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1
2 An act relating to health care services; amending s.
3 322.142, F.S.; authorizing the Department of Highway
4 Safety and Motor Vehicles to provide the Agency for
5 Health Care Administration with access to certain
6 digital and photographic records; amending s.
7 409.9128, F.S.; conforming provisions to changes made
8 by the act; amending s. 395.602, F.S.; revising the
9 definition of "rural hospital" to include specified
10 hospitals; amending 409.285, F.S.; requiring appeals
11 related to Medicaid programs directly administered by
12 the agency to be directed to the agency; providing
13 requirements for appeals directed to the agency;
14 providing an exemption from the uniform rules of
15 procedure and from a requirement that certain
16 proceedings be heard before an administrative law
17 judge for specified hearings; requiring the agency to
18 seek federal approval of its authority to oversee
19 appeals; amending s. 409.811, F.S.; defining the term
20 "lawfully residing child"; deleting the definition of
21 the term "qualified alien"; conforming provisions to
22 changes made by the act; amending s. 409.814, F.S.;
23 revising eligibility for the Florida Kidcare program
24 to conform to changes made by the act; specifying that
25 undocumented immigrants are excluded from eligibility;
26 amending s. 409.904, F.S.; providing eligibility for



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27 optional payments for medical assistance and related
28 services for certain lawfully residing children;
29 specifying that undocumented immigrants are excluded
30 from eligibility; amending s. 409.905, F.S.; requiring
31 the agency to implement a prospective payment system
32 for such services by a specified date; removing a
33 limitation on Medicaid reimbursement for certain
34 hospital emergency services for certain recipients;
35 deleting references to cost-based reimbursement
36 methodology for outpatient services; amending s.
37 409.906, F.S.; directing the agency to seek federal
38 approval to provide temporary housing assistance for
39 certain persons; amending s. 393.063, F.S.; revising
40 the definition of the term "developmental disability"
41 to include Down syndrome and Phelan-McDermid syndrome;
42 amending s. 393.063, F.S.; defining the term "Phelan-
43 McDermid syndrome"; amending s. 393.065, F.S.;
44 providing for the assignment of priority to clients
45 waiting for waiver services; requiring an agency to
46 allow a certain individual to receive such services if
47 the individual's parent or legal guardian is an
48 active-duty military service member; requiring the
49 agency to send an annual letter to clients and their
50 guardians or families; requiring the agency to allow a
51 certain individual to receive such services if the
52 individual has Phelan-McDermid syndrome; providing



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53 | that certain agency action does not establish a right
54 | to a hearing or an administrative proceeding; amending
55 | s. 393.0662, F.S.; revising the allocations
56 | methodology that the agency is required to use to
57 | develop each client's iBudget; adding client needs
58 | that qualify as extraordinary needs, which may result
59 | in the approval of an increase in a client's allocated
60 | funds; providing for contingent effect; reenacting s.
61 | 393.067(15), F.S., relating to contracts between the
62 | agency and licensed facilities; providing contingent
63 | abrogation of the scheduled expiration and reversion
64 | of amendments to s. 393.067(15), F.S., pursuant to s.
65 | 24 of chapter 2015-222, Laws of Florida; reenacting s.
66 | 393.18, F.S., relating to the comprehensive
67 | transitional education program; providing contingent
68 | abrogation of the scheduled expiration and reversion
69 | of amendments to s. 393.18, F.S., pursuant to s. 26 of
70 | chapter 2015-222, Laws of Florida; amending s.
71 | 409.907, F.S.; authorizing the agency to certify that
72 | a Medicaid provider is out of business; creating s.
73 | 409.9072, F.S.; directing the agency to pay private
74 | schools and charter schools that are Medicaid
75 | providers for specified school-based services under
76 | certain parameters; authorizing the agency to review a
77 | school that has applied to the program for capability
78 | requirements; amending s. 409.908, F.S.; limiting



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79 Medicaid reimbursement for certain types of hospitals;
80 requiring the agency to implement a prospective
81 payment system for ambulatory surgical centers;
82 amending s. 409.909, F.S.; defining the term
83 "qualifying institution" for purposes of the Statewide
84 Medicaid Residency Program; conforming provisions of
85 the statewide Medicaid program to the implementation
86 of a prospective payment system; adding psychiatry to
87 a list of primary care specialties under the Statewide
88 Medicaid Residency Program; providing for annual
89 updates to the statewide physician supply-and-demand
90 deficit; amending s. 409.967, F.S.; defining the term
91 "Medicaid rate" for determination of specified managed
92 care plan payments for emergency services in
93 compliance with federal law; requiring annual
94 publication of fee schedules on the agency's website;
95 amending s. 409.968, F.S.; directing the agency to
96 establish a payment methodology for managed care plans
97 providing housing assistance to specified persons;
98 amending s. 409.975, F.S.; defining the term
99 "essential provider"; providing for determination of
100 Medicaid rates for emergency services paid by certain
101 managed care plans; revising provisions relating to
102 certain payment negotiations between managed care
103 plans and hospitals; amending s. 624.91, F.S.;

104 conforming provisions to changes made by the act;



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105 | amending s. 641.513, F.S.; specifying parameters for
106 | payments by a health maintenance organization to a
107 | noncontracted provider of emergency services under
108 | certain circumstances; conforming provisions to
109 | changes made by the act; amending chapter 2012-33,
110 | Laws of Florida; authorizing a Program of All-
111 | inclusive Care for the Elderly (PACE) organization
112 | granted certain enrollee slots for frail elders
113 | residing in Broward County to use such slots for
114 | enrollees residing in Miami-Dade County; authorizing
115 | the agency to contract with an organization in
116 | Escambia County to provide services under the federal
117 | Program of All-inclusive Care for the Elderly in
118 | specified areas; exempting the organization from
119 | chapter 641, F.S., relating to health care service
120 | programs; authorizing Program of All-inclusive Care
121 | for the Elderly services in Clay, Duval, St. Johns,
122 | Baker and Nassau Counties, subject to federal
123 | approval; authorizing the agency to contract with not-
124 | for-profit organizations in Lake and Hillsborough
125 | Counties to offer hospice services via the Program of
126 | All-inclusive Care for the Elderly, subject to federal
127 | approval; amending ss. 391.055, 427.0135, 1002.385,
128 | and 1011.70, F.S.; conforming cross-references;
129 | providing effective dates.

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

132

133 Section 1. Effective upon this act becoming a law,
 134 paragraphs (k) and (l) of subsection (4) of section 322.142,
 135 Florida Statutes, are amended, and paragraph (m) is added to
 136 that section, to read:

137 322.142 Color photographic or digital imaged licenses.—

138 (4) The department may maintain a film negative or print
 139 file. The department shall maintain a record of the digital
 140 image and signature of the licensees, together with other data
 141 required by the department for identification and retrieval.
 142 Reproductions from the file or digital record are exempt from
 143 the provisions of s. 119.07(1) and may be made and issued only:

144 (k) To district medical examiners pursuant to an
 145 interagency agreement for the purpose of identifying a deceased
 146 individual, determining cause of death, and notifying next of
 147 kin of any investigations, including autopsies and other
 148 laboratory examinations, authorized in s. 406.11; ~~or~~

149 (l) To the following persons for the purpose of
 150 identifying a person as part of the official work of a court:

- 151 1. A justice or judge of this state;
- 152 2. An employee of the state courts system who works in a
 153 position that is designated in writing for access by the Chief
 154 Justice of the Supreme Court or a chief judge of a district or
 155 circuit court, or by his or her designee; or
- 156 3. A government employee who performs functions on behalf



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157 of the state courts system in a position that is designated in
 158 writing for access by the Chief Justice or a chief judge, or by
 159 his or her designee; or

160 (m) To the Agency for Health Care Administration pursuant
 161 to an interagency agreement to prevent health care fraud. If the
 162 Agency for Health Care Administration enters into an agreement
 163 with a private entity to carry out duties relating to health
 164 care fraud prevention, such contracts shall include, but need
 165 not be limited to:

166 1. Provisions requiring internal controls and audit
 167 processes to identify access, use, and unauthorized access of
 168 information.

169 2. A requirement to report unauthorized access or use to
 170 the Agency for Health Care Administration within 1 business day
 171 after the discovery of the unauthorized access or use.

172 3. Provisions for liquidated damages for unauthorized
 173 access or use of no less than \$5,000 per occurrence.

174 Section 2. Subsection (5) of section 409.9128, Florida
 175 Statutes, is amended to read:

176 409.9128 Requirements for providing emergency services and
 177 care.—

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

182 (a) The provider's charges;



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

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

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

188 Section 3. Paragraph (e) of subsection (2) of section
 189 395.602, Florida Statutes, is amended to read:

190 395.602 Rural hospitals.—

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

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

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

197 2. An acute care hospital, in a county with a population
 198 density of up to 100 persons per square mile, which is at least
 199 30 minutes of travel time, on normally traveled roads under
 200 normal traffic conditions, from any other acute care hospital
 201 within the same county;

202 3. A hospital supported by a tax district or subdistrict
 203 whose boundaries encompass a population of up to 100 persons per
 204 square mile;

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

207 ~~5.4.~~ A hospital with a service area that has a population
 208 of up to 100 persons per square mile. As used in this



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209 subparagraph, the term "service area" means the fewest number of
210 zip codes that account for 75 percent of the hospital's
211 discharges for the most recent 5-year period, based on
212 information available from the hospital inpatient discharge
213 database in the Florida Center for Health Information and Policy
214 Analysis at the agency; or

215 ~~6.5.~~ A hospital designated as a critical access hospital,
216 as defined in s. 408.07.

217
218 Population densities used in this paragraph must be based upon
219 the most recently completed United States census. A hospital
220 that received funds under s. 409.9116 for a quarter beginning no
221 later than July 1, 2002, is deemed to have been and shall
222 continue to be a rural hospital from that date through June 30,
223 2021, if the hospital continues to have up to 100 licensed beds
224 and an emergency room. An acute care hospital that has not
225 previously been designated as a rural hospital and that meets
226 the criteria of this paragraph shall be granted such designation
227 upon application, including supporting documentation, to the
228 agency. A hospital that was licensed as a rural hospital during
229 the 2010-2011 or 2011-2012 fiscal year shall continue to be a
230 rural hospital from the date of designation through June 30,
231 2021, if the hospital continues to have up to 100 licensed beds
232 and an emergency room.

233 Section 4. Section 409.285, Florida Statutes, is amended
234 to read:



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235 409.285 Opportunity for hearing and appeal.—

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

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

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

256 (2) Appeals related to Medicaid programs directly
 257 administered by the Agency for Health Care Administration,
 258 including appeals related to Florida's Statewide Medicaid
 259 Managed Care program and associated federal waivers, filed on or
 260 after March 1, 2017, must be directed to the agency in the



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261 manner and form prescribed by the agency. The department and the
262 agency shall establish a transition process to transfer
263 administration of these appeals from the department to the
264 agency by March 1, 2017.

265 (a) The hearing authority for appeals heard by the Agency
266 for Health Care Administration may be the Secretary of Health
267 Care Administration, a panel of agency officials, or a hearing
268 officer appointed for that purpose. The hearing authority is
269 responsible for a final administrative decision in the name of
270 the agency on all issues that have been the subject of a
271 hearing. A decision of the hearing authority is final and
272 binding on the agency. The agency is responsible for ensuring
273 that the decision is promptly carried out.

274 (b) Notwithstanding ss. 120.569 and 120.57, hearings
275 conducted by the Agency for Health Care Administration pursuant
276 to this subsection are subject to federal regulations and
277 requirements relating to Medicaid appeals, are exempt from the
278 uniform rules of procedure under s. 120.54(5), and are not
279 required to be conducted by an administrative law judge assigned
280 by the Division of Administrative Hearings.

281 (c) The Agency for Health Care Administration shall seek
282 federal approval necessary to implement this subsection and may
283 adopt rules necessary to administer this subsection. Before such
284 rules are adopted, the agency shall follow the rules applicable
285 to the Medicaid hearings pursuant to s. 409.285(1).

286 (3) Appeals related to Medicaid programs administered by



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287 | the Agency for Persons with Disabilities are subject to s.
288 | 393.125.

289 | Section 5. Subsections (17) through (22) of section
290 | 409.811, Florida Statutes, are renumbered as subsections (18)
291 | through (23), respectively, a new subsection (17) is added to
292 | that section, and present subsections (23) and (24) of that
293 | section are amended, to read:

294 | 409.811 Definitions relating to Florida Kidcare Act.—As
295 | used in ss. 409.810-409.821, the term:

296 | (17) "Lawfully residing child" means a child who is
297 | lawfully present in the United States, meets Medicaid or
298 | Children's Health Insurance Program (CHIP) residency
299 | requirements, and may be eligible for medical assistance with
300 | federal financial participation as provided under s. 214 of the
301 | Children's Health Insurance Program Reauthorization Act of 2009,
302 | Pub. L. No. 111-3, and related federal regulations.

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

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

308 | Section 6. Paragraph (c) of subsection (4) of section
309 | 409.814, Florida Statutes, is amended to read:

310 | 409.814 Eligibility.—A child who has not reached 19 years
311 | of age whose family income is equal to or below 200 percent of
312 | the federal poverty level is eligible for the Florida Kidcare



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313 program as provided in this section. If an enrolled individual
314 is determined to be ineligible for coverage, he or she must be
315 immediately disenrolled from the respective Florida Kidcare
316 program component.

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

322 (c) A child who is an alien~~7~~ but who does not meet the
323 definition of a lawfully residing child ~~qualified alien, in the~~
324 ~~United States. This paragraph does not extend eligibility for~~
325 the Florida Kidcare program to an undocumented immigrant.

326 Section 7. Subsections (8) and (9) of section 409.904,
327 Florida Statutes, are renumbered as subsections (9) and (10),
328 respectively, and a new subsection (8) is added to that section
329 to read:

330 409.904 Optional payments for eligible persons.—The agency
331 may make payments for medical assistance and related services on
332 behalf of the following persons who are determined to be
333 eligible subject to the income, assets, and categorical
334 eligibility tests set forth in federal and state law. Payment on
335 behalf of these Medicaid eligible persons is subject to the
336 availability of moneys and any limitations established by the
337 General Appropriations Act or chapter 216.

338 (8) A child who has not attained 19 years of age and who,



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339 notwithstanding s. 414.095(3), would be eligible for Medicaid
340 under s. 409.903, except that the child is a lawfully residing
341 child as defined in s. 409.811. This subsection does not extend
342 eligibility for optional Medicaid payments or related services
343 to an undocumented immigrant.

344 Section 8. Subsection (5) of section 409.905, Florida
345 Statutes, is amended to read:

346 409.905 Mandatory Medicaid services.—The agency may make
347 payments for the following services, which are required of the
348 state by Title XIX of the Social Security Act, furnished by
349 Medicaid providers to recipients who are determined to be
350 eligible on the dates on which the services were provided. Any
351 service under this section shall be provided only when medically
352 necessary and in accordance with state and federal law.

353 Mandatory services rendered by providers in mobile units to
354 Medicaid recipients may be restricted by the agency. Nothing in
355 this section shall be construed to prevent or limit the agency
356 from adjusting fees, reimbursement rates, lengths of stay,
357 number of visits, number of services, or any other adjustments
358 necessary to comply with the availability of moneys and any
359 limitations or directions provided for in the General
360 Appropriations Act or chapter 216.

361 (5) HOSPITAL INPATIENT SERVICES.—The agency shall pay for
362 all covered services provided for the medical care and treatment
363 of a recipient who is admitted as an inpatient by a licensed
364 physician or dentist to a hospital licensed under part I of



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365 chapter 395. However, the agency shall limit the payment for
366 inpatient hospital services for a Medicaid recipient 21 years of
367 age or older to 45 days or the number of days necessary to
368 comply with the General Appropriations Act. ~~Effective August 1,~~
369 ~~2012, the agency shall limit payment for hospital emergency~~
370 ~~department visits for a nonpregnant Medicaid recipient 21 years~~
371 ~~of age or older to six visits per fiscal year.~~

372 (a) The agency may implement reimbursement and utilization
373 management reforms in order to comply with any limitations or
374 directions in the General Appropriations Act, which may include,
375 but are not limited to: prior authorization for inpatient
376 psychiatric days; prior authorization for nonemergency hospital
377 inpatient admissions for individuals 21 years of age and older;
378 authorization of emergency and urgent-care admissions within 24
379 hours after admission; enhanced utilization and concurrent
380 review programs for highly utilized services; reduction or
381 elimination of covered days of service; adjusting reimbursement
382 ceilings for variable costs; adjusting reimbursement ceilings
383 for fixed and property costs; and implementing target rates of
384 increase. The agency may limit prior authorization for hospital
385 inpatient services to selected diagnosis-related groups, based
386 on an analysis of the cost and potential for unnecessary
387 hospitalizations represented by certain diagnoses. Admissions
388 for normal delivery and newborns are exempt from requirements
389 for prior authorization. In implementing the provisions of this
390 section related to prior authorization, the agency shall ensure



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391 that the process for authorization is accessible 24 hours per
392 day, 7 days per week and authorization is automatically granted
393 when not denied within 4 hours after the request. Authorization
394 procedures must include steps for review of denials. Upon
395 implementing the prior authorization program for hospital
396 inpatient services, the agency shall discontinue its hospital
397 retrospective review program.

398 (b) A licensed hospital maintained primarily for the care
399 and treatment of patients having mental disorders or mental
400 diseases is not eligible to participate in the hospital
401 inpatient portion of the Medicaid program except as provided in
402 federal law. However, the department shall apply for a waiver,
403 within 9 months after June 5, 1991, designed to provide
404 hospitalization services for mental health reasons to children
405 and adults in the most cost-effective and lowest cost setting
406 possible. Such waiver shall include a request for the
407 opportunity to pay for care in hospitals known under federal law
408 as "institutions for mental disease" or "IMD's." The waiver
409 proposal shall propose no additional aggregate cost to the state
410 or Federal Government, and shall be conducted in Hillsborough
411 County, Highlands County, Hardee County, Manatee County, and
412 Polk County. The waiver proposal may incorporate competitive
413 bidding for hospital services, comprehensive brokering, prepaid
414 capitated arrangements, or other mechanisms deemed by the
415 department to show promise in reducing the cost of acute care
416 and increasing the effectiveness of preventive care. When



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417 developing the waiver proposal, the department shall take into
418 account price, quality, accessibility, linkages of the hospital
419 to community services and family support programs, plans of the
420 hospital to ensure the earliest discharge possible, and the
421 comprehensiveness of the mental health and other health care
422 services offered by participating providers.

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

439 1. Adjustments may not be made to the rates after October
440 31 of the state fiscal year in which the rates take effect,
441 except for cases of insufficient collections of
442 intergovernmental transfers authorized under s. 409.908(1) or



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443 the General Appropriations Act. In such cases, the agency shall
444 submit a budget amendment or amendments under chapter 216
445 requesting approval of rate reductions by amounts necessary for
446 the aggregate reduction to equal the dollar amount of
447 intergovernmental transfers not collected and the corresponding
448 federal match. Notwithstanding the \$1 million limitation on
449 increases to an approved operating budget contained in ss.
450 216.181(11) and 216.292(3), a budget amendment exceeding that
451 dollar amount is subject to notice and objection procedures set
452 forth in s. 216.177.

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

465 (d) The agency shall implement a comprehensive utilization
466 management program for hospital neonatal intensive care stays in
467 certain high-volume participating hospitals, select counties, or
468 statewide, and replace existing hospital inpatient utilization



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469 management programs for neonatal intensive care admissions. The
470 program shall be designed to manage appropriate admissions and
471 discharges for children being treated in neonatal intensive care
472 units and must seek medically appropriate discharge to the
473 child's home or other less costly treatment setting. The agency
474 may competitively bid a contract for the selection of a
475 qualified organization to provide neonatal intensive care
476 utilization management services. The agency may seek federal
477 waivers to implement this initiative.

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

481 Section 9. Effective July 1, 2017, paragraph (b) of
482 subsection (6) of section 409.905, Florida Statutes, is amended
483 to read:

484 409.905 Mandatory Medicaid services.—The agency may make
485 payments for the following services, which are required of the
486 state by Title XIX of the Social Security Act, furnished by
487 Medicaid providers to recipients who are determined to be
488 eligible on the dates on which the services were provided. Any
489 service under this section shall be provided only when medically
490 necessary and in accordance with state and federal law.

491 Mandatory services rendered by providers in mobile units to
492 Medicaid recipients may be restricted by the agency. Nothing in
493 this section shall be construed to prevent or limit the agency
494 from adjusting fees, reimbursement rates, lengths of stay,



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495 number of visits, number of services, or any other adjustments
496 necessary to comply with the availability of moneys and any
497 limitations or directions provided for in the General
498 Appropriations Act or chapter 216.

499 (6) HOSPITAL OUTPATIENT SERVICES.—

500 (b) The agency shall implement a prospective payment
501 methodology for establishing ~~base~~ reimbursement rates for
502 outpatient hospital services ~~for each hospital based on~~
503 ~~allowable costs, as defined by the agency.~~ Rates shall be
504 calculated annually and take effect July 1, 2017, and July 1 of
505 each year thereafter. The methodology shall categorize the
506 amount and type of services used in various ambulatory visits
507 which group together procedures and medical visits that share
508 similar characteristics and resource utilization ~~based on the~~
509 ~~most recent complete and accurate cost report submitted by each~~
510 ~~hospital.~~

511 1. Adjustments may not be made to the rates after July 31
512 ~~October 31~~ of the state fiscal year in which the rates take
513 effect, ~~except for cases of insufficient collections of~~
514 ~~intergovernmental transfers authorized under s. 409.908(1) or~~
515 ~~the General Appropriations Act.~~ In such cases, the agency shall
516 submit a budget amendment or amendments under chapter 216
517 requesting approval of rate reductions by amounts necessary for
518 the aggregate reduction to equal the dollar amount of
519 intergovernmental transfers not collected and the corresponding
520 federal match. Notwithstanding the \$1 million limitation on



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521 ~~increases to an approved operating budget under ss. 216.181(11)~~
522 ~~and 216.292(3), a budget amendment exceeding that dollar amount~~
523 ~~is subject to notice and objection procedures set forth in s.~~
524 ~~216.177.~~

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

537 Section 10. Paragraph (e) is added to subsection (13) of
538 section 409.906, Florida Statutes, to read:

539 409.906 Optional Medicaid services.—Subject to specific
540 appropriations, the agency may make payments for services which
541 are optional to the state under Title XIX of the Social Security
542 Act and are furnished by Medicaid providers to recipients who
543 are determined to be eligible on the dates on which the services
544 were provided. Any optional service that is provided shall be
545 provided only when medically necessary and in accordance with
546 state and federal law. Optional services rendered by providers



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547 in mobile units to Medicaid recipients may be restricted or
 548 prohibited by the agency. Nothing in this section shall be
 549 construed to prevent or limit the agency from adjusting fees,
 550 reimbursement rates, lengths of stay, number of visits, or
 551 number of services, or making any other adjustments necessary to
 552 comply with the availability of moneys and any limitations or
 553 directions provided for in the General Appropriations Act or
 554 chapter 216. If necessary to safeguard the state's systems of
 555 providing services to elderly and disabled persons and subject
 556 to the notice and review provisions of s. 216.177, the Governor
 557 may direct the Agency for Health Care Administration to amend
 558 the Medicaid state plan to delete the optional Medicaid service
 559 known as "Intermediate Care Facilities for the Developmentally
 560 Disabled." Optional services may include:

561 (13) HOME AND COMMUNITY-BASED SERVICES.—

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

568 Section 11. Subsection (9) of section 393.063, Florida
 569 Statutes, is amended to read:

570 393.063 Definitions.—For the purposes of this chapter, the
 571 term:

572 (9) "Developmental disability" means a disorder or



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573 syndrome that is attributable to intellectual disability,
574 cerebral palsy, autism, spina bifida, Down syndrome, Phelan-
575 McDermid syndrome, or Prader-Willi syndrome; that manifests
576 before the age of 18; and that constitutes a substantial
577 handicap that can reasonably be expected to continue
578 indefinitely.

579 Section 12. Subsections (25) through (41) of section
580 393.063, Florida Statutes, are renumbered as subsections (26)
581 through (42), respectively, and a new subsection (25) is added
582 to that section to read:

583 393.063 Definitions.—For the purposes of this chapter, the
584 term:

585 (25) "Phelan-McDermid syndrome" means a disorder caused by
586 the loss of the terminal segment of the long arm of chromosome
587 22, which occurs near the end of the chromosome at a location
588 designated q13.3, typically leading to developmental delay,
589 intellectual disability, dolicocephaly, hypotonia, or absent or
590 delayed speech.

591 Section 13. Paragraphs (a) and (b) of subsection (5) of
592 section 393.065, Florida Statutes, are amended, subsections (6)
593 and (7) are renumbered as subsections (9) and (10),
594 respectively, present subsection (7) is amended, and new
595 subsections (6), (7), and (8) are added to that section, to
596 read:

597 393.065 Application and eligibility determination.—

598 (5) Except as otherwise directed by law, beginning July 1,



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599 | 2010, The agency shall assign and provide priority to clients
600 | waiting for waiver services in the following order:

601 | (a) Category 1, which includes clients deemed to be in
602 | crisis as described in rule, shall be given first priority in
603 | moving from the waiting list to the waiver.

604 | (b) Category 2, which includes individuals on the waiting
605 | children on the wait list who are:

606 | 1. From the child welfare system with an open case in the
607 | Department of Children and Families' statewide automated child
608 | welfare information system and who are either:

609 | a. Transitioning out of the child welfare system at the
610 | finalization of an adoption, a reunification with family
611 | members, a permanent placement with a relative, or a
612 | guardianship with a nonrelative; or

613 | b. At least 18 years but not yet 22 years of age and who
614 | need both waiver services and extended foster care services; or

615 | 2. At least 18 years but not yet 22 years of age and who
616 | withdrew consent pursuant to s. 39.6251(5)(c) to remain in the
617 | extended foster care system.

618 |
619 | For individuals who are at least 18 years but not yet 22 years
620 | of age and who are eligible under sub-subparagraph 1.b., the
621 | agency shall provide waiver services, including residential
622 | habilitation, and the community-based care lead agency shall
623 | fund room and board at the rate established in s. 409.145(4) and
624 | provide case management and related services as defined in s.



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625 409.986(3)(e). Individuals may receive both waiver services and
626 services under s. 39.6251. Services may not duplicate services
627 available through the Medicaid state plan.

628
629 Within categories 3, 4, 5, 6, and 7, the agency shall maintain a
630 wait list of clients placed in the order of the date that the
631 client is determined eligible for waiver services.

632 (6) The agency shall allow an individual who meets the
633 eligibility requirements of subsection (1) to receive home and
634 community-based services in this state if the individual's
635 parent or legal guardian is an active-duty military
636 servicemember and if, at the time of the servicemember's
637 transfer to this state, the individual was receiving home and
638 community-based services in another state.

639 (7) The agency shall allow an individual with a diagnosis
640 of Phelan-McDermid syndrome who meets the eligibility
641 requirements of subsection (1) to receive home and community-
642 based services.

643 (8) Agency action that selects individuals to receive
644 waiver services pursuant to this section does not establish a
645 right to a hearing or an administrative proceeding under chapter
646 120 for individuals remaining on the waiting list.

647 (9)~~(7)~~ The agency and the Agency for Health Care
648 Administration may adopt rules specifying application
649 procedures, criteria associated with the waiting list ~~wait-list~~
650 categories, procedures for administering the waiting ~~wait~~ list,



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651 including tools for prioritizing waiver enrollment within
652 categories, and eligibility criteria as needed to administer
653 this section.

654 Section 14. If CS/CS/HB 1083 or similar legislation
655 adopted at the 2016 Regular Session of the Legislature or an
656 extension thereof amending paragraph (b) of subsection (1) of
657 section 393.0662, Florida Statutes, fails to become law,
658 paragraph (b) of subsection (1) of section 393.0662, Florida
659 Statutes, is amended to read:

660 393.0662 Individual budgets for delivery of home and
661 community-based services; iBudget system established.—The
662 Legislature finds that improved financial management of the
663 existing home and community-based Medicaid waiver program is
664 necessary to avoid deficits that impede the provision of
665 services to individuals who are on the waiting list for
666 enrollment in the program. The Legislature further finds that
667 clients and their families should have greater flexibility to
668 choose the services that best allow them to live in their
669 community within the limits of an established budget. Therefore,
670 the Legislature intends that the agency, in consultation with
671 the Agency for Health Care Administration, develop and implement
672 a comprehensive redesign of the service delivery system using
673 individual budgets as the basis for allocating the funds
674 appropriated for the home and community-based services Medicaid
675 waiver program among eligible enrolled clients. The service
676 delivery system that uses individual budgets shall be called the



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677 iBudget system.

678 (1) The agency shall establish an individual budget,
679 referred to as an iBudget, for each individual served by the
680 home and community-based services Medicaid waiver program. The
681 funds appropriated to the agency shall be allocated through the
682 iBudget system to eligible, Medicaid-enrolled clients. For the
683 iBudget system, eligible clients shall include individuals with
684 a diagnosis of Down syndrome or a developmental disability as
685 defined in s. 393.063. The iBudget system shall be designed to
686 provide for: enhanced client choice within a specified service
687 package; appropriate assessment strategies; an efficient
688 consumer budgeting and billing process that includes
689 reconciliation and monitoring components; a redefined role for
690 support coordinators that avoids potential conflicts of
691 interest; a flexible and streamlined service review process; and
692 a methodology and process that ensures the equitable allocation
693 of available funds to each client based on the client's level of
694 need, as determined by the variables in the allocation
695 algorithm.

696 (b) The allocation methodology shall provide the algorithm
697 that determines the amount of funds allocated to a client's
698 iBudget. The agency may approve an increase in the amount of
699 funds allocated, as determined by the algorithm, based on the
700 client having one or more of the following needs that cannot be
701 accommodated within the funding as determined by the algorithm
702 and having no other resources, supports, or services available



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703 to meet the need:

704 1. An extraordinary need that would place the health and
705 safety of the client, the client's caregiver, or the public in
706 immediate, serious jeopardy unless the increase is approved. An
707 extraordinary need may include, but is not limited to:

708 a. A documented history of significant, potentially life-
709 threatening behaviors, such as recent attempts at suicide,
710 arson, nonconsensual sexual behavior, or self-injurious behavior
711 requiring medical attention;

712 b. A complex medical condition that requires active
713 intervention by a licensed nurse on an ongoing basis that cannot
714 be taught or delegated to a nonlicensed person;

715 c. A chronic comorbid condition. As used in this
716 subparagraph, the term "comorbid condition" means a medical
717 condition existing simultaneously but independently with another
718 medical condition in a patient; or

719 d. A need for total physical assistance with activities
720 such as eating, bathing, toileting, grooming, and personal
721 hygiene.

722

723 However, the presence of an extraordinary need alone does not
724 warrant an increase in the amount of funds allocated to a
725 client's iBudget as determined by the algorithm.

726 2. A significant need for one-time or temporary support or
727 services that, if not provided, would place the health and
728 safety of the client, the client's caregiver, or the public in



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729 serious jeopardy, unless the increase is approved. A significant
730 need may include, but is not limited to, the provision of
731 environmental modifications, durable medical equipment, services
732 to address the temporary loss of support from a caregiver, or
733 special services or treatment for a serious temporary condition
734 when the service or treatment is expected to ameliorate the
735 underlying condition. As used in this subparagraph, the term
736 "temporary" means a period of fewer than 12 continuous months.
737 However, the presence of such significant need for one-time or
738 temporary supports or services alone does not warrant an
739 increase in the amount of funds allocated to a client's iBudget
740 as determined by the algorithm.

741 3. A significant increase in the need for services after
742 the beginning of the service plan year that would place the
743 health and safety of the client, the client's caregiver, or the
744 public in serious jeopardy because of substantial changes in the
745 client's circumstances, including, but not limited to, permanent
746 or long-term loss or incapacity of a caregiver, loss of services
747 authorized under the state Medicaid plan due to a change in age,
748 or a significant change in medical or functional status which
749 requires the provision of additional services on a permanent or
750 long-term basis that cannot be accommodated within the client's
751 current iBudget. As used in this subparagraph, the term "long-
752 term" means a period of 12 or more continuous months. However,
753 such significant increase in need for services of a permanent or
754 long-term nature alone does not warrant an increase in the



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755 amount of funds allocated to a client's iBudget as determined by
756 the algorithm.

757 4. A significant need for transportation services to a
758 waiver-funded adult day training program or to waiver-funded
759 employment services when such need cannot be accommodated within
760 a client's iBudget as determined by the algorithm without
761 affecting the health and safety of the client, if public
762 transportation is not an option due to the unique needs of the
763 client or other transportation resources are not reasonably
764 available.

765

766 The agency shall reserve portions of the appropriation for the
767 home and community-based services Medicaid waiver program for
768 adjustments required pursuant to this paragraph and may use the
769 services of an independent actuary in determining the amount of
770 the portions to be reserved.

771 Section 15. If CS/CS/HB 1083 or similar legislation
772 adopted at the 2016 Regular Session of the Legislature or an
773 extension thereof amending subsection (15) of section 393.067,
774 Florida Statutes, fails to become law, notwithstanding the
775 expiration date in section 24 of chapter 2015-222, Laws of
776 Florida, subsection (15) of section 393.067, Florida Statutes,
777 is reenacted to read:

778 393.067 Facility licensure.—

779 (15) The agency is not required to contract with
780 facilities licensed pursuant to this chapter.



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781 Section 16. If CS/CS/HB 1083 or similar legislation
782 adopted at the 2016 Regular Session of the Legislature or an
783 extension thereof amending section 393.18, Florida Statutes,
784 fails to become law, notwithstanding the expiration date in
785 section 26 of chapter 2015-222, Laws of Florida, section 393.18,
786 Florida Statutes, is reenacted to read:

787 393.18 Comprehensive transitional education program.—A
788 comprehensive transitional education program is a group of
789 jointly operating centers or units, the collective purpose of
790 which is to provide a sequential series of educational care,
791 training, treatment, habilitation, and rehabilitation services
792 to persons who have developmental disabilities and who have
793 severe or moderate maladaptive behaviors. However, this section
794 does not require such programs to provide services only to
795 persons with developmental disabilities. All such services shall
796 be temporary in nature and delivered in a structured residential
797 setting, having the primary goal of incorporating the principle
798 of self-determination in establishing permanent residence for
799 persons with maladaptive behaviors in facilities that are not
800 associated with the comprehensive transitional education
801 program. The staff shall include behavior analysts and teachers,
802 as appropriate, who shall be available to provide services in
803 each component center or unit of the program. A behavior analyst
804 must be certified pursuant to s. 393.17.

805 (1) Comprehensive transitional education programs shall
806 include a minimum of two component centers or units, one of



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807 | which shall be an intensive treatment and educational center or
808 | a transitional training and educational center, which provides
809 | services to persons with maladaptive behaviors in the following
810 | sequential order:

811 | (a) Intensive treatment and educational center.—This
812 | component is a self-contained residential unit providing
813 | intensive behavioral and educational programming for persons
814 | with severe maladaptive behaviors whose behaviors preclude
815 | placement in a less restrictive environment due to the threat of
816 | danger or injury to themselves or others. Continuous-shift staff
817 | shall be required for this component.

818 | (b) Transitional training and educational center.—This
819 | component is a residential unit for persons with moderate
820 | maladaptive behaviors providing concentrated psychological and
821 | educational programming that emphasizes a transition toward a
822 | less restrictive environment. Continuous-shift staff shall be
823 | required for this component.

824 | (c) Community transition residence.—This component is a
825 | residential center providing educational programs and any
826 | support services, training, and care that are needed to assist
827 | persons with maladaptive behaviors to avoid regression to more
828 | restrictive environments while preparing them for more
829 | independent living. Continuous-shift staff shall be required for
830 | this component.

831 | (d) Alternative living center.—This component is a
832 | residential unit providing an educational and family living



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833 environment for persons with maladaptive behaviors in a
834 moderately unrestricted setting. Residential staff shall be
835 required for this component.

836 (e) Independent living education center.—This component is
837 a facility providing a family living environment for persons
838 with maladaptive behaviors in a largely unrestricted setting and
839 includes education and monitoring that is appropriate to support
840 the development of independent living skills.

841 (2) Components of a comprehensive transitional education
842 program are subject to the license issued under s. 393.067 to a
843 comprehensive transitional education program and may be located
844 on a single site or multiple sites.

845 (3) Comprehensive transitional education programs shall
846 develop individual education plans for each person with
847 maladaptive behaviors who receives services from the program.
848 Each individual education plan shall be developed in accordance
849 with the criteria specified in 20 U.S.C. ss. 401 et seq., and 34
850 C.F.R. part 300.

851 (4) For comprehensive transitional education programs, the
852 total number of residents who are being provided with services
853 may not in any instance exceed the licensed capacity of 120
854 residents and each residential unit within the component centers
855 of the program authorized under this section may not in any
856 instance exceed 15 residents. However, a program that was
857 authorized to operate residential units with more than 15
858 residents before July 1, 2015, may continue to operate such



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859 units.

860 Section 17. Subsection (12) of section 409.907, Florida
 861 Statutes, is renumbered as subsection (13), and a new subsection
 862 (12) is added to that subsection to read:

863 409.907 Medicaid provider agreements.—The agency may make
 864 payments for medical assistance and related services rendered to
 865 Medicaid recipients only to an individual or entity who has a
 866 provider agreement in effect with the agency, who is performing
 867 services or supplying goods in accordance with federal, state,
 868 and local law, and who agrees that no person shall, on the
 869 grounds of handicap, race, color, or national origin, or for any
 870 other reason, be subjected to discrimination under any program
 871 or activity for which the provider receives payment from the
 872 agency.

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

877 Section 18. Section 409.9072, Florida Statutes, is created
 878 to read:

879 409.9072 Medicaid provider agreements for charter schools
 880 and private schools.—

881 (1) Subject to a specific appropriation by the
 882 Legislature, the agency shall reimburse private schools as
 883 defined in s. 1002.01 and schools designated as charter schools
 884 under s. 1002.33 which are Medicaid providers for school-based



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885 services pursuant to the rehabilitative services option provided
886 under 42 U.S.C. s. 1396d(a)(13) to children younger than 21
887 years of age with specified disabilities who are eligible for
888 both Medicaid and part B or part H of the Individuals with
889 Disabilities Education Act (IDEA) or the exceptional student
890 education program, or who have an individualized educational
891 plan.

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

895 (a) Verify Medicaid eligibility. The agency shall work
896 cooperatively with a private school or a charter school that is
897 a Medicaid provider to facilitate the school's verification of
898 Medicaid eligibility.

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

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

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

909 (3) The types of school-based services for which schools
910 may be reimbursed under this section are those included in s.



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911 1011.70(1). Private schools and charter schools may not be
912 reimbursed by the agency for providing services that are
913 excluded by that subsection.

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

923 (5) For reimbursements to private schools and charter
924 schools under this section, the agency shall apply the
925 reimbursement schedule developed under s. 409.9071(5). Health
926 care practitioners engaged by a school to provide services under
927 this section must be enrolled as Medicaid providers and meet the
928 qualifications specified under 42 C.F.R. s. 440.110, as
929 applicable. Each school's continued participation in providing
930 Medicaid services under this section is contingent upon the
931 school providing to the agency an annual accounting of how the
932 Medicaid reimbursements are used.

933 (6) For Medicaid provider agreements issued under this
934 section, the agency's and the school's confidentiality is waived
935 in relation to the state's efforts to control Medicaid fraud.
936 The agency and the school shall provide any information or



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937 documents relating to this section to the Medicaid Fraud Control
938 Unit in the Department of Legal Affairs, upon request, pursuant
939 to the Attorney General's authority under s. 409.920.

940 Section 19. Paragraph (a) of subsection (1) of section
941 409.908, Florida Statutes, is amended, subsections (6) through
942 (24) are renumbered as subsections (7) through (25),
943 respectively, and a new subsection (6) is added to that section
944 to read:

945 409.908 Reimbursement of Medicaid providers.—Subject to
946 specific appropriations, the agency shall reimburse Medicaid
947 providers, in accordance with state and federal law, according
948 to methodologies set forth in the rules of the agency and in
949 policy manuals and handbooks incorporated by reference therein.
950 These methodologies may include fee schedules, reimbursement
951 methods based on cost reporting, negotiated fees, competitive
952 bidding pursuant to s. 287.057, and other mechanisms the agency
953 considers efficient and effective for purchasing services or
954 goods on behalf of recipients. If a provider is reimbursed based
955 on cost reporting and submits a cost report late and that cost
956 report would have been used to set a lower reimbursement rate
957 for a rate semester, then the provider's rate for that semester
958 shall be retroactively calculated using the new cost report, and
959 full payment at the recalculated rate shall be effected
960 retroactively. Medicare-granted extensions for filing cost
961 reports, if applicable, shall also apply to Medicaid cost
962 reports. Payment for Medicaid compensable services made on



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963 | behalf of Medicaid eligible persons is subject to the
964 | availability of moneys and any limitations or directions
965 | provided for in the General Appropriations Act or chapter 216.
966 | Further, nothing in this section shall be construed to prevent
967 | or limit the agency from adjusting fees, reimbursement rates,
968 | lengths of stay, number of visits, or number of services, or
969 | making any other adjustments necessary to comply with the
970 | availability of moneys and any limitations or directions
971 | provided for in the General Appropriations Act, provided the
972 | adjustment is consistent with legislative intent.

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

976 | (a) Reimbursement for inpatient care is limited as
977 | provided in s. 409.905(5), except as otherwise provided in this
978 | subsection.

979 | 1. If authorized by the General Appropriations Act, the
980 | agency may modify reimbursement for specific types of services
981 | or diagnoses, recipient ages, and hospital provider types.

982 | 2. The agency may establish an alternative methodology to
983 | the DRG-based prospective payment system to set reimbursement
984 | rates for:

- 985 | a. State-owned psychiatric hospitals.
986 | b. Newborn hearing screening services.
987 | c. Transplant services for which the agency has
988 | established a global fee.



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989 d. Recipients who have tuberculosis that is resistant to
990 therapy who are in need of long-term, hospital-based treatment
991 pursuant to s. 392.62.

992 e. Class III psychiatric hospitals.

993 3. The agency shall modify reimbursement according to
994 other methodologies recognized in the General Appropriations
995 Act.

996
997 The agency may receive funds from state entities, including, but
998 not limited to, the Department of Health, local governments, and
999 other local political subdivisions, for the purpose of making
1000 special exception payments, including federal matching funds,
1001 through the Medicaid inpatient reimbursement methodologies.
1002 Funds received for this purpose shall be separately accounted
1003 for and may not be commingled with other state or local funds in
1004 any manner. The agency may certify all local governmental funds
1005 used as state match under Title XIX of the Social Security Act,
1006 to the extent and in the manner authorized under the General
1007 Appropriations Act and pursuant to an agreement between the
1008 agency and the local governmental entity. In order for the
1009 agency to certify such local governmental funds, a local
1010 governmental entity must submit a final, executed letter of
1011 agreement to the agency, which must be received by October 1 of
1012 each fiscal year and provide the total amount of local
1013 governmental funds authorized by the entity for that fiscal year
1014 under this paragraph, paragraph (b), or the General



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1015 Appropriations Act. The local governmental entity shall use a
1016 certification form prescribed by the agency. At a minimum, the
1017 certification form must identify the amount being certified and
1018 describe the relationship between the certifying local
1019 governmental entity and the local health care provider. The
1020 agency shall prepare an annual statement of impact which
1021 documents the specific activities undertaken during the previous
1022 fiscal year pursuant to this paragraph, to be submitted to the
1023 Legislature annually by January 1.

1024 (6) Effective July 1, 2017, an ambulatory surgical center
1025 shall be reimbursed pursuant to a prospective payment
1026 methodology. The agency shall implement a prospective payment
1027 methodology for establishing reimbursement rates for ambulatory
1028 surgical centers. Rates shall be calculated annually and take
1029 effect July 1, 2017, and on July 1 each year thereafter. The
1030 methodology shall categorize the amount and type of services
1031 used in various ambulatory visits which group together
1032 procedures and medical visits that share similar characteristics
1033 and resource utilization.

1034 Section 20. Paragraphs (a) and (b) of subsection (2),
1035 subsections (3) and (4), and paragraph (a) of subsection (5) of
1036 section 409.909, Florida Statutes, are amended, paragraph (c) of
1037 subsection (2) is redesignated as paragraph (d), and a new
1038 paragraph (c) is added to that subsection, to read:

1039 409.909 Statewide Medicaid Residency Program.—

1040 (2) On or before September 15 of each year, the agency



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1041 shall calculate an allocation fraction to be used for
1042 distributing funds to participating hospitals. On or before the
1043 final business day of each quarter of a state fiscal year, the
1044 agency shall distribute to each participating hospital one-
1045 fourth of that hospital's annual allocation calculated under
1046 subsection (4). The allocation fraction for each participating
1047 hospital is based on the hospital's number of full-time
1048 equivalent residents and the amount of its Medicaid payments. As
1049 used in this section, the term:

1050 (a) "Full-time equivalent," or "FTE," means a resident who
1051 is in his or her residency period, with the initial residency
1052 period defined as the minimum number of years of training
1053 required before the resident may become eligible for board
1054 certification by the American Osteopathic Association Bureau of
1055 Osteopathic Specialists or the American Board of Medical
1056 Specialties in the specialty in which he or she first began
1057 training, not to exceed 5 years. The residency specialty is
1058 defined as reported using the current residency type codes in
1059 the Intern and Resident Information System (IRIS), required by
1060 Medicare. A resident training beyond the initial residency
1061 period is counted as 0.5 FTE, unless his or her chosen specialty
1062 is in primary care, in which case the resident is counted as 1.0
1063 FTE. For the purposes of this section, primary care specialties
1064 include:

- 1065 1. Family medicine;
- 1066 2. General internal medicine;



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- 1067 | 3. General pediatrics;
- 1068 | 4. Preventive medicine;
- 1069 | 5. Geriatric medicine;
- 1070 | 6. Osteopathic general practice;
- 1071 | 7. Obstetrics and gynecology;
- 1072 | 8. Emergency medicine; ~~and~~
- 1073 | 9. General surgery; and
- 1074 | 10. Psychiatry.

1075 | (b) "Medicaid payments" means the estimated total payments
 1076 | for reimbursing a hospital for direct inpatient services for the
 1077 | fiscal year in which the allocation fraction is calculated based
 1078 | on the hospital inpatient appropriation and the parameters for
 1079 | the inpatient diagnosis-related group base rate, including
 1080 | applicable intergovernmental transfers, specified in the General
 1081 | Appropriations Act, as determined by the agency. Effective July
 1082 | 1, 2017, the term "Medicaid payments" means the estimated total
 1083 | payments for reimbursing a hospital for direct inpatient and
 1084 | outpatient services for the fiscal year in which the allocation
 1085 | fraction is calculated based on the hospital inpatient
 1086 | appropriation and outpatient appropriation and the parameters
 1087 | for the inpatient diagnosis-related group base rate, including
 1088 | applicable intergovernmental transfers, specified in the General
 1089 | Appropriations Act, as determined by the agency.

1090 | (c) "Qualifying institution" means a federally Qualified
 1091 | Health Center holding an Accreditation Council for Graduate
 1092 | Medical Education institutional accreditation.



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1093 (3) The agency shall use the following formula to
1094 calculate a participating hospital's and qualifying
1095 institution's allocation fraction:
1096
$$\text{HAF} = [0.9 \times (\text{HFTE}/\text{TFTE})] + [0.1 \times (\text{HMP}/\text{TMP})]$$

1097 Where:
1098 HAF=A hospital's and qualifying institution's allocation
1099 fraction.
1100 HFTE=A hospital's and qualifying institution's total number
1101 of FTE residents.
1102 TFTE=The total FTE residents for all participating
1103 hospitals and qualifying institutions.
1104 HMP=A hospital's and qualifying institution's Medicaid
1105 payments.
1106 TMP=The total Medicaid payments for all participating
1107 hospitals and qualifying institutions.
1108 (4) A hospital's and qualifying institution's annual
1109 allocation shall be calculated by multiplying the funds
1110 appropriated for the Statewide Medicaid Residency Program in the
1111 General Appropriations Act by that hospital's and qualifying
1112 institution's allocation fraction. If the calculation results in
1113 an annual allocation that exceeds two times the average per FTE
1114 resident amount for all hospitals and qualifying institutions,
1115 the hospital's and qualifying institution's annual allocation
1116 shall be reduced to a sum equaling no more than two times the
1117 average per FTE resident. The funds calculated for that hospital
1118 and qualifying institution in excess of two times the average



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1119 | per FTE resident amount for all hospitals and qualifying
1120 | institutions shall be redistributed to participating hospitals
1121 | and qualifying institutions whose annual allocation does not
1122 | exceed two times the average per FTE resident amount for all
1123 | hospitals and qualifying institutions, using the same
1124 | methodology and payment schedule specified in this section.

1125 | (5) The Graduate Medical Education Startup Bonus Program
1126 | is established to provide resources for the education and
1127 | training of physicians in specialties which are in a statewide
1128 | supply-and-demand deficit. Hospitals eligible for participation
1129 | in subsection (1) are eligible to participate in the Graduate
1130 | Medical Education Startup Bonus Program established under this
1131 | subsection. Notwithstanding subsection (4) or an FTE's residency
1132 | period, and in any state fiscal year in which funds are
1133 | appropriated for the startup bonus program, the agency shall
1134 | allocate a \$100,000 startup bonus for each newly created
1135 | resident position that is authorized by the Accreditation
1136 | Council for Graduate Medical Education or Osteopathic
1137 | Postdoctoral Training Institution in an initial or established
1138 | accredited training program that is in a physician specialty in
1139 | statewide supply-and-demand deficit. In any year in which
1140 | funding is not sufficient to provide \$100,000 for each newly
1141 | created resident position, funding shall be reduced pro rata
1142 | across all newly created resident positions in physician
1143 | specialties in statewide supply-and-demand deficit.

1144 | (a) Hospitals applying for a startup bonus must submit to



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1145 | the agency by March 1 their Accreditation Council for Graduate
1146 | Medical Education or Osteopathic Postdoctoral Training
1147 | Institution approval validating the new resident positions
1148 | approved on or after March 2 of the prior fiscal year through
1149 | March 1 of the current fiscal year for the physician specialties
1150 | identified in a statewide supply-and-demand deficit as provided
1151 | in the current fiscal year's General Appropriations Act ~~in~~
1152 | ~~physician specialties in statewide supply and demand deficit in~~
1153 | ~~the current fiscal year.~~ An applicant hospital may validate a
1154 | change in the number of residents by comparing the number in the
1155 | prior period Accreditation Council for Graduate Medical
1156 | Education or Osteopathic Postdoctoral Training Institution
1157 | approval to the number in the current year.

1158 | Section 21. Paragraph (b) of subsection (2) of section
1159 | 409.967, Florida Statutes, is amended to read:

1160 | 409.967 Managed care plan accountability.—

1161 | (2) The agency shall establish such contract requirements
1162 | as are necessary for the operation of the statewide managed care
1163 | program. In addition to any other provisions the agency may deem
1164 | necessary, the contract must require:

1165 | (b) Emergency services.—Managed care plans shall pay for
1166 | services required by ss. 395.1041 and 401.45 and rendered by a
1167 | noncontracted provider. The plans must comply with s. 641.3155.
1168 | Reimbursement for services under this paragraph is the lesser
1169 | of:

1170 | 1. The provider's charges;



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1171 2. The usual and customary provider charges for similar
 1172 services in the community where the services were provided;
 1173 3. The charge mutually agreed to by the entity and the
 1174 provider within 60 days after submittal of the claim; or
 1175 4. The Medicaid rate, which, for the purposes of this
 1176 paragraph, means the amount the provider would collect from the
 1177 agency on a fee-for-service basis, less any amounts for the
 1178 indirect costs of medical education and the direct costs of
 1179 graduate medical education that are otherwise included in the
 1180 agency's fee-for-service payment, as required under 42 U.S.C. s.
 1181 1396u-2(b)(2)(D) ~~the agency would have paid on the most recent~~
 1182 October 1st. For the purpose of establishing the amounts
 1183 specified in this subparagraph, the agency shall publish on its
 1184 website annually, or more frequently as needed, the applicable
 1185 fee-for-service fee schedules and their effective dates, less
 1186 any amounts for indirect costs of medical education and direct
 1187 costs of graduate medical education that are otherwise included
 1188 in the agency's fee-for-service payments.

1189 Section 22. Subsection (4) of section 409.968, Florida
 1190 Statutes, is renumbered as subsection (5), and a new subsection
 1191 (4) is added to that section to read:

1192 409.968 Managed care plan payments.—

1193 (4) (a) Subject to a specific appropriation and federal
 1194 approval under s. 409.906(13)(e), the agency shall establish a
 1195 payment methodology to fund managed care plans for flexible
 1196 services for persons with severe mental illness and substance



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1197 use disorders, including, but not limited to, temporary housing
 1198 assistance. A managed care plan eligible for these payments must
 1199 do all of the following:

1200 1. Participate as a specialty plan for severe mental
 1201 illness or substance use disorders or participate in counties
 1202 designated by the General Appropriations Act;

1203 2. Include providers of behavioral health services
 1204 pursuant to chapters 394 and 397 in the managed care plan's
 1205 provider network; and

1206 3. Document a capability to provide housing assistance
 1207 through agreements with housing providers, relationships with
 1208 local housing coalitions, and other appropriate arrangements.

1209 (b) After receiving payments authorized by this subsection
 1210 for at least 1 year, a managed care plan must document the
 1211 results of its efforts to maintain the target population in
 1212 stable housing up to the maximum duration allowed under federal
 1213 approval.

1214 Section 23. Subsections (1) and (6) of section 409.975,
 1215 Florida Statutes, are amended to read:

1216 409.975 Managed care plan accountability.—In addition to
 1217 the requirements of s. 409.967, plans and providers
 1218 participating in the managed medical assistance program shall
 1219 comply with the requirements of this section.

1220 (1) PROVIDER NETWORKS.—Managed care plans must develop and
 1221 maintain provider networks that meet the medical needs of their
 1222 enrollees in accordance with standards established pursuant to



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1223 s. 409.967(2)(c). Except as provided in this section, managed
 1224 care plans may limit the providers in their networks based on
 1225 credentials, quality indicators, and price.

1226 (a) Plans must include all providers in the region that
 1227 are classified by the agency as essential Medicaid providers,
 1228 unless the agency approves, in writing, an alternative
 1229 arrangement for securing the types of services offered by the
 1230 essential providers. Providers are essential for serving
 1231 Medicaid enrollees if they offer services that are not available
 1232 from any other provider within a reasonable access standard, or
 1233 if they provided a substantial share of the total units of a
 1234 particular service used by Medicaid patients within the region
 1235 during the last 3 years and the combined capacity of other
 1236 service providers in the region is insufficient to meet the
 1237 total needs of the Medicaid patients. The agency may not
 1238 classify physicians and other practitioners as essential
 1239 providers. The agency, at a minimum, shall determine which
 1240 providers in the following categories are essential Medicaid
 1241 providers:

- 1242 1. Federally qualified health centers.
- 1243 2. Statutory teaching hospitals as defined in s.
 1244 408.07(45).
- 1245 3. Hospitals that are trauma centers as defined in s.
 1246 395.4001(14).
- 1247 4. Hospitals located at least 25 miles from any other
 1248 hospital with similar services.



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1249
1250 Managed care plans that have not contracted with all essential
1251 providers in the region as of the first date of recipient
1252 enrollment, or with whom an essential provider has terminated
1253 its contract, must negotiate in good faith with such essential
1254 providers for 1 year or until an agreement is reached, whichever
1255 is first. Payments for services rendered by a nonparticipating
1256 essential provider shall be made at the applicable Medicaid rate
1257 as of the first day of the contract between the agency and the
1258 plan. A rate schedule for all essential providers shall be
1259 attached to the contract between the agency and the plan. After
1260 1 year, managed care plans that are unable to contract with
1261 essential providers shall notify the agency and propose an
1262 alternative arrangement for securing the essential services for
1263 Medicaid enrollees. The arrangement must rely on contracts with
1264 other participating providers, regardless of whether those
1265 providers are located within the same region as the
1266 nonparticipating essential service provider. If the alternative
1267 arrangement is approved by the agency, payments to
1268 nonparticipating essential providers after the date of the
1269 agency's approval shall equal 90 percent of the applicable
1270 Medicaid rate. Except for payment for emergency services, if the
1271 alternative arrangement is not approved by the agency, payment
1272 to nonparticipating essential providers shall equal 110 percent
1273 of the applicable Medicaid rate.

1274 (b) Certain providers are statewide resources and



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1275 essential providers for all managed care plans in all regions.
 1276 All managed care plans must include these essential providers in
 1277 their networks. Statewide essential providers include:
 1278 1. Faculty plans of Florida medical schools.
 1279 2. Regional perinatal intensive care centers as defined in
 1280 s. 383.16(2).
 1281 3. Hospitals licensed as specialty children's hospitals as
 1282 defined in s. 395.002(28).
 1283 4. Accredited and integrated systems serving medically
 1284 complex children which comprise ~~that are comprised of~~ separately
 1285 licensed, but commonly owned, health care providers delivering
 1286 at least the following services: medical group home, in-home and
 1287 outpatient nursing care and therapies, pharmacy services,
 1288 durable medical equipment, and Prescribed Pediatric Extended
 1289 Care.
 1290
 1291 Managed care plans that have not contracted with all statewide
 1292 essential providers in all regions as of the first date of
 1293 recipient enrollment must continue to negotiate in good faith.
 1294 Payments to physicians on the faculty of nonparticipating
 1295 Florida medical schools shall be made at the applicable Medicaid
 1296 rate. Payments for services rendered by regional perinatal
 1297 intensive care centers shall be made at the applicable Medicaid
 1298 rate as of the first day of the contract between the agency and
 1299 the plan. Except for payments for emergency services, payments
 1300 to nonparticipating specialty children's hospitals shall equal



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1301 the highest rate established by contract between that provider
1302 and any other Medicaid managed care plan.

1303 (c) After 12 months of active participation in a plan's
1304 network, the plan may exclude any essential provider from the
1305 network for failure to meet quality or performance criteria. If
1306 the plan excludes an essential provider from the plan, the plan
1307 must provide written notice to all recipients who have chosen
1308 that provider for care. The notice shall be provided at least 30
1309 days before the effective date of the exclusion. For purposes of
1310 this paragraph, the term "essential provider" includes providers
1311 determined by the agency to be essential Medicaid providers
1312 under paragraph (a) and the statewide essential providers
1313 specified in paragraph (b).

1314 (d) The applicable Medicaid rates for emergency services
1315 paid by a plan under this section to a provider with which the
1316 plan does not have an active contract shall be determined
1317 according to s. 409.967(2)(b).

1318 ~~(e)~~ Each managed care plan must offer a network
1319 contract to each home medical equipment and supplies provider in
1320 the region which meets quality and fraud prevention and
1321 detection standards established by the plan and which agrees to
1322 accept the lowest price previously negotiated between the plan
1323 and another such provider.

1324 (6) PROVIDER PAYMENT.—Managed care plans and hospitals
1325 shall negotiate mutually acceptable rates, methods, and terms of
1326 payment. ~~For rates, methods, and terms of payment negotiated~~



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1327 ~~after the contract between the agency and the plan is executed,~~
 1328 ~~plans shall pay hospitals, at a minimum, the rate the agency~~
 1329 ~~would have paid on the first day of the contract between the~~
 1330 ~~provider and the plan.~~ Such payments to hospitals may not exceed
 1331 120 percent of the rate the agency would have paid on the first
 1332 day of the contract between the provider and the plan, unless
 1333 specifically approved by the agency. Payment rates may be
 1334 updated periodically.

1335 Section 24. Paragraph (b) of subsection (3) of section
 1336 624.91, Florida Statutes, is amended to read:

1337 624.91 The Florida Healthy Kids Corporation Act.—

1338 (3) ELIGIBILITY FOR STATE-FUNDED ASSISTANCE.—Only the
 1339 following individuals are eligible for state-funded assistance
 1340 in paying Florida Healthy Kids premiums:

1341 (b) Notwithstanding s. 409.814, a legal alien ~~aliens~~ who
 1342 is ~~are~~ enrolled in the Florida Healthy Kids program as of
 1343 January 31, 2004, who does ~~do~~ not qualify for Title XXI federal
 1344 funds because he or she is ~~they are~~ not a lawfully residing
 1345 child ~~qualified aliens~~ as defined in s. 409.811.

1346 Section 25. Subsection (6) of section 641.513, Florida
 1347 Statutes, is amended, and subsection (7) is added to that
 1348 section, to read:

1349 641.513 Requirements for providing emergency services and
 1350 care.—

1351 (6) Reimbursement for services under this section provided
 1352 to subscribers who are Medicaid recipients by a provider for



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1353 whom no contract exists between the provider and the health
1354 maintenance organization shall be determined under chapter 409.
1355 ~~the lesser of:~~

1356 ~~(a) The provider's charges;~~

1357 ~~(b) The usual and customary provider charges for similar
1358 services in the community where the services were provided;~~

1359 ~~(c) The charge mutually agreed to by the entity and the
1360 provider within 60 days after submittal of the claim; or~~

1361 ~~(d) The Medicaid rate.~~

1362 (7) Reimbursement for services under this section provided
1363 to subscribers who are enrolled in a health maintenance
1364 organization pursuant to s. 624.91 by a provider for whom no
1365 contract exists between the provider and the health maintenance
1366 organization shall be the lesser of:

1367 (a) The provider's charges;

1368 (b) The usual and customary provider charges for similar
1369 services in the community where the services were provided;

1370 (c) The charge mutually agreed to by the entity and the
1371 provider within 60 days after submittal of the claim; or

1372 (d) The Medicaid rate.

1373 Section 26. Section 18 of chapter 2012-33, Laws of
1374 Florida, is amended to read:

1375 Section 18. Notwithstanding s. 430.707, Florida Statutes,
1376 and subject to federal approval of an additional site for the
1377 Program of All-Inclusive Care for the Elderly (PACE), the Agency
1378 for Health Care Administration shall contract with a current



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1379 PACE organization authorized to provide PACE services in
1380 Southeast Florida to develop and operate a PACE program in
1381 Broward County to serve frail elders who reside in Broward
1382 County or Miami-Dade County. The organization shall be exempt
1383 from chapter 641, Florida Statutes. The agency, in consultation
1384 with the Department of Elderly Affairs and subject to an
1385 appropriation, shall approve up to 150 initial enrollee slots in
1386 the Broward program established by the organization.

1387 Section 27. Subject to federal approval of the application
1388 to be a site for the Program of All-inclusive Care for the
1389 Elderly (PACE), the Agency for Health Care Administration shall
1390 contract with one private, not-for-profit hospice organization
1391 located in Escambia County that owns and manages health care
1392 organizations licensed in Hospice Service Areas 1, 2A, and 2B
1393 which provide comprehensive services, including, but not limited
1394 to, hospice and palliative care, to frail elders who reside in
1395 those Hospice Service Areas. The organization is exempt from the
1396 requirements of chapter 641, Florida Statutes. The agency, in
1397 consultation with the Department of Elderly Affairs and subject
1398 to the appropriation of funds by the Legislature, shall approve
1399 up to 100 initial enrollees in the Program of All-inclusive Care
1400 for the Elderly established by the organization to serve frail
1401 elders who reside in Hospice Service Areas 1, 2A, and 2B.

1402 Section 28. Subject to federal approval of the application
1403 to be a site for the Program of All-inclusive Care for the
1404 Elderly (PACE), the Agency for Health Care Administration shall



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1405 contract with a not-for-profit organization that has been
1406 jointly formed by a lead agency that has been designated
1407 pursuant to s. 430.205, Florida Statutes, and by a not-for-
1408 profit hospice provider that has been licensed for more than 30
1409 years to serve individuals and families in Clay, Duval, St.
1410 Johns, Baker, and Nassau Counties. The not-for-profit
1411 organization shall leverage existing community-based care
1412 providers and health care organizations to provide PACE services
1413 to frail elders who reside in Clay, Duval, St. Johns, Baker, and
1414 Nassau Counties. The organization is exempt from the
1415 requirements of chapter 641, Florida Statutes. The agency, in
1416 consultation with the Department of Elderly Affairs and subject
1417 to the appropriation of funds by the Legislature, shall approve
1418 up to 300 initial enrollees in the Program of All-inclusive Care
1419 for the Elderly established by the organization to serve frail
1420 elders who reside in Clay, Duval, St. Johns, Baker, and Nassau
1421 Counties.

1422 Section 29. Subject to federal approval of the application
1423 to be a site for the Program of All-inclusive Care for the
1424 Elderly (PACE), the Agency for Health Care Administration shall
1425 contract with one private, not-for-profit hospice organization
1426 located in Lake County which operates health care organizations
1427 licensed in Hospice Areas 7B and 3E and which provides
1428 comprehensive services, including hospice and palliative care,
1429 to frail elders who reside in these service areas. The
1430 organization is exempt from the requirements of chapter 641,



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1431 Florida Statutes. The agency, in consultation with the
1432 Department of Elderly Affairs and subject to the appropriation
1433 of funds by the Legislature, shall approve up to 150 initial
1434 enrollees in the Program of All-inclusive Care for the Elderly
1435 established by the organization to serve frail elders who reside
1436 in Hospice Service Areas 7B and 3E.

1437 Section 30. Subject to federal approval of the application
1438 to be a site for the Program of All-inclusive Care for the
1439 Elderly (PACE), the Agency for Health Care Administration shall
1440 contract with one not-for-profit organization that has more than
1441 30 years' experience as a licensed hospice and is currently a
1442 licensed hospice serving individuals and families in Pinellas
1443 County, service area 5B. This not-for-profit organization shall
1444 provide PACE services to frail elders who reside in Hillsborough
1445 County. The organization is exempt from the requirements of
1446 chapter 641, Florida Statutes. The agency, in consultation with
1447 the Department of Elderly Affairs and subject to the
1448 appropriation of funds by the Legislature, shall approve up to
1449 150 initial enrollees in the Program of All-inclusive Care for
1450 the Elderly established by the organization to serve frail
1451 elders who reside in Hillsborough County.

1452 Section 31. Subsection (3) of section 391.055, Florida
1453 Statutes, is amended to read:

1454 391.055 Service delivery systems.—

1455 (3) The Children's Medical Services network may contract
1456 with school districts participating in the certified school



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1457 match program pursuant to ss. 409.908(22) ~~409.908(21)~~ and
1458 1011.70 for the provision of school-based services, as provided
1459 for in s. 409.9071, for Medicaid-eligible children who are
1460 enrolled in the Children's Medical Services network.

1461 Section 32. Subsection (3) of section 427.0135, Florida
1462 Statutes, is amended to read:

1463 427.0135 Purchasing agencies; duties and
1464 responsibilities.—Each purchasing agency, in carrying out the
1465 policies and procedures of the commission, shall:

1466 (3) Not procure transportation disadvantaged services
1467 without initially negotiating with the commission, as provided
1468 in s. 287.057(3)(e)12., or unless otherwise authorized by
1469 statute. If the purchasing agency, after consultation with the
1470 commission, determines that it cannot reach mutually acceptable
1471 contract terms with the commission, the purchasing agency may
1472 contract for the same transportation services provided in a more
1473 cost-effective manner and of comparable or higher quality and
1474 standards. The Medicaid agency shall implement this subsection
1475 in a manner consistent with s. 409.908(19) ~~409.908(18)~~ and as
1476 otherwise limited or directed by the General Appropriations Act.

1477 Section 33. Paragraph (d) of subsection (2) of section
1478 1002.385, Florida Statutes, is amended to read:

1479 1002.385 Florida personal learning scholarship accounts.—

1480 (2) DEFINITIONS.—As used in this section, the term:

1481 (d) "Disability" means, for a student in kindergarten to
1482 grade 12, autism, as defined in s. 393.063(3); cerebral palsy,



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1483 as defined in s. 393.063(4); Down syndrome, as defined in s.
 1484 393.063(13); an intellectual disability, as defined in s.
 1485 393.063(21); Phelan-McDermid syndrome, as defined in s.
 1486 393.063(25); Prader-Willi syndrome, as defined in s. 393.063(26)
 1487 ~~393.063(25);~~ or spina bifida, as defined in s. 393.063(37)
 1488 ~~393.063(36);~~ for a student in kindergarten, being a high-risk
 1489 child, as defined in s. 393.063(20) (a); and Williams syndrome.

1490 Section 34. Subsections (1) and (5) of section 1011.70,
 1491 Florida Statutes, are amended to read:

1492 1011.70 Medicaid certified school funding maximization.—

1493 (1) Each school district, subject to the provisions of ss.
 1494 409.9071 and 409.908(22) ~~409.908(21)~~ and this section, is
 1495 authorized to certify funds provided for a category of required
 1496 Medicaid services termed "school-based services," which are
 1497 reimbursable under the federal Medicaid program. Such services
 1498 shall include, but not be limited to, physical, occupational,
 1499 and speech therapy services, behavioral health services, mental
 1500 health services, transportation services, Early Periodic
 1501 Screening, Diagnosis, and Treatment (EPSDT) administrative
 1502 outreach for the purpose of determining eligibility for
 1503 exceptional student education, and any other such services, for
 1504 the purpose of receiving federal Medicaid financial
 1505 participation. Certified school funding shall not be available
 1506 for the following services:

- 1507 (a) Family planning.
- 1508 (b) Immunizations.



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1509 (c) Prenatal care.

1510 (5) Lab schools, as authorized under s. 1002.32, shall be
1511 authorized to participate in the Medicaid certified school match
1512 program on the same basis as school districts subject to the
1513 provisions of subsections (1)-(4) and ss. 409.9071 and
1514 409.908(22) ~~409.908(21)~~.

1515 Section 35. Except as otherwise provided in this act and
1516 except for this section, which shall take effect upon this act
1517 becoming a law, this act shall take effect July 1, 2016.