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LEGISLATIVE ACTION

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05/08/2017 04:19 PM	.	05/08/2017 07:47 PM
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The Conference Committee on SB 2514, 1st Eng. recommended the following:

Senate Conference Committee Amendment (with title amendment)

Delete everything after the enacting clause
and insert:

Section 1. Paragraph (c) of subsection (2) of section 210.20, Florida Statutes, is amended to read:

210.20 Employees and assistants; distribution of funds.—

(2) As collections are received by the division from such cigarette taxes, it shall pay the same into a trust fund in the

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State Treasury designated "Cigarette Tax Collection Trust Fund" which shall be paid and distributed as follows:

(c) Beginning July 1, 2017 ~~2013~~, and continuing through June 30, 2033, the division shall from month to month certify to the Chief Financial Officer the amount derived from the cigarette tax imposed by s. 210.02, less the service charges provided for in s. 215.20 and less 0.9 percent of the amount derived from the cigarette tax imposed by s. 210.02, which shall be deposited into the Alcoholic Beverage and Tobacco Trust Fund, specifying an amount equal to 1 percent of the net collections, not to exceed $3 million annually, and that amount shall be deposited into the Biomedical Research Trust Fund in the Department of Health. These funds are appropriated annually ~~in an amount not to exceed $3 million~~ from the Biomedical Research Trust Fund for the advancement of cures for cancers afflicting pediatric populations through basic or applied research, including, but not limited to, clinical trials and nontoxic drug discovery. These funds are not included in the calculation for the distribution of funds pursuant to s. 381.915; however, these funds shall be distributed to cancer centers participating in the Florida Consortium of National Cancer Institute Centers Program in the same proportion as is allocated to each cancer center in accordance with s. 381.915 and are in addition to any funds distributed pursuant to that section ~~Department of Health and the Sanford-Burnham Medical Research Institute to work in conjunction for the purpose of establishing activities and grant opportunities in relation to biomedical research~~.

Section 2. Subsection (2) of section 381.922, Florida Statutes, is amended to read:


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381.922 William G. “Bill” Bankhead, Jr., and David Coley Cancer Research Program.—

(2) The program shall provide grants for cancer research to further the search for cures for cancer.

(a) Emphasis shall be given to the following goals, as those goals support the advancement of such cures:

1. Efforts to significantly expand cancer research capacity in the state by:

a. Identifying ways to attract new research talent and attendant national grant-producing researchers to cancer research facilities in this state;

b. Implementing a peer-reviewed, competitive process to identify and fund the best proposals to expand cancer research institutes in this state;

c. Funding through available resources for those proposals that demonstrate the greatest opportunity to attract federal research grants and private financial support;

d. Encouraging the employment of bioinformatics in order to create a cancer informatics infrastructure that enhances information and resource exchange and integration through researchers working in diverse disciplines, to facilitate the full spectrum of cancer investigations;

e. Facilitating the technical coordination, business development, and support of intellectual property as it relates to the advancement of cancer research; and

f. Aiding in other multidisciplinary research-support activities as they inure to the advancement of cancer research.

2. Efforts to improve both research and treatment through greater participation in clinical trials networks by:

a. Identifying ways to increase pediatric and adult enrollment in cancer clinical trials;

b. Supporting public and private professional education programs designed to increase the awareness and knowledge about cancer clinical trials;

c. Providing tools to cancer patients and community-based oncologists to aid in the identification of cancer clinical trials available in the state; and

d. Creating opportunities for the state's academic cancer centers to collaborate with community-based oncologists in cancer clinical trials networks.

3. Efforts to reduce the impact of cancer on disparate groups by:

a. Identifying those cancers that disproportionately impact certain demographic groups; and

b. Building collaborations designed to reduce health disparities as they relate to cancer.

(b) Preference may be given to grant proposals that foster collaborations among institutions, researchers, and community practitioners, as such proposals support the advancement of cures through basic or applied research, including clinical trials involving cancer patients and related networks.

(c) There is established within the program the Live Like Bella Initiative. The purpose of the initiative is to advance progress toward curing pediatric cancer by awarding grants through the peer-reviewed, competitive process established under subsection (3). This paragraph is subject to the annual appropriation of funds by the Legislature.

Section 3. Paragraph (a) of subsection (10) of section


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394.9082, Florida Statutes, is republished, paragraph (b) of that subsection is amended, and paragraph (f) is added to that subsection, to read:

394.9082 Behavioral health managing entities.—

(10) ACUTE CARE SERVICES UTILIZATION DATABASE.—The department shall develop, implement, and maintain standards under which a managing entity shall collect utilization data from all public receiving facilities situated within its geographical service area and all detoxification and addictions receiving facilities under contract with the managing entity. As used in this subsection, the term "public receiving facility" means an entity that meets the licensure requirements of, and is designated by, the department to operate as a public receiving facility under s. 394.875 and that is operating as a licensed crisis stabilization unit.

(a) The department shall develop standards and protocols to be used for data collection, storage, transmittal, and analysis. The standards and protocols shall allow for compatibility of data and data transmittal between public receiving facilities, detoxification facilities, addictions receiving facilities, managing entities, and the department for the implementation, and to meet the requirements, of this subsection.

(b) A managing entity shall require providers specified in paragraph (a) to submit data, in real time or at least daily, to the managing entity for:

1. All admissions and discharges of clients receiving public receiving facility services who qualify as indigent, as defined in s. 394.4787.

2. All admissions and discharges of clients receiving

substance abuse services in an addictions receiving facility or detoxification facility pursuant to parts IV and V of chapter 397 who qualify as indigent.

3. The current active census of total licensed ~~and utilized~~ beds, the number of beds purchased by the department, the number of clients qualifying as indigent occupying ~~who occupy any of~~ those beds, and the total number of unoccupied licensed beds, regardless of funding~~, and the number in excess of licensed capacity. Crisis units licensed for both adult and child use will report as a single unit~~.

(f) The department shall post on its website, by facility, the data collected pursuant to this subsection and update such posting monthly.

Section 4. Paragraph (e) of subsection (2) of section 395.602, Florida Statutes, is amended to read:

395.602 Rural hospitals.—

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

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

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

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

3. A hospital supported by a tax district or subdistrict whose boundaries encompass a population of up to 100 persons per


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square mile;

4. A hospital classified as a sole community hospital under 42 C.F.R. s. 412.92, regardless of the number of ~~which has up to 175~~ licensed beds;

5. A hospital with a service area that has a population of up to 100 persons per square mile. As used in this subparagraph, the term "service area" means the fewest number of zip codes that account for 75 percent of the hospital's discharges for the most recent 5-year period, based on information available from the hospital inpatient discharge database in the Florida Center for Health Information and Transparency at the agency; or

6. A hospital designated as a critical access hospital, as defined in s. 408.07.

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


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Section 5. Effective October 1, 2018, paragraph (d) of subsection (2) of section 400.179, Florida Statutes, is amended to read:

400.179 Liability for Medicaid underpayments and overpayments.—

(2) Because any transfer of a nursing facility may expose the fact that Medicaid may have underpaid or overpaid the transferor, and because in most instances, any such underpayment or overpayment can only be determined following a formal field audit, the liabilities for any such underpayments or overpayments shall be as follows:

(d) Where the transfer involves a facility that has been leased by the transferor:

1. The transferee shall, as a condition to being issued a license by the agency, acquire, maintain, and provide proof to the agency of a bond with a term of 30 months, renewable annually, in an amount not less than the total of 3 months' Medicaid payments to the facility computed on the basis of the preceding 12-month average Medicaid payments to the facility.

2. A leasehold licensee may meet the requirements of subparagraph 1. by payment of a nonrefundable fee, paid at initial licensure, paid at the time of any subsequent change of ownership, and paid annually thereafter, in the amount of 1 percent of the total of 3 months' Medicaid payments to the facility computed on the basis of the preceding 12-month average Medicaid payments to the facility. If a preceding 12-month average is not available, projected Medicaid payments may be used. The fee shall be deposited into the Grants and Donations Trust Fund and shall be accounted for separately as a Medicaid


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nursing home overpayment account. These fees shall be used at the sole discretion of the agency to repay nursing home Medicaid overpayments or for enhanced payments to nursing facilities as specified in the General Appropriations Act or other law. Payment of this fee shall not release the licensee from any liability for any Medicaid overpayments, nor shall payment bar the agency from seeking to recoup overpayments from the licensee and any other liable party. As a condition of exercising this lease bond alternative, licensees paying this fee must maintain an existing lease bond through the end of the 30-month term period of that bond. The agency is herein granted specific authority to promulgate all rules pertaining to the administration and management of this account, including withdrawals from the account, subject to federal review and approval. This provision shall take effect upon becoming law and shall apply to any leasehold license application. The financial viability of the Medicaid nursing home overpayment account shall be determined by the agency through annual review of the account balance and the amount of total outstanding, unpaid Medicaid overpayments owing from leasehold licensees to the agency as determined by final agency audits. By March 31 of each year, the agency shall assess the cumulative fees collected under this subparagraph, minus any amounts used to repay nursing home Medicaid overpayments and amounts transferred to contribute to the General Revenue Fund pursuant to s. 215.20. If the net cumulative collections, minus amounts utilized to repay nursing home Medicaid overpayments, exceed $25 million, the provisions of this subparagraph shall not apply for the subsequent fiscal year.


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3. The leasehold licensee may meet the bond requirement through other arrangements acceptable to the agency. The agency is herein granted specific authority to promulgate rules pertaining to lease bond arrangements.

4. All existing nursing facility licensees, operating the facility as a leasehold, shall acquire, maintain, and provide proof to the agency of the 30-month bond required in subparagraph 1., above, on and after July 1, 1993, for each license renewal.

5. It shall be the responsibility of all nursing facility operators, operating the facility as a leasehold, to renew the 30-month bond and to provide proof of such renewal to the agency annually.

6. Any failure of the nursing facility operator to acquire, maintain, renew annually, or provide proof to the agency shall be grounds for the agency to deny, revoke, and suspend the facility license to operate such facility and to take any further action, including, but not limited to, enjoining the facility, asserting a moratorium pursuant to part II of chapter 408, or applying for a receiver, deemed necessary to ensure compliance with this section and to safeguard and protect the health, safety, and welfare of the facility's residents. A lease agreement required as a condition of bond financing or refinancing under s. 154.213 by a health facilities authority or required under s. 159.30 by a county or municipality is not a leasehold for purposes of this paragraph and is not subject to the bond requirement of this paragraph.

Section 6. Subsection (11) is added to section 409.904, Florida Statutes, to read:

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

(11) Subject to federal waiver approval, a person diagnosed with acquired immune deficiency syndrome (AIDS) who has an AIDS-related opportunistic infection and is at risk of hospitalization as determined by the agency and whose income is at or below 300 percent of the Federal Benefit Rate.

Section 7. Paragraph (b) of subsection (13) of section 409.906, Florida Statutes, is amended to read:

409.906 Optional Medicaid services.—Subject to specific appropriations, the agency may make payments for services which are optional to the state under Title XIX of the Social Security Act and are furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any optional service that is provided shall be provided only when medically necessary and in accordance with state and federal law. Optional services rendered by providers in mobile units to Medicaid recipients may be restricted or prohibited by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or

directions provided for in the General Appropriations Act or chapter 216. If necessary to safeguard the state's systems of providing services to elderly and disabled persons and subject to the notice and review provisions of s. 216.177, the Governor may direct the Agency for Health Care Administration to amend the Medicaid state plan to delete the optional Medicaid service known as "Intermediate Care Facilities for the Developmentally Disabled." Optional services may include:

(13) HOME AND COMMUNITY-BASED SERVICES.—

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

Section 8. Effective October 1, 2018, subsection (2) of section 409.908, Florida Statutes, is amended to read:

409.908 Reimbursement of Medicaid providers.—Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. If a provider is reimbursed based


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on cost reporting and submits a cost report late and that cost report would have been used to set a lower reimbursement rate for a rate semester, then the provider's rate for that semester shall be retroactively calculated using the new cost report, and full payment at the recalculated rate shall be effected retroactively. Medicare-granted extensions for filing cost reports, if applicable, shall also apply to Medicaid cost reports. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(2)(a)1. Reimbursement to nursing homes licensed under part II of chapter 400 and state-owned-and-operated intermediate care facilities for the developmentally disabled licensed under part VIII of chapter 400 must be made prospectively.

2. Unless otherwise limited or directed in the General Appropriations Act, reimbursement to hospitals licensed under part I of chapter 395 for the provision of swing-bed nursing home services must be made on the basis of the average statewide nursing home payment, and reimbursement to a hospital licensed under part I of chapter 395 for the provision of skilled nursing services must be made on the basis of the average nursing home

payment for those services in the county in which the hospital is located. When a hospital is located in a county that does not have any community nursing homes, reimbursement shall be determined by averaging the nursing home payments in counties that surround the county in which the hospital is located. Reimbursement to hospitals, including Medicaid payment of Medicare copayments, for skilled nursing services shall be limited to 30 days, unless a prior authorization has been obtained from the agency. Medicaid reimbursement may be extended by the agency beyond 30 days, and approval must be based upon verification by the patient's physician that the patient requires short-term rehabilitative and recuperative services only, in which case an extension of no more than 15 days may be approved. Reimbursement to a hospital licensed under part I of chapter 395 for the temporary provision of skilled nursing services to nursing home residents who have been displaced as the result of a natural disaster or other emergency may not exceed the average county nursing home payment for those services in the county in which the hospital is located and is limited to the period of time which the agency considers necessary for continued placement of the nursing home residents in the hospital.

(b) Subject to any limitations or directions in the General Appropriations Act, the agency shall establish and implement a state Title XIX Long-Term Care Reimbursement Plan for nursing home care in order to provide care and services in conformance with the applicable state and federal laws, rules, regulations, and quality and safety standards and to ensure that individuals eligible for medical assistance have reasonable geographic

access to such care.

1. The agency shall amend the long-term care reimbursement plan and cost reporting system to create direct care and indirect care subcomponents of the patient care component of the per diem rate. These two subcomponents together shall equal the patient care component of the per diem rate. Separate prices ~~cost-based ceilings~~ shall be calculated for each patient care subcomponent, initially based on the September 2016 rate setting cost reports and subsequently based on the most recently audited cost report used during a rebasing year. The direct care subcomponent of the per diem rate for any providers still being reimbursed on a cost basis shall be limited by the cost-based class ceiling, and the indirect care subcomponent may be limited by the lower of the cost-based class ceiling, the target rate class ceiling, or the individual provider target. The ceilings and targets apply only to providers being reimbursed on a cost-based system. Effective October 1, 2018, a prospective payment methodology shall be implemented for rate setting purposes with the following parameters:

a. Peer Groups, including:

(I) North-SMMC Regions 1-9, less Palm Beach and Okeechobee Counties; and

(II) South-SMMC Regions 10-11, plus Palm Beach and Okeechobee Counties.

b. Percentage of Median Costs based on the cost reports used for September 2016 rate setting:

(I) Direct Care Costs.....100 percent.

(II) Indirect Care Costs.....92 percent.

(III) Operating Costs.....86 percent.

c. Floors:

(I) Direct Care Component.....95 percent.

(II) Indirect Care Component.....92.5 percent.

(III) Operating Component.....None.

d. Pass-through Payments...Real Estate and Personal Property Taxes and Property Insurance.

e. Quality Incentive Program Payment Pool.....6 percent of September 2016 non-property related payments of included facilities.

f. Quality Score Threshold to Quality for Quality Incentive Payment.....20th percentile of included facilities.

g. Fair Rental Value System Payment Parameters:

(I) Building Value per Square Foot based on 2018 RS Means.

(II) Land Valuation.....10 percent of Gross Building value.

(III) Facility Square Footage.....Actual Square Footage.

(IV) Moveable Equipment Allowance.....$8,000 per bed.

(V) Obsolescence Factor.....1.5 percent.

(VI) Fair Rental Rate of Return.....8 percent.

(VII) Minimum Occupancy.....90 percent.

(VIII) Maximum Facility Age.....40 years.

(IX) Minimum Square Footage per Bed.....350.

(X) Maximum Square Footage for Bed.....500.

(XI) Minimum Cost of a renovation/replacements.$500 per bed.

h. Ventilator Supplemental payment of $200 per Medicaid day of 40,000 ventilator Medicaid days per fiscal year.

2. The direct care subcomponent shall include salaries and benefits of direct care staff providing nursing services including registered nurses, licensed practical nurses, and certified nursing assistants who deliver care directly to


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residents in the nursing home facility, allowable therapy costs, and dietary costs. This excludes nursing administration, staff development, the staffing coordinator, and the administrative portion of the minimum data set and care plan coordinators. The direct care subcomponent also includes medically necessary dental care, vision care, hearing care, and podiatric care.

3. All other patient care costs shall be included in the indirect care cost subcomponent of the patient care per diem rate, including complex medical equipment, medical supplies, and other allowable ancillary costs. Costs may not be allocated directly or indirectly to the direct care subcomponent from a home office or management company.

4. On July 1 of each year, the agency shall report to the Legislature direct and indirect care costs, including average direct and indirect care costs per resident per facility and direct care and indirect care salaries and benefits per category of staff member per facility.

5. Every fourth year, the agency shall rebase nursing home prospective payment rates to reflect changes in cost based on the most recently audited cost report for each participating provider ~~In order to offset the cost of general and professional liability insurance, the agency shall amend the plan to allow for interim rate adjustments to reflect increases in the cost of general or professional liability insurance for nursing homes. This provision shall be implemented to the extent existing appropriations are available~~.

6. A direct care supplemental payment may be made to providers whose direct care hours per patient day are above the 80th percentile and who provide Medicaid services to a larger


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percentage of Medicaid patients than the state average.

7. For the period beginning on October 1, 2018, and ending on September 30, 2021, the agency shall reimburse providers the greater of their September 2016 cost-based rate or their prospective payment rate. Effective October 1, 2021, the agency shall reimburse providers the greater of 95 percent of their cost-based rate or their rebased prospective payment rate, using the most recently audited cost report for each facility. This subparagraph shall expire September 30, 2023.

8. Pediatric, Florida Department of Veterans Affairs, and government-owned facilities are exempt from the pricing model established in this subsection and shall remain on a cost-based prospective payment system. Effective October 1, 2018, the agency shall set rates for all facilities remaining on a cost-based prospective payment system using each facility's most recently audited cost report, eliminating retroactive settlements.

It is the intent of the Legislature that the reimbursement plan achieve the goal of providing access to health care for nursing home residents who require large amounts of care while encouraging diversion services as an alternative to nursing home care for residents who can be served within the community. The agency shall base the establishment of any maximum rate of payment, whether overall or component, on the available moneys as provided for in the General Appropriations Act. The agency may base the maximum rate of payment on the results of scientifically valid analysis and conclusions derived from objective statistical data pertinent to the particular maximum

rate of payment.

Section 9. Subsections (6) through (26) of section 409.908, Florida Statutes, are renumbered as subsections (5) through (25), respectively, present subsections (5), (14), and (24) are amended, and a new subsection (26) is added to that section, to read:

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


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lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

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

(13)~~(14)~~ Medicare premiums for persons eligible for both Medicare and Medicaid coverage shall be paid at the rates established by Title XVIII of the Social Security Act. For Medicare services rendered to Medicaid-eligible persons, Medicaid shall pay Medicare deductibles and coinsurance as follows:

(a) Medicaid’s financial obligation for deductibles and coinsurance payments shall be based on Medicare allowable fees, not on a provider’s billed charges.

(b) Medicaid will pay no portion of Medicare deductibles and coinsurance when payment that Medicare has made for the service equals or exceeds what Medicaid would have paid if it had been the sole payor. The combined payment of Medicare and Medicaid shall not exceed the amount Medicaid would have paid had it been the sole payor. The Legislature finds that there has been confusion regarding the reimbursement for services rendered to dually eligible Medicare beneficiaries. Accordingly, the Legislature clarifies that it has always been the intent of the Legislature before and after 1991 that, in reimbursing in accordance with fees established by Title XVIII for premiums, deductibles, and coinsurance for Medicare services rendered by


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physicians to Medicaid eligible persons, physicians be reimbursed at the lesser of the amount billed by the physician or the Medicaid maximum allowable fee established by the Agency for Health Care Administration, as is permitted by federal law. It has never been the intent of the Legislature with regard to such services rendered by physicians that Medicaid be required to provide any payment for deductibles, coinsurance, or copayments for Medicare cost sharing, or any expenses incurred relating thereto, in excess of the payment amount provided for under the State Medicaid plan for such service. This payment methodology is applicable even in those situations in which the payment for Medicare cost sharing for a qualified Medicare beneficiary with respect to an item or service is reduced or eliminated. This expression of the Legislature is in clarification of existing law and shall apply to payment for, and with respect to provider agreements with respect to, items or services furnished on or after the effective date of this act. This paragraph applies to payment by Medicaid for items and services furnished before the effective date of this act if such payment is the subject of a lawsuit that is based on the provisions of this section, and that is pending as of, or is initiated after, the effective date of this act.

(c) Notwithstanding paragraphs (a) and (b):

1. Medicaid payments for Nursing Home Medicare part A coinsurance are limited to the Medicaid nursing home per diem rate less any amounts paid by Medicare, but only up to the amount of Medicare coinsurance. The Medicaid per diem rate shall be the rate in effect for the dates of service of the crossover claims and may not be subsequently adjusted due to subsequent

per diem rate adjustments.

2. Medicaid shall pay all deductibles and coinsurance for Medicare-eligible recipients receiving freestanding end stage renal dialysis center services.

3. Medicaid payments for general and specialty hospital inpatient services are limited to the Medicare deductible and coinsurance per spell of illness. Medicaid payments for hospital Medicare Part A coinsurance shall be limited to the Medicaid hospital per diem rate less any amounts paid by Medicare, but only up to the amount of Medicare coinsurance. Medicaid payments for coinsurance shall be limited to the Medicaid per diem rate in effect for the dates of service of the crossover claims and may not be subsequently adjusted due to subsequent per diem adjustments.

4. Medicaid shall pay all deductibles and coinsurance for Medicare emergency transportation services provided by ambulances licensed pursuant to chapter 401.

5. Medicaid shall pay all deductibles and coinsurance for portable X-ray Medicare Part B services provided in a nursing home, in an assisted living facility, or in the patient's home.

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

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

(c) Base rate reimbursement for outpatient services under

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an enhanced ambulatory payment group methodology shall be provided in the General Appropriations Act.

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

~~1. Inpatient hospitals.~~

~~2. Outpatient hospitals.~~

1. ~~3.~~ Nursing homes.

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

~~5. Prepaid health plans.~~

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

(26) The agency may receive funds from state entities, including, but not limited to, the Department of Health, local governments, and other local political subdivisions, for the purpose of making special exception payments, including federal matching funds. Funds received for this purpose shall be separately accounted for and may not be commingled with other state or local funds in any manner. The agency may certify all local governmental funds used as state match under Title XIX of the Social Security Act to the extent and in the manner authorized under the General Appropriations Act and pursuant to an agreement between the agency and the local governmental entity. In order for the agency to certify such local governmental funds, a local governmental entity must submit a final, executed letter of agreement to the agency, which must be received by October 1 of each fiscal year and provide the total amount of local governmental funds authorized by the entity for that fiscal year under the General Appropriations Act. The local governmental entity shall use a certification form prescribed by


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the agency. At a minimum, the certification form must identify the amount being certified and describe the relationship between the certifying local governmental entity and the local health care provider. Local governmental funds outlined in the letters of agreement must be received by the agency no later than October 31 of each fiscal year in which such funds are pledged, unless an alternative plan is specifically approved by the agency.

Section 10. Effective October 1, 2018, subsection (4) of section 409.9082, Florida Statutes, is amended to read:

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

(4) The purpose of the nursing home facility quality assessment is to ensure continued quality of care. Collected assessment funds shall be used to obtain federal financial participation through the Medicaid program to make Medicaid payments for nursing home facility services up to the amount of nursing home facility Medicaid rates as calculated in accordance with the approved state Medicaid plan in effect on December 31, 2007. The quality assessment and federal matching funds shall be used exclusively for the following purposes and in the following order of priority:

(a) To reimburse the Medicaid share of the quality assessment as a pass-through, Medicaid-allowable cost;

(b) To increase to each nursing home facility’s Medicaid rate, as needed, an amount that restores rate reductions effective on or after January 1, 2008, as provided in the General Appropriations Act; and


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(c) To partially fund the quality incentive payment program for nursing facilities that exceed quality benchmarks ~~increase each nursing home facility's Medicaid rate that accounts for the portion of the total assessment not included in paragraphs (a) and (b) which begins a phase-in to a pricing model for the operating cost component~~.

Section 11. Section 409.909, Florida Statutes, is amended to read:

409.909 Statewide Medicaid Residency Program.—

(1) The Statewide Medicaid Residency Program is established to improve the quality of care and access to care for Medicaid recipients, expand graduate medical education on an equitable basis, and increase the supply of highly trained physicians statewide. The agency shall make payments to hospitals licensed under part I of chapter 395 and to qualifying institutions as defined in paragraph (2)(c) for graduate medical education associated with the Medicaid program. This system of payments is designed to generate federal matching funds under Medicaid and distribute the resulting funds to participating hospitals on a quarterly basis in each fiscal year for which an appropriation is made.

(2) On or before September 15 of each year, the agency shall calculate an allocation fraction to be used for distributing funds to participating hospitals and to qualifying institutions as defined in paragraph (2)(c). On or before the final business day of each quarter of a state fiscal year, the agency shall distribute to each participating hospital one-fourth of that hospital's annual allocation calculated under subsection (4). The allocation fraction for each participating

hospital is based on the hospital's number of full-time equivalent residents and the amount of its Medicaid payments. As used in this section, the term:

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

1. Family medicine;
2. General internal medicine;
3. General pediatrics;
4. Preventive medicine;
5. Geriatric medicine;
6. Osteopathic general practice;
7. Obstetrics and gynecology;
8. Emergency medicine;
9. General surgery; and
10. Psychiatry.

(b) "Medicaid payments" means the estimated total payments


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for reimbursing a hospital for direct inpatient services for the fiscal year in which the allocation fraction is calculated based on the hospital inpatient appropriation and the parameters for the inpatient diagnosis-related group base rate and the parameters for the outpatient enhanced ambulatory payment group rate, including applicable intergovernmental transfers, specified in the General Appropriations Act, as determined by the agency. Effective July 1, 2017, the term "Medicaid payments" means the estimated total payments for reimbursing a hospital and qualifying institutions as defined in paragraph (2)(c) for direct inpatient and outpatient services for the fiscal year in which the allocation fraction is calculated based on the hospital inpatient appropriation and outpatient appropriation and the parameters for the inpatient diagnosis-related group base rate and the parameters for the outpatient enhanced ambulatory payment group rate, including applicable intergovernmental transfers, specified in the General Appropriations Act, as determined by the agency.

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

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

(3) The agency shall use the following formula to calculate

a participating hospital's and qualifying institution's allocation fraction:

HAF=[0.9 x (HFTE/TFTE)] + [0.1 x (HMP/TMP)]

Where:

HAF=A hospital's and qualifying institution's allocation fraction.

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

TFTE=The total FTE residents for all participating hospitals and qualifying institutions.

HMP=A hospital's and qualifying institution's Medicaid payments.

TMP=The total Medicaid payments for all participating hospitals and qualifying institutions.

(4) A hospital's and qualifying institution's annual allocation shall be calculated by multiplying the funds appropriated for the Statewide Medicaid Residency Program in the General Appropriations Act by that hospital's and qualifying institution's allocation fraction. If the calculation results in an annual allocation that exceeds two times the average per FTE resident amount for all hospitals and qualifying institutions, the hospital's and qualifying institution's annual allocation shall be reduced to a sum equaling no more than two times the average per FTE resident. The funds calculated for that hospital and qualifying institution in excess of two times the average per FTE resident amount for all hospitals and qualifying


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

(5) The Graduate Medical Education Startup Bonus Program is established to provide resources for the education and training of physicians in specialties which are in a statewide supply-and-demand deficit. Hospitals and qualifying institutions as defined in paragraph (2)(c) eligible for participation in subsection (1) are eligible to participate in the Graduate Medical Education Startup Bonus Program established under this subsection. Notwithstanding subsection (4) or an FTE's residency period, and in any state fiscal year in which funds are appropriated for the startup bonus program, the agency shall allocate a $100,000 startup bonus for each newly created resident position that is authorized by the Accreditation Council for Graduate Medical Education or Osteopathic Postdoctoral Training Institution in an initial or established accredited training program that is in a physician specialty in statewide supply-and-demand deficit. In any year in which funding is not sufficient to provide $100,000 for each newly created resident position, funding shall be reduced pro rata across all newly created resident positions in physician specialties in statewide supply-and-demand deficit.

(a) Hospitals and qualifying institutions as defined in paragraph (2)(c) applying for a startup bonus must submit to the agency by March 1 their Accreditation Council for Graduate Medical Education or Osteopathic Postdoctoral Training


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Institution approval validating the new resident positions approved on or after March 2 of the prior fiscal year through March 1 of the current fiscal year for the physician specialties identified in a statewide supply-and-demand deficit as provided in the current fiscal year's General Appropriations Act. An applicant hospital or qualifying institution as defined in paragraph (2)(c) may validate a change in the number of residents by comparing the number in the prior period Accreditation Council for Graduate Medical Education or Osteopathic Postdoctoral Training Institution approval to the number in the current year.

(b) Any unobligated startup bonus funds on April 15 of each fiscal year shall be proportionally allocated to hospitals and to qualifying institutions as defined in paragraph (2)(c) participating under subsection (3) for existing FTE residents in the physician specialties in statewide supply-and-demand deficit. This nonrecurring allocation shall be in addition to the funds allocated in subsection (4). Notwithstanding subsection (4), the allocation under this subsection may not exceed $100,000 per FTE resident.

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

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

(6) Beginning in the 2015-2016 state fiscal year, the

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

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

Section 12. Paragraph (a) of subsection (2) of section 409.911, Florida Statutes, is amended, and paragraph (b) of that subsection is republished, to read:

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

(2) The Agency for Health Care Administration shall use the following actual audited data to determine the Medicaid days and charity care to be used in calculating the disproportionate share payment:

(a) The average of the 2009, 2010, and 2011 ~~2007, 2008, and~~


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

(b) If the Agency for Health Care Administration does not have the prescribed 3 years of audited disproportionate share data as noted in paragraph (a) for a hospital, the agency shall use the average of the years of the audited disproportionate share data as noted in paragraph (a) which is available.

Section 13. Section 409.9119, Florida Statutes, is amended to read:

409.9119 Disproportionate share program for specialty hospitals for children.—In addition to the payments made under s. 409.911, the Agency for Health Care Administration shall develop and implement a system under which disproportionate share payments are made to those hospitals that are separately licensed by the state as specialty hospitals for children, have a federal Centers for Medicare and Medicaid Services certification number in the 3300-3399 range, have Medicaid days that exceed 55 percent of their total days and Medicare days that are less than 5 percent of their total days, and were licensed on January 1, 2013 ~~January 1, 2000~~, as specialty hospitals for children. This system of payments must conform to federal requirements and must distribute funds in each fiscal year for which an appropriation is made by making quarterly Medicaid payments. Notwithstanding s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals that serve a disproportionate share of low-income patients. The agency may make disproportionate share payments to specialty hospitals for children as provided


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for in the General Appropriations Act.

(1) Unless specified in the General Appropriations Act, the agency shall use the following formula to calculate the total amount earned for hospitals that participate in the specialty hospital for children disproportionate share program:

$$TAE = DSR \times BMPD \times MD$$

Where:

TAE = total amount earned by a specialty hospital for children.

DSR = disproportionate share rate.

BMPD = base Medicaid per diem.

MD = Medicaid days.

(2) The agency shall calculate the total additional payment for hospitals that participate in the specialty hospital for children disproportionate share program as follows:

$$TAP = (TAE \times TA) \div STAE$$

Where:

TAP = total additional payment for a specialty hospital for children.

TAE = total amount earned by a specialty hospital for children.

TA = total appropriation for the specialty hospital for children disproportionate share program.

STAE = sum of total amount earned by each hospital that

participates in the specialty hospital for children disproportionate share program.

(3) A hospital may not receive any payments under this section until it achieves full compliance with the applicable rules of the agency. A hospital that is not in compliance for two or more consecutive quarters may not receive its share of the funds. Any forfeited funds must be distributed to the remaining participating specialty hospitals for children that are in compliance.

(4) Notwithstanding any provision of this section to the contrary, for the 2017-2018 ~~2016-2017~~ state fiscal year, for hospitals achieving full compliance under subsection (3), the agency shall make disproportionate share payments to specialty hospitals for children as provided in the 2017-2018 ~~2016-2017~~ General Appropriations Act. This subsection expires July 1, 2018 ~~2017~~.

Section 14. Subsection (36) of section 409.913, Florida Statutes, is amended to read:

409.913 Oversight of the integrity of the Medicaid program.—The agency shall operate a program to oversee the activities of Florida Medicaid recipients, and providers and their representatives, to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible, and to recover overpayments and impose sanctions as appropriate. Beginning January 1, 2003, and each year thereafter, the agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs shall submit a joint report to the Legislature documenting the effectiveness of the state's


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efforts to control Medicaid fraud and abuse and to recover Medicaid overpayments during the previous fiscal year. The report must describe the number of cases opened and investigated each year; the sources of the cases opened; the disposition of the cases closed each year; the amount of overpayments alleged in preliminary and final audit letters; the number and amount of fines or penalties imposed; any reductions in overpayment amounts negotiated in settlement agreements or by other means; the amount of final agency determinations of overpayments; the amount deducted from federal claiming as a result of overpayments; the amount of overpayments recovered each year; the amount of cost of investigation recovered each year; the average length of time to collect from the time the case was opened until the overpayment is paid in full; the amount determined as uncollectible and the portion of the uncollectible amount subsequently reclaimed from the Federal Government; the number of providers, by type, that are terminated from participation in the Medicaid program as a result of fraud and abuse; and all costs associated with discovering and prosecuting cases of Medicaid overpayments and making recoveries in such cases. The report must also document actions taken to prevent overpayments and the number of providers prevented from enrolling in or reenrolling in the Medicaid program as a result of documented Medicaid fraud and abuse and must include policy recommendations necessary to prevent or recover overpayments and changes necessary to prevent and detect Medicaid fraud. All policy recommendations in the report must include a detailed fiscal analysis, including, but not limited to, implementation costs, estimated savings to the Medicaid program, and the return


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on investment. The agency must submit the policy recommendations and fiscal analyses in the report to the appropriate estimating conference, pursuant to s. 216.137, by February 15 of each year. The agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs each must include detailed unit-specific performance standards, benchmarks, and metrics in the report, including projected cost savings to the state Medicaid program during the following fiscal year.

(36) ~~At least three times a year,~~ The agency may ~~shall~~ provide to a sample of ~~each~~ Medicaid recipients ~~recipient~~ or their representatives through the distribution of explanations ~~his or her representative an explanation~~ of benefits information about services reimbursed by the Medicaid program for goods and services to such recipients, including ~~in the form of a letter that is mailed to the most recent address of the recipient on the record with the Department of Children and Families. The explanation of benefits must include the patient's name, the name of the health care provider and the address of the location where the service was provided, a description of all services billed to Medicaid in terminology that should be understood by a reasonable person, and~~ information on how to report inappropriate or incorrect billing to the agency or other law enforcement entities for review or investigation~~. At least once a year~~, ~~the letter also must include~~ information on how to report criminal Medicaid fraud to~~,~~ the Medicaid Fraud Control Unit's toll-free hotline number, and information about the rewards available under s. 409.9203. The explanation of benefits may not be mailed for Medicaid independent laboratory services as described in s. 409.905(7) or for Medicaid certified match


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services as described in ss. 409.9071 and 1011.70.

Section 15. Paragraph (e) of subsection (1) of section 409.975, Florida Statutes, is amended, to read:

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

(1) PROVIDER NETWORKS.—Managed care plans must develop and maintain provider networks that meet the medical needs of their enrollees in accordance with standards established pursuant to s. 409.967(2)(c). Except as provided in this section, managed care plans may limit the providers in their networks based on credentials, quality indicators, and price.

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

Section 16. Subsections (1) and (2) of section 409.979, Florida Statutes, are amended to read:

409.979 Eligibility.—

(1) PREREQUISITE CRITERIA FOR ELIGIBILITY.—Medicaid recipients who meet all of the following criteria are eligible to receive long-term care services and must receive long-term care services by participating in the long-term care managed care program. The recipient must be:

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

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

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

2. Hospital level of care, for individuals diagnosed with cystic fibrosis.

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

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

1. Traumatic Brain and Spinal Cord Injury Waiver.

2. Adult Cystic Fibrosis Waiver.

3. Project AIDS Care Waiver.

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

Section 17. Effective October 1, 2018, subsection (6) of section 409.983, Florida Statutes, is amended to read:

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

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

Section 18. Subsection (27) of section 409.901, Florida Statutes, is amended to read:

409.901 Definitions; ss. 409.901-409.920.—As used in ss. 409.901-409.920, except as otherwise specifically provided, the term:

(27) "Third party" means an individual, entity, or program, excluding Medicaid, that is, may be, could be, should be, or has been liable for all or part of the cost of medical services related to any medical assistance covered by Medicaid. A third party includes a third-party administrator; ~~or~~ a pharmacy benefits manager; a health insurer; a self-insured plan; a group health plan, as defined in s. 607(1) of the Employee Retirement Income Security Act of 1974; a service benefit plan; a managed care organization; liability insurance, including self-insurance; no-fault insurance; workers' compensation laws or plans; or other parties that are, by statute, contract, or

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agreement, legally responsible for payment of a claim for a health care item or service.

Section 19. Subsection (4), paragraph (c) of subsection (6), paragraph (h) of subsection (11), subsection (16), paragraph (b) of subsection (17), and subsection (20) of section 409.910, Florida Statutes, are amended to read:

409.910 Responsibility for payments on behalf of Medicaid-eligible persons when other parties are liable.—

(4) After the agency has provided medical assistance under the Medicaid program, it shall seek ~~recovery of~~ reimbursement from third-party benefits to the limit of legal liability and for the full amount of third-party benefits, but not in excess of the amount of medical assistance paid by Medicaid, as to:

(a) Claims for which the agency has a waiver pursuant to federal law; or

(b) Situations in which the agency learns of the existence of a liable third party or in which third-party benefits are discovered or become available after medical assistance has been provided by Medicaid.

(6) When the agency provides, pays for, or becomes liable for medical care under the Medicaid program, it has the following rights, as to which the agency may assert independent principles of law, which shall nevertheless be construed together to provide the greatest recovery from third-party benefits:

(c) The agency is entitled to, and has, an automatic lien for the full amount of medical assistance provided by Medicaid to or on behalf of the recipient for medical care furnished as a result of any covered injury or illness for which a third party


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is or may be liable, upon the collateral, as defined in s. 409.901.

1. The lien attaches automatically when a recipient first receives treatment for which the agency may be obligated to provide medical assistance under the Medicaid program. The lien is perfected automatically at the time of attachment.

2. The agency is authorized to file a verified claim of lien. The claim of lien shall be signed by an authorized employee of the agency, and shall be verified as to the employee's knowledge and belief. The claim of lien may be filed and recorded with the clerk of the circuit court in the recipient's last known county of residence or in any county deemed appropriate by the agency. The claim of lien, to the extent known by the agency, shall contain:

a. The name and last known address of the person to whom medical care was furnished.

b. The date of injury.

c. The period for which medical assistance was provided.

d. The amount of medical assistance provided or paid, or for which Medicaid is otherwise liable.

e. The names and addresses of all persons claimed by the recipient to be liable for the covered injuries or illness.

3. The filing of the claim of lien pursuant to this section shall be notice thereof to all persons.

4. If the claim of lien is filed within 3 years ~~1 year~~ after the later of the date when the last item of medical care relative to a specific covered injury or illness was paid, or the date of discovery by the agency of the liability of any third party, or the date of discovery of a cause of action

against a third party brought by a recipient or his or her legal representative, record notice shall relate back to the time of attachment of the lien.

5. If the claim of lien is filed after 3 years ~~1 year~~ after the later of the events specified in subparagraph 4., notice shall be effective as of the date of filing.

6. Only one claim of lien need be filed to provide notice as set forth in this paragraph and shall provide sufficient notice as to any additional or after-paid amount of medical assistance provided by Medicaid for any specific covered injury or illness. The agency may, in its discretion, file additional, amended, or substitute claims of lien at any time after the initial filing, until the agency has been repaid the full amount of medical assistance provided by Medicaid or otherwise has released the liable parties and recipient.

7. No release or satisfaction of any cause of action, suit, claim, counterclaim, demand, judgment, settlement, or settlement agreement shall be valid or effectual as against a lien created under this paragraph, unless the agency joins in the release or satisfaction or executes a release of the lien. An acceptance of a release or satisfaction of any cause of action, suit, claim, counterclaim, demand, or judgment and any settlement of any of the foregoing in the absence of a release or satisfaction of a lien created under this paragraph shall prima facie constitute an impairment of the lien, and the agency is entitled to recover damages on account of such impairment. In an action on account of impairment of a lien, the agency may recover from the person accepting the release or satisfaction or making the settlement the full amount of medical assistance provided by Medicaid.

Nothing in this section shall be construed as creating a lien or other obligation on the part of an insurer which in good faith has paid a claim pursuant to its contract without knowledge or actual notice that the agency has provided medical assistance for the recipient related to a particular covered injury or illness. However, notice or knowledge that an insured is, or has been a Medicaid recipient within 1 year from the date of service for which a claim is being paid creates a duty to inquire on the part of the insurer as to any injury or illness for which the insurer intends or is otherwise required to pay benefits.

8. The lack of a properly filed claim of lien shall not affect the agency's assignment or subrogation rights provided in this subsection, nor shall it affect the existence of the lien, but only the effective date of notice as provided in subparagraph 5.

9. The lien created by this paragraph is a first lien and superior to the liens and charges of any provider, and shall exist for a period of 7 years, if recorded, after the date of recording; and shall exist for a period of 7 years after the date of attachment, if not recorded. If recorded, the lien may be extended for one additional period of 7 years by rerecording the claim of lien within the 90-day period preceding the expiration of the lien.

10. The clerk of the circuit court for each county in the state shall endorse on a claim of lien filed under this paragraph the date and hour of filing and shall record the claim of lien in the official records of the county as for other records received for filing. The clerk shall receive as his or her fee for filing and recording any claim of lien or release of

lien under this paragraph the total sum of $2. Any fee required to be paid by the agency shall not be required to be paid in advance of filing and recording, but may be billed to the agency after filing and recording of the claim of lien or release of lien.

11. After satisfaction of any lien recorded under this paragraph, the agency shall, within 60 days after satisfaction, either file with the appropriate clerk of the circuit court or mail to any appropriate party, or counsel representing such party, if represented, a satisfaction of lien in a form acceptable for filing in Florida.

(11) The agency may, as a matter of right, in order to enforce its rights under this section, institute, intervene in, or join any legal or administrative proceeding in its own name in one or more of the following capacities: individually, as subrogee of the recipient, as assignee of the recipient, or as lienholder of the collateral.

(h) Except as otherwise provided in this section, actions to enforce the rights of the agency under this section shall be commenced within 6 ~~5~~ years after the date a cause of action accrues, with the period running from the later of the date of discovery by the agency of a case filed by a recipient or his or her legal representative, or of discovery of any judgment, award, or settlement contemplated in this section, or of discovery of facts giving rise to a cause of action under this section. Nothing in this paragraph affects or prevents a proceeding to enforce a lien during the existence of the lien as set forth in subparagraph (6)(c)9.

(16) Any transfer or encumbrance of any right, title, or


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interest to which the agency has a right pursuant to this section, with the intent, likelihood, or practical effect of defeating, hindering, or reducing reimbursement to ~~recovery by~~ the agency for ~~reimbursement of~~ medical assistance provided by Medicaid, shall be deemed to be a fraudulent conveyance, and such transfer or encumbrance shall be void and of no effect against the claim of the agency, unless the transfer was for adequate consideration and the proceeds of the transfer are reimbursed in full to the agency, but not in excess of the amount of medical assistance provided by Medicaid.

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(b) If federal law limits the agency to reimbursement from the recovered medical expense damages, a recipient, or his or her legal representative, may contest the amount designated as recovered medical expense damages payable to the agency pursuant to the formula specified in paragraph (11)(f) by filing a petition under chapter 120 within 21 days after the date of payment of funds to the agency or after the date of placing the full amount of the third-party benefits in the trust account for the benefit of the agency pursuant to paragraph (a). The petition shall be filed with the Division of Administrative Hearings. For purposes of chapter 120, the payment of funds to the agency or the placement of the full amount of the third-party benefits in the trust account for the benefit of the agency constitutes final agency action and notice thereof. Final order authority for the proceedings specified in this subsection rests with the Division of Administrative Hearings. This procedure is the exclusive method for challenging the amount of third-party benefits payable to the agency. In order to

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successfully challenge the amount designated as recovered medical expenses ~~payable to the agency~~, the recipient must prove, by clear and convincing evidence, that the ~~a lesser~~ portion of the total recovery which should be allocated as ~~reimbursement for~~ past and future medical expenses is less than the amount calculated by the agency pursuant to the formula set forth in paragraph (11)(f). Alternatively, the recipient must prove by clear and convincing evidence ~~or~~ that Medicaid provided a lesser amount of medical assistance than that asserted by the agency.

(20)(a) Entities providing health insurance as defined in s. 624.603, health maintenance organizations and prepaid health clinics as defined in chapter 641, and, on behalf of their clients, third-party administrators, ~~and~~ pharmacy benefits managers, and any other third parties, as defined in s. 409.901(27), which are legally responsible for payment of a claim for a health care item or service as a condition of doing business in the state or providing coverage to residents of this state, shall provide such records and information as are necessary to accomplish the purpose of this section, unless such requirement results in an unreasonable burden.

(b) An entity must respond to a request for payment with payment on the claim, a written request for additional information with which to process the claim, or a written reason for denial of the claim within 90 working days after receipt of written proof of loss or claim for payment for a health care item or service provided to a Medicaid recipient who is covered by the entity. Failure to pay or deny a claim within 140 days after receipt of the claim creates an uncontestable obligation

to pay the claim.

~~(a) The director of the agency and the Director of the Office of Insurance Regulation of the Financial Services Commission shall enter into a cooperative agreement for requesting and obtaining information necessary to effect the purpose and objective of this section.~~

~~1. The agency shall request only that information necessary to determine whether health insurance as defined pursuant to s. 624.603, or those health services provided pursuant to chapter 641, could be, should be, or have been claimed and paid with respect to items of medical care and services furnished to any person eligible for services under this section.~~

~~2. All information obtained pursuant to subparagraph 1. is confidential and exempt from s. 119.07(1). The agency shall provide the information obtained pursuant to subparagraph 1. to the Department of Revenue for purposes of administering the state Title IV-D program. The agency and the Department of Revenue shall enter into a cooperative agreement for purposes of implementing this requirement.~~

~~3. The cooperative agreement or rules adopted under this subsection may include financial arrangements to reimburse the reporting entities for reasonable costs or a portion thereof incurred in furnishing the requested information. Neither the cooperative agreement nor the rules shall require the automation of manual processes to provide the requested information.~~

~~(b) The agency and the Financial Services Commission jointly shall adopt rules for the development and administration of the cooperative agreement. The rules shall include the following:~~

~~1. A method for identifying those entities subject to furnishing information under the cooperative agreement.~~

~~2. A method for furnishing requested information.~~

~~3. Procedures for requesting exemption from the cooperative agreement based on an unreasonable burden to the reporting entity.~~

Section 20. Notwithstanding section 27 of chapter 2016-65, Laws of Florida, and subject to federal approval of the application to be a site for the Program of All-inclusive Care for the Elderly (PACE), the Agency for Health Care Administration shall contract with a not-for-profit organization, formed by a partnership with a not-for-profit hospital, a not-for-profit agency serving elders, and a not-for-profit hospice in Leon County. The not-for-profit PACE shall serve eligible PACE enrollees in Gadsden, Jefferson, Leon, and Wakulla Counties. The Agency for Health Care Administration, in consultation with the Department of Elderly Affairs and subject to an appropriation, shall approve up to 300 initial enrollees for the additional PACE site.

Section 21. Section 17 of chapter 2011-61, Laws of Florida, is amended to read:

Section 17. Notwithstanding s. 430.707, Florida Statutes, and subject to federal approval of the application to be a site for the Program of All-inclusive Care for the Elderly, the Agency for Health Care Administration shall contract with one private health care organization, the sole member of which is a private, not-for-profit corporation that owns and manages health care organizations which provide comprehensive long-term care services, including nursing home, assisted living, independent


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housing, home care, adult day care, and care management, with a board-certified, trained geriatrician as the medical director. This organization shall provide these services to frail and elderly persons who reside in Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie Counties ~~County~~. The organization is exempt from the requirements of chapter 641, Florida Statutes. The agency, in consultation with the Department of Elderly Affairs and subject to an appropriation, shall approve up to 150 initial enrollees who reside in Palm Beach County and up to 150 initial enrollees who reside in Martin County in the Program of All-inclusive Care for the Elderly established by this organization to serve elderly persons ~~who reside in Palm Beach County~~.

Section 22. Section 29 of chapter 2016-65, Laws of Florida, is amended to read:

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


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in Hospice Service Areas 7B and 3E. The agency, in consultation with the department and subject to an appropriation, shall approve up to 150 enrollees in the Program of All-inclusive Care for the Elderly established by this organization to serve frail elders who reside in Hospice Service Area 7C.

Section 23. Subsection (3) of section 391.055, Florida Statutes, is amended to read:

391.055 Service delivery systems.—

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

Section 24. Subsection (7) of section 393.0661, Florida Statutes, is amended to read:

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

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

Section 25. Paragraph (a) of subsection (4) of section 409.968, Florida Statutes, is amended to read:

409.968 Managed care plan payments.—


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

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

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

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

Section 26. Subsection (3) of section 427.0135, Florida Statutes, is amended to read:

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

(3) Not procure transportation disadvantaged services without initially negotiating with the commission, as provided in s. 287.057(3)(e)12., or unless otherwise authorized by statute. If the purchasing agency, after consultation with the commission, determines that it cannot reach mutually acceptable contract terms with the commission, the purchasing agency may contract for the same transportation services provided in a more cost-effective manner and of comparable or higher quality and


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standards. The Medicaid agency shall implement this subsection in a manner consistent with s. 409.908(18) ~~409.908(19)~~ and as otherwise limited or directed by the General Appropriations Act.

Section 27. Subsections (1) and (5) of section 1011.70, Florida Statutes, are amended to read:

1011.70 Medicaid certified school funding maximization.—

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

(a) Family planning.

(b) Immunizations.

(c) Prenatal care.

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

Section 28. For the 2017-2018 fiscal year, $578,918,460 in

nonrecurring funds from the Grants and Donations Trust Fund and $924,467,313 in nonrecurring funds from the Medical Care Trust Fund are appropriated to the Agency for Health Care Administration for the purpose of implementing a Low-Income Pool Program. These funds shall be held in reserve. Subject to the federal approval of the final terms and conditions of the Low-Income Pool, the Agency for Health Care Administration shall submit a budget amendment requesting release of the funds held in reserve pursuant to chapter 216, Florida Statutes. If the chair and vice chair of the Legislative Budget Commission or the President of the Senate and the Speaker of the House of Representatives object in writing to a proposed amendment within 14 days after notification, the Governor shall void the action. In addition to the proposed amendment, the agency must submit: the Reimbursement and Funding Methodology Document, as specified in the terms and conditions, which documents permissible Low-Income Pool expenditures; a proposed distribution model by entity; and a proposed listing of entities contributing Intergovernmental Transfers to support the state match required. Low-Income Pool payments to providers under this section are contingent upon the nonfederal share being provided through intergovernmental transfers in the Grants and Donations Trust Fund. In the event the funds are not available in the Grants and Donations Trust Fund, the State of Florida is not obligated to make payments under this section. This section expires July 1, 2018.

Section 29. For the 2017-2018 fiscal year, $94,414,800 in nonrecurring funds from the Grants and Donations Trust Fund and $151,585,200 in nonrecurring funds from the Medical Care Trust


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Funds are appropriated to the Agency for Health Care Administration to continue medical school faculty physician supplemental payments. These funds shall be held in reserve. These funds shall be used to continue supplemental payments for services provided by doctors of medicine and osteopathy, as well as other licensed health care practitioners acting under the supervision of those doctors, who are employed by or under contract with a medical school in Florida. These funds may also be used for pass-through, sub-capitation, differential fee, or directed lump sum payments for doctors of medicine and osteopathy, as well as other licensed health care practitioners acting under the supervision of those doctors, who are employed by or under contract with a medical school in Florida. Subject to federal approval to continue the supplemental and/or pass-through, sub-capitation, differential fee, or directed lump sum payments, the Agency for Health Care Administration may submit a budget amendment requesting release of the funds held in reserve pursuant to the provisions of chapter 216, Florida Statutes. If the chair and vice chair of the Legislative Budget Commission or the President of the Senate and the Speaker of the House of Representatives object in writing to a proposed amendment within 14 days following notification, the Governor shall void the action. The amendment shall include the federal approvals, a proposed distribution model by entity, and a proposed listing of entities contributing Intergovernmental Transfers to support the state match required. Payments to providers under this section are contingent upon the nonfederal share being provided through intergovernmental transfers in the Grants and Donations Trust Fund. In the event the funds are not available in the Grants and

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Donations Trust Fund, the State of Florida is not obligated to make payments under this section. This section expires July 1, 2018.

Section 30. Except as otherwise expressly provided in this act, this act shall take effect July 1, 2017.

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

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to health care; amending s. 210.20, F.S.; providing that a specified percentage of the cigarette tax, up to a specified amount, be paid annually to the Florida Consortium of National Cancer Institute Centers Program, rather than the Sanford-Burnham Medical Research Institute; requiring that the funds be used to advance cures for cancers afflicting pediatric populations through basic or applied research; amending s. 381.922, F.S.; revising the goals of the William G. "Bill" Bankhead, Jr., and David Coley Cancer Research Program to include identifying ways to increase pediatric enrollment in cancer clinical trials; establishing the Live Like Bella Initiative to advance progress toward curing pediatric cancer, subject to an appropriation; amending s. 394.9082, F.S.; revising the reporting requirements of the acute care services utilization database; requiring the Department of Children and


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Families to post certain data on its website; amending s. 395.602, F.S.; revising the definition of the term "rural hospital" to include a hospital classified as a sole community hospital, regardless of the number of licensed beds; amending s. 400.179, F.S.; providing that certain fees deposited into the Medicaid nursing home overpayment account in the Grants and Donations Trust Fund may be used by the agency for enhanced payments to nursing facilities as specified in the General Appropriations Act or other law; amending s. 409.904, F.S.; authorizing the agency to make payments for medical assistance and related services on behalf of a person diagnosed with acquired immune deficiency syndrome who meets certain criteria, subject to the availability of moneys and specified limitations; amending s. 409.906, F.S.; deleting a provision relating to consolidation of waiver services to conform to changes made by the act; amending s. 409.908, F.S.; revising requirements related to the long-term care reimbursement plan and cost reporting system; requiring the calculation of separate prices for each patient care subcomponent based on specified cost reports; providing that certain ceilings and targets apply only to providers being reimbursed on a cost-based system; requiring implementation of a prospective payment methodology for rate setting purposes; providing parameters; expanding the direct care subcomponent to include allowable therapy and dietary costs; specifying that allowable ancillary


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costs are included in the indirect care cost subcomponent; requiring that nursing home prospective payment rates be rebased at a specified interval; authorizing the payment of a direct care supplemental payment to certain providers; specifying the amount providers will be reimbursed for a specified period of time, which may be a cost-based rate or a prospective payment rate; providing for expiration of this reimbursement mechanism on a specified date; requiring the agency to reimburse providers on a cost-based rate or a rebased prospective payment rate, beginning on a specified date; requiring that Medicaid pay deductibles and coinsurance for certain X-ray services provided in an assisted living facility or in the patient’s home; deleting a provision relating to reimbursement rate parameters for certain Medicaid providers; authorizing the agency to receive funds from certain governmental entities for specified purposes; providing requirements for letters of agreement executed by a local governmental entity; amending s. 409.9082, F.S.; revising the uses of quality assessment and federal matching funds to include the partial funding of the quality incentive payment program for nursing facilities that exceed quality benchmarks; amending s. 409.909, F.S.; providing that the agency shall make payments and distribute funds to qualifying institutions in addition to hospitals under the Statewide Medicaid Residency Program; amending s. 409.911, F.S.; updating


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obsolete language; amending s. 409.9119, F.S.; revising criteria for the participation of hospitals in the disproportionate share program for specialty hospitals for children; amending s. 409.913, F.S.; removing a requirement that the agency provide each Medicaid recipient with an explanation of benefits; authorizing the agency to provide an explanation of benefits to a sample of Medicaid recipients or their representatives; amending s. 409.975, F.S.; authorizing, rather than requiring, a managed care plan to offer a network contract to certain medical equipment and supplies providers in the region; amending s. 409.979, F.S.; expanding eligibility for long-term care services to include hospital level of care for certain individuals diagnosed with cystic fibrosis; revising eligibility for certain Medicaid recipients in the long-term care managed care program; amending s. 409.983, F.S.; eliminating the requirement that the agency consider facility costs adjusted for inflation and other factors in the establishment of certain payment rates for nursing facilities; amending s. 409.901, F.S.; revising the definition of the term "third party"; amending s. 409.910, F.S.; revising provisions relating to responsibility for Medicaid payments in settlement proceedings; extending period of time for filing a claim of lien filed for purposes of third-party liability; extending the period of time within which the agency is authorized to pursue certain causes of action; revising procedures for a


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recipient to contest the amount payable to the agency when federal law limits reimbursement under certain circumstances; requiring certain entities responsible for payment of claims to provide certain records and information and respond to requests for payment of claims within a specified timeframe as a condition of doing business in the state; providing circumstances under which such parties are obligated to pay claims; deleting provisions relating to cooperative agreements between the agency, the Office of Insurance Regulation, and the Department of Revenue; requiring the agency to contract with a specified not-for-profit organization, a not-for-profit agency serving elders, and a not-for-profit hospice in Leon County to be a site for the Program for All-inclusive Care for the Elderly (PACE), subject to federal approval of the application site; authorizing PACE to serve eligible enrollees in Gadsden, Jefferson, Leon, and Wakulla Counties; requiring the agency, in consultation with the department, to approve a certain number of initial enrollees in PACE at the new site, subject to an appropriation; amending s. 17 of chapter 2011-61, Laws of Florida; requiring the agency, in consultation with the department, to approve a certain number of initial enrollees in PACE to serve frail elders who reside in certain counties; amending s. 29 of chapter 2016-65, Laws of Florida; requiring the agency, in consultation with the department, to approve a certain number of enrollees in the PACE established to serve frail


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elders who reside in Hospice Service Area 7C; requiring the agency, in consultation with the department, to approve a certain number of initial enrollees in PACE at the new site, subject to certain conditions; amending ss. 391.055, 393.0661, 409.968, 427.0135, and 1011.70, F.S.; conforming cross-references; providing appropriations; providing effective dates.