide supply-and-demand deficit.
1016 (a) Hospitals applying for a startup bonus must submit to
1017 the agency by March 1 their Accreditation Council for Graduate
1018 Medical Education or Osteopathic Postdoctoral Training
1019 Institution approval validating the new resident positions
1020 approved on or after March 2 of the prior fiscal year through
1021 March 1 of the current fiscal year for the physician specialties
1022 identified in a statewide supply-and-demand deficit as provided
1023 in the current fiscal year's General Appropriations Act ~~in~~
1024 ~~physician specialties in statewide supply-and-demand deficit in~~
1025 ~~the current fiscal year~~. An applicant hospital may validate a
1026 change in the number of residents by comparing the number in the
1027 prior period Accreditation Council for Graduate Medical
1028 Education or Osteopathic Postdoctoral Training Institution

1029 approval to the number in the current year.

1030 Section 21. Paragraph (b) of subsection (2) of section
1031 409.967, Florida Statutes, is amended to read:

1032 409.967 Managed care plan accountability.—

1033 (2) The agency shall establish such contract requirements
1034 as are necessary for the operation of the statewide managed care
1035 program. In addition to any other provisions the agency may deem
1036 necessary, the contract must require:

1037 (b) Emergency services.—Managed care plans shall pay for
1038 services required by ss. 395.1041 and 401.45 and rendered by a
1039 noncontracted provider. The plans must comply with s. 641.3155.
1040 Reimbursement for services under this paragraph is the lesser
1041 of:

1042 1. The provider's charges;

1043 2. The usual and customary provider charges for similar
1044 services in the community where the services were provided;

1045 3. The charge mutually agreed to by the entity and the
1046 provider within 60 days after submittal of the claim; or

1047 4. The Medicaid rate, which, for the purposes of this
1048 paragraph, means the amount the provider would collect from the
1049 agency on a fee-for-service basis, less any amounts for the
1050 indirect costs of medical education and the direct costs of
1051 graduate medical education that are otherwise included in the
1052 agency's fee-for-service payment, as required under 42 U.S.C. s.
1053 1396u-2(b)(2)(D) ~~the agency would have paid on the most recent~~
1054 ~~October 1st~~. For the purpose of establishing the amounts

1055 specified in this subparagraph, the agency shall publish on its
1056 website annually, or more frequently as needed, the applicable
1057 fee-for-service fee schedules and their effective dates, less
1058 any amounts for indirect costs of medical education and direct
1059 costs of graduate medical education that are otherwise included
1060 in the agency's fee-for-service payments.

1061 Section 22. Subsection (4) of section 409.968, Florida
1062 Statutes, is renumbered as subsection (5), and a new subsection
1063 (4) is added to that section to read:

1064 409.968 Managed care plan payments.—

1065 (4)(a) Subject to a specific appropriation and federal
1066 approval under s. 409.906(13)(e), the agency shall establish a
1067 payment methodology to fund managed care plans for flexible
1068 services for persons with severe mental illness and substance
1069 use disorders, including, but not limited to, temporary housing
1070 assistance. A managed care plan eligible for these payments must
1071 do all of the following:

1072 1. Participate as a specialty plan for severe mental
1073 illness or substance use disorders or participate in counties
1074 designated by the General Appropriations Act;

1075 2. Include providers of behavioral health services
1076 pursuant to chapters 394 and 397 in the managed care plan's
1077 provider network; and

1078 3. Document a capability to provide housing assistance
1079 through agreements with housing providers, relationships with
1080 local housing coalitions, and other appropriate arrangements.

1081 (b) After receiving payments authorized by this subsection
1082 for at least 1 year, a managed care plan must document the
1083 results of its efforts to maintain the target population in
1084 stable housing up to the maximum duration allowed under federal
1085 approval.
1086 Section 23. Subsections (1) and (6) of section 409.975,
1087 Florida Statutes, are amended to read:
1088 409.975 Managed care plan accountability.—In addition to
1089 the requirements of s. 409.967, plans and providers
1090 participating in the managed medical assistance program shall
1091 comply with the requirements of this section.
1092 (1) PROVIDER NETWORKS.—Managed care plans must develop and
1093 maintain provider networks that meet the medical needs of their
1094 enrollees in accordance with standards established pursuant to
1095 s. 409.967(2)(c). Except as provided in this section, managed
1096 care plans may limit the providers in their networks based on
1097 credentials, quality indicators, and price.
1098 (a) Plans must include all providers in the region that
1099 are classified by the agency as essential Medicaid providers,
1100 unless the agency approves, in writing, an alternative
1101 arrangement for securing the types of services offered by the
1102 essential providers. Providers are essential for serving
1103 Medicaid enrollees if they offer services that are not available
1104 from any other provider within a reasonable access standard, or
1105 if they provided a substantial share of the total units of a
1106 particular service used by Medicaid patients within the region

1107 during the last 3 years and the combined capacity of other
1108 service providers in the region is insufficient to meet the
1109 total needs of the Medicaid patients. The agency may not
1110 classify physicians and other practitioners as essential
1111 providers. The agency, at a minimum, shall determine which
1112 providers in the following categories are essential Medicaid
1113 providers:
1114 1. Federally qualified health centers.
1115 2. Statutory teaching hospitals as defined in s.
1116 408.07(45).
1117 3. Hospitals that are trauma centers as defined in s.
1118 395.4001(14).
1119 4. Hospitals located at least 25 miles from any other
1120 hospital with similar services.
1121
1122 Managed care plans that have not contracted with all essential
1123 providers in the region as of the first date of recipient
1124 enrollment, or with whom an essential provider has terminated
1125 its contract, must negotiate in good faith with such essential
1126 providers for 1 year or until an agreement is reached, whichever
1127 is first. Payments for services rendered by a nonparticipating
1128 essential provider shall be made at the applicable Medicaid rate
1129 as of the first day of the contract between the agency and the
1130 plan. A rate schedule for all essential providers shall be
1131 attached to the contract between the agency and the plan. After
1132 1 year, managed care plans that are unable to contract with

1133 essential providers shall notify the agency and propose an
1134 alternative arrangement for securing the essential services for
1135 Medicaid enrollees. The arrangement must rely on contracts with
1136 other participating providers, regardless of whether those
1137 providers are located within the same region as the
1138 nonparticipating essential service provider. If the alternative
1139 arrangement is approved by the agency, payments to
1140 nonparticipating essential providers after the date of the
1141 agency's approval shall equal 90 percent of the applicable
1142 Medicaid rate. <u>Except for payment for emergency services,</u> if the
1143 alternative arrangement is not approved by the agency, payment
1144 to nonparticipating essential providers shall equal 110 percent
1145 of the applicable Medicaid rate.
1146 (b) Certain providers are statewide resources and
1147 essential providers for all managed care plans in all regions.
1148 All managed care plans must include these essential providers in
1149 their networks. Statewide essential providers include:
1150 1. Faculty plans of Florida medical schools.
1151 2. Regional perinatal intensive care centers as defined in
1152 s. 383.16(2).
1153 3. Hospitals licensed as specialty children's hospitals as
1154 defined in s. 395.002(28).
1155 4. Accredited and integrated systems serving medically
1156 complex children <u>which comprise</u> ~~that are comprised of~~ separately
1157 licensed, but commonly owned, health care providers delivering
1158 at least the following services: medical group home, in-home and

1159 outpatient nursing care and therapies, pharmacy services,
1160 durable medical equipment, and Prescribed Pediatric Extended
1161 Care.
1162
1163 Managed care plans that have not contracted with all statewide
1164 essential providers in all regions as of the first date of
1165 recipient enrollment must continue to negotiate in good faith.
1166 Payments to physicians on the faculty of nonparticipating
1167 Florida medical schools shall be made at the applicable Medicaid
1168 rate. Payments for services rendered by regional perinatal
1169 intensive care centers shall be made at the applicable Medicaid
1170 rate as of the first day of the contract between the agency and
1171 the plan. Except for payments for emergency services, payments
1172 to nonparticipating specialty children's hospitals shall equal
1173 the highest rate established by contract between that provider
1174 and any other Medicaid managed care plan.
1175 (c) After 12 months of active participation in a plan's
1176 network, the plan may exclude any essential provider from the
1177 network for failure to meet quality or performance criteria. If
1178 the plan excludes an essential provider from the plan, the plan
1179 must provide written notice to all recipients who have chosen
1180 that provider for care. The notice shall be provided at least 30
1181 days before the effective date of the exclusion. For purposes of
1182 this paragraph, the term "essential provider" includes providers
1183 determined by the agency to be essential Medicaid providers
1184 under paragraph (a) and the statewide essential providers

1185 <u>specified in paragraph (b).</u>
1186 <u>(d) The applicable Medicaid rates for emergency services</u>
1187 <u>paid by a plan under this section to a provider with which the</u>
1188 <u>plan does not have an active contract shall be determined</u>
1189 <u>according to s. 409.967(2)(b).</u>
1190 <u>(e)</u>~~(d)~~ Each managed care plan must offer a network
1191 contract to each home medical equipment and supplies provider in
1192 the region which meets quality and fraud prevention and
1193 detection standards established by the plan and which agrees to
1194 accept the lowest price previously negotiated between the plan
1195 and another such provider.
1196 (6) PROVIDER PAYMENT.—Managed care plans and hospitals
1197 shall negotiate mutually acceptable rates, methods, and terms of
1198 payment. ~~For rates, methods, and terms of payment negotiated~~
1199 ~~after the contract between the agency and the plan is executed,~~
1200 ~~plans shall pay hospitals, at a minimum, the rate the agency~~
1201 ~~would have paid on the first day of the contract between the~~
1202 ~~provider and the plan.~~ Such payments to hospitals may not exceed
1203 120 percent of the rate the agency would have paid on the first
1204 day of the contract between the provider and the plan, unless
1205 specifically approved by the agency. Payment rates may be
1206 updated periodically.
1207 Section 24. Paragraph (b) of subsection (3) of section
1208 624.91, Florida Statutes, is amended to read:
1209 624.91 The Florida Healthy Kids Corporation Act.—
1210 (3) ELIGIBILITY FOR STATE-FUNDED ASSISTANCE.—Only the

1211 following individuals are eligible for state-funded assistance
1212 in paying Florida Healthy Kids premiums:
1213 (b) Notwithstanding s. 409.814, a legal alien ~~aliens~~ who
1214 is ~~are~~ enrolled in the Florida Healthy Kids program as of
1215 January 31, 2004, who does ~~do~~ not qualify for Title XXI federal
1216 funds because he or she is ~~they are~~ not a lawfully residing
1217 child ~~qualified aliens~~ as defined in s. 409.811.
1218 Section 25. Subsection (6) of section 641.513, Florida
1219 Statutes, is amended, and subsection (7) is added to that
1220 section, to read:
1221 641.513 Requirements for providing emergency services and
1222 care.—
1223 (6) Reimbursement for services under this section provided
1224 to subscribers who are Medicaid recipients by a provider for
1225 whom no contract exists between the provider and the health
1226 maintenance organization shall be determined under chapter 409.
1227 ~~the lesser of:~~
1228 ~~(a) The provider's charges;~~
1229 ~~(b) The usual and customary provider charges for similar~~
1230 ~~services in the community where the services were provided;~~
1231 ~~(c) The charge mutually agreed to by the entity and the~~
1232 ~~provider within 60 days after submittal of the claim; or~~
1233 ~~(d) The Medicaid rate.~~
1234 (7) Reimbursement for services under this section provided
1235 to subscribers who are enrolled in a health maintenance
1236 organization pursuant to s. 624.91 by a provider for whom no

1237 contract exists between the provider and the health maintenance
1238 organization shall be the lesser of:
1239 (a) The provider's charges;
1240 (b) The usual and customary provider charges for similar
1241 services in the community where the services were provided;
1242 (c) The charge mutually agreed to by the entity and the
1243 provider within 60 days after submittal of the claim; or
1244 (d) The Medicaid rate.
1245 Section 26. Section 18 of chapter 2012-33, Laws of
1246 Florida, is amended to read:
1247 Section 18. Notwithstanding s. 430.707, Florida Statutes,
1248 and subject to federal approval of an additional site for the
1249 Program of All-Inclusive Care for the Elderly (PACE), the Agency
1250 for Health Care Administration shall contract with a current
1251 PACE organization authorized to provide PACE services in
1252 Southeast Florida to develop and operate a PACE program in
1253 Broward County to serve frail elders who reside in Broward
1254 County or Miami-Dade County. The organization shall be exempt
1255 from chapter 641, Florida Statutes. The agency, in consultation
1256 with the Department of Elderly Affairs and subject to an
1257 appropriation, shall approve up to 150 initial enrollee slots in
1258 the Broward program established by the organization.
1259 Section 27. Subject to federal approval of the application
1260 to be a site for the Program of All-inclusive Care for the
1261 Elderly (PACE), the Agency for Health Care Administration shall
1262 contract with one private, not-for-profit hospice organization

1263 located in Escambia County that owns and manages health care
1264 organizations licensed in Hospice Service Areas 1, 2A, and 2B
1265 which provide comprehensive services, including, but not limited
1266 to, hospice and palliative care, to frail elders who reside in
1267 those Hospice Service Areas. The organization is exempt from the
1268 requirements of chapter 641, Florida Statutes. The agency, in
1269 consultation with the Department of Elderly Affairs and subject
1270 to the appropriation of funds by the Legislature, shall approve
1271 up to 100 initial enrollees in the Program of All-inclusive Care
1272 for the Elderly established by the organization to serve frail
1273 elders who reside in Hospice Service Areas 1, 2A, and 2B.
1274 Section 28. Subject to federal approval of the application
1275 to be a site for the Program of All-inclusive Care for the
1276 Elderly (PACE), the Agency for Health Care Administration shall
1277 contract with a not-for-profit organization that has been
1278 jointly formed by a lead agency that has been designated
1279 pursuant to s. 430.205, Florida Statutes, and by a not-for-
1280 profit hospice provider that has been licensed for more than 30
1281 years to serve individuals and families in Clay, Duval, St.
1282 Johns, Baker, and Nassau Counties. The not-for-profit
1283 organization shall leverage existing community-based care
1284 providers and health care organizations to provide PACE services
1285 to frail elders who reside in Clay, Duval, St. Johns, Baker, and
1286 Nassau Counties. The organization is exempt from the
1287 requirements of chapter 641, Florida Statutes. The agency, in
1288 consultation with the Department of Elderly Affairs and subject

1289 to the appropriation of funds by the Legislature, shall approve
1290 up to 300 initial enrollees in the Program of All-inclusive Care
1291 for the Elderly established by the organization to serve frail
1292 elders who reside in Clay, Duval, St. Johns, Baker, and Nassau
1293 Counties.

1294 Section 29. Subject to federal approval of the application
1295 to be a site for the Program of All-inclusive Care for the
1296 Elderly (PACE), the Agency for Health Care Administration shall
1297 contract with one private, not-for-profit hospice organization
1298 located in Lake County which operates health care organizations
1299 licensed in Hospice Areas 7B and 3E and which provides
1300 comprehensive services, including hospice and palliative care,
1301 to frail elders who reside in these service areas. The
1302 organization is exempt from the requirements of chapter 641,
1303 Florida Statutes. The agency, in consultation with the
1304 Department of Elderly Affairs and subject to the appropriation
1305 of funds by the Legislature, shall approve up to 150 initial
1306 enrollees in the Program of All-inclusive Care for the Elderly
1307 established by the organization to serve frail elders who reside
1308 in Hospice Service Areas 7B and 3E.

1309 Section 30. Subject to federal approval of the application
1310 to be a site for the Program of All-inclusive Care for the
1311 Elderly (PACE), the Agency for Health Care Administration shall
1312 contract with one not-for-profit organization that has more than
1313 30 years' experience as a licensed hospice and is currently a
1314 licensed hospice serving individuals and families in Pinellas

1315 County, service area 5B. This not-for-profit organization shall
1316 provide PACE services to frail elders who reside in Hillsborough
1317 County. The organization is exempt from the requirements of
1318 chapter 641, Florida Statutes. The agency, in consultation with
1319 the Department of Elderly Affairs and subject to the
1320 appropriation of funds by the Legislature, shall approve up to
1321 150 initial enrollees in the Program of All-inclusive Care for
1322 the Elderly established by the organization to serve frail
1323 elders who reside in Hillsborough County.
1324 Section 31. Subsection (3) of section 391.055, Florida
1325 Statutes, is amended to read:
1326 391.055 Service delivery systems.—
1327 (3) The Children's Medical Services network may contract
1328 with school districts participating in the certified school
1329 match program pursuant to ss. 409.908(22) ~~409.908(21)~~ and
1330 1011.70 for the provision of school-based services, as provided
1331 for in s. 409.9071, for Medicaid-eligible children who are
1332 enrolled in the Children's Medical Services network.
1333 Section 32. Subsection (3) of section 427.0135, Florida
1334 Statutes, is amended to read:
1335 427.0135 Purchasing agencies; duties and
1336 responsibilities.—Each purchasing agency, in carrying out the
1337 policies and procedures of the commission, shall:
1338 (3) Not procure transportation disadvantaged services
1339 without initially negotiating with the commission, as provided
1340 in s. 287.057(3)(e)12., or unless otherwise authorized by

1341 statute. If the purchasing agency, after consultation with the
1342 commission, determines that it cannot reach mutually acceptable
1343 contract terms with the commission, the purchasing agency may
1344 contract for the same transportation services provided in a more
1345 cost-effective manner and of comparable or higher quality and
1346 standards. The Medicaid agency shall implement this subsection
1347 in a manner consistent with s. 409.908(19) ~~409.908(18)~~ and as
1348 otherwise limited or directed by the General Appropriations Act.
1349 Section 33. Paragraph (d) of subsection (2) of section
1350 1002.385, Florida Statutes, is amended to read:
1351 1002.385 Florida personal learning scholarship accounts.—
1352 (2) DEFINITIONS.—As used in this section, the term:
1353 (d) "Disability" means, for a student in kindergarten to
1354 grade 12, autism, as defined in s. 393.063(3); cerebral palsy,
1355 as defined in s. 393.063(4); Down syndrome, as defined in s.
1356 393.063(13); an intellectual disability, as defined in s.
1357 393.063(21); Phelan-McDermid syndrome, as defined in s.
1358 393.063(25); Prader-Willi syndrome, as defined in s. 393.063(26)
1359 ~~393.063(25)~~; or spina bifida, as defined in s. 393.063(37)
1360 ~~393.063(36)~~; for a student in kindergarten, being a high-risk
1361 child, as defined in s. 393.063(20)(a); and Williams syndrome.
1362 Section 34. Subsections (1) and (5) of section 1011.70,
1363 Florida Statutes, are amended to read:
1364 1011.70 Medicaid certified school funding maximization.—
1365 (1) Each school district, subject to the provisions of ss.
1366 409.9071 and 409.908(22) ~~409.908(21)~~ and this section, is

1367 authorized to certify funds provided for a category of required
1368 Medicaid services termed "school-based services," which are
1369 reimbursable under the federal Medicaid program. Such services
1370 shall include, but not be limited to, physical, occupational,
1371 and speech therapy services, behavioral health services, mental
1372 health services, transportation services, Early Periodic
1373 Screening, Diagnosis, and Treatment (EPSDT) administrative
1374 outreach for the purpose of determining eligibility for
1375 exceptional student education, and any other such services, for
1376 the purpose of receiving federal Medicaid financial
1377 participation. Certified school funding shall not be available
1378 for the following services:
1379 (a) Family planning.
1380 (b) Immunizations.
1381 (c) Prenatal care.
1382 (5) Lab schools, as authorized under s. 1002.32, shall be
1383 authorized to participate in the Medicaid certified school match
1384 program on the same basis as school districts subject to the
1385 provisions of subsections (1)-(4) and ss. 409.9071 and
1386 409.908(22) ~~409.908(21)~~.
1387 Section 35. Except as otherwise provided in this act and
1388 except for this section, which shall take effect upon this act
1389 becoming a law, this act shall take effect July 1, 2016.
1390
1391 ---
1392 **T I T L E A M E N D M E N T**

1393 Remove everything before the enacting clause and insert:
1394 A bill to be entitled
1395 An act relating to health care services; amending s.
1396 322.142, F.S.; authorizing the Department of Highway
1397 Safety and Motor Vehicles to provide the Agency for
1398 Health Care Administration with access to certain
1399 digital and photographic records; amending s.
1400 409.9128, F.S.; conforming provisions to changes made
1401 by the act; amending s. 395.602, F.S.; revising the
1402 definition of "rural hospital" to include specified
1403 hospitals; amending 409.285, F.S.; requiring appeals
1404 related to Medicaid programs directly administered by
1405 the agency to be directed to the agency; providing
1406 requirements for appeals directed to the agency;
1407 providing an exemption from the uniform rules of
1408 procedure and from a requirement that certain
1409 proceedings be heard before an administrative law
1410 judge for specified hearings; requiring the agency to
1411 seek federal approval of its authority to oversee
1412 appeals; amending s. 409.811, F.S.; defining the term
1413 "lawfully residing child"; deleting the definition of
1414 the term "qualified alien"; conforming provisions to
1415 changes made by the act; amending s. 409.814, F.S.;
1416 revising eligibility for the Florida Kidcare program
1417 to conform to changes made by the act; specifying that
1418 undocumented immigrants are excluded from eligibility;

1419 amending s. 409.904, F.S.; providing eligibility for
1420 optional payments for medical assistance and related
1421 services for certain lawfully residing children;
1422 specifying that undocumented immigrants are excluded
1423 from eligibility; amending s. 409.905, F.S.; requiring
1424 the agency to implement a prospective payment system
1425 for such services by a specified date; removing a
1426 limitation on Medicaid reimbursement for certain
1427 hospital emergency services for certain recipients;
1428 deleting references to cost-based reimbursement
1429 methodology for outpatient services; amending s.
1430 409.906, F.S.; directing the agency to seek federal
1431 approval to provide temporary housing assistance for
1432 certain persons; amending s. 393.063, F.S.; revising
1433 the definition of the term "developmental disability"
1434 to include Down syndrome and Phelan-McDermid syndrome;
1435 amending s. 393.063, F.S.; defining the term "Phelan-
1436 McDermid syndrome"; amending s. 393.065, F.S.;
1437 providing for the assignment of priority to clients
1438 waiting for waiver services; requiring an agency to
1439 allow a certain individual to receive such services if
1440 the individual's parent or legal guardian is an
1441 active-duty military service member; requiring the
1442 agency to send an annual letter to clients and their
1443 guardians or families; requiring the agency to allow a
1444 certain individual to receive such services if the

1445 individual has Phelan-McDermid syndrome; providing
1446 that certain agency action does not establish a right
1447 to a hearing or an administrative proceeding; amending
1448 s. 393.0662, F.S.; revising the allocations
1449 methodology that the agency is required to use to
1450 develop each client's iBudget; adding client needs
1451 that qualify as extraordinary needs, which may result
1452 in the approval of an increase in a client's allocated
1453 funds; providing for contingent effect; reenacting s.
1454 393.067(15), F.S., relating to contracts between the
1455 agency and licensed facilities; providing contingent
1456 abrogation of the scheduled expiration and reversion
1457 of amendments to s. 393.067(15), F.S., pursuant to s.
1458 24 of chapter 2015-222, Laws of Florida; reenacting s.
1459 393.18, F.S., relating to the comprehensive
1460 transitional education program; providing contingent
1461 abrogation of the scheduled expiration and reversion
1462 of amendments to s. 393.18, F.S., pursuant to s. 26 of
1463 chapter 2015-222, Laws of Florida; amending s.
1464 409.907, F.S.; authorizing the agency to certify that
1465 a Medicaid provider is out of business; creating s.
1466 409.9072, F.S.; directing the agency to pay private
1467 schools and charter schools that are Medicaid
1468 providers for specified school-based services under
1469 certain parameters; authorizing the agency to review a
1470 school that has applied to the program for capability

1471 requirements; amending s. 409.908, F.S.; limiting
1472 Medicaid reimbursement for certain types of hospitals;
1473 requiring the agency to implement a prospective
1474 payment system for ambulatory surgical centers;
1475 amending s. 409.909, F.S.; defining the term
1476 "qualifying institution" for purposes of the Statewide
1477 Medicaid Residency Program; conforming provisions of
1478 the statewide Medicaid program to the implementation
1479 of a prospective payment system; adding psychiatry to
1480 a list of primary care specialties under the Statewide
1481 Medicaid Residency Program; providing for annual
1482 updates to the statewide physician supply-and-demand
1483 deficit; amending s. 409.967, F.S.; defining the term
1484 "Medicaid rate" for determination of specified managed
1485 care plan payments for emergency services in
1486 compliance with federal law; requiring annual
1487 publication of fee schedules on the agency's website;
1488 amending s. 409.968, F.S.; directing the agency to
1489 establish a payment methodology for managed care plans
1490 providing housing assistance to specified persons;
1491 amending s. 409.975, F.S.; defining the term
1492 "essential provider"; providing for determination of
1493 Medicaid rates for emergency services paid by certain
1494 managed care plans; revising provisions relating to
1495 certain payment negotiations between managed care
1496 palns and hospitals; amending s. 624.91, F.S.;

1497 conforming provisions to changes made by the act;
1498 amending s. 641.513, F.S.; specifying parameters for
1499 payments by a health maintenance organization to a
1500 noncontracted provider of emergency services under
1501 certain circumstances; conforming provisions to
1502 changes made by the act; amending chapter 2012-33,
1503 Laws of Florida; authorizing a Program of All-
1504 inclusive Care for the Elderly (PACE) organization
1505 granted certain enrollee slots for frail elders
1506 residing in Broward County to use such slots for
1507 enrollees residing in Miami-Dade County; authorizing
1508 the agency to contract with an organization in
1509 Escambia County to provide services under the federal
1510 Program of All-inclusive Care for the Elderly in
1511 specified areas; exempting the organization from
1512 chapter 641, F.S., relating to health care service
1513 programs; authorizing Program of All-inclusive Care
1514 for the Elderly services in Clay, Duval, St. Johns,
1515 Baker and Nassau Counties, subject to federal
1516 approval; authorizing the agency to contract with not-
1517 for-profit organizations in Lake and Hillsborough
1518 Counties to offer hospice services via the Program of
1519 All-inclusive Care for the Elderly, subject to federal
1520 approval; amending ss. 391.055, 427.0135, 1002.385,
1521 and 1011.70, F.S.; conforming cross-references;
1522 providing effective dates.