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1 A bill to be entitled
2 An act relating to health care; amending s. 210.20,
3 F.S.; providing that a specified percentage of the
4 cigarette tax, up to a specified amount, be paid
5 annually to the Florida Consortium of National Cancer
6 Institute Centers Program, rather than the Sanford-
7 Burnham Medical Research Institute; requiring that the
8 funds be used to advance cures for cancers afflicting
9 pediatric populations through basic or applied
10 research; amending s. 381.922, F.S.; revising the
11 goals of the William G. "Bill" Bankhead, Jr., and
12 David Coley Cancer Research Program to include
13 identifying ways to increase pediatric enrollment in
14 cancer clinical trials; establishing the Live Like
15 Bella Initiative to advance progress toward curing
16 pediatric cancer, subject to an appropriation;
17 amending s. 394.9082, F.S.; revising the reporting
18 requirements of the acute care services utilization
19 database; requiring the Department of Children and
20 Families to post certain data on its website; amending
21 s. 395.602, F.S.; revising the definition of the term
22 "rural hospital" to include a hospital classified as a
23 sole community hospital, regardless of the number of
24 licensed beds; amending s. 400.179, F.S.; providing
25 that certain fees deposited into the Medicaid nursing
26 home overpayment account in the Grants and Donations
27 Trust Fund may be used by the agency for enhanced
28 payments to nursing facilities as specified in the
29 General Appropriations Act or other law; amending s.

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30 409.904, F.S.; authorizing the agency to make payments
31 for medical assistance and related services on behalf
32 of a person diagnosed with acquired immune deficiency
33 syndrome who meets certain criteria, subject to the
34 availability of moneys and specified limitations;
35 amending s. 409.906, F.S.; deleting a provision
36 relating to consolidation of waiver services to
37 conform to changes made by the act; amending s.
38 409.908, F.S.; revising requirements related to the
39 long-term care reimbursement plan and cost reporting
40 system; requiring the calculation of separate prices
41 for each patient care subcomponent based on specified
42 cost reports; providing that certain ceilings and
43 targets apply only to providers being reimbursed on a
44 cost-based system; requiring implementation of a
45 prospective payment methodology for rate setting
46 purposes; providing parameters; expanding the direct
47 care subcomponent to include allowable therapy and
48 dietary costs; specifying that allowable ancillary
49 costs are included in the indirect care cost
50 subcomponent; requiring that nursing home prospective
51 payment rates be rebased at a specified interval;
52 authorizing the payment of a direct care supplemental
53 payment to certain providers; specifying the amount
54 providers will be reimbursed for a specified period of
55 time, which may be a cost-based rate or a prospective
56 payment rate; providing for expiration of this
57 reimbursement mechanism on a specified date; requiring
58 the agency to reimburse providers on a cost-based rate

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59 or a rebased prospective payment rate, beginning on a
60 specified date; requiring that Medicaid pay
61 deductibles and coinsurance for certain X-ray services
62 provided in an assisted living facility or in the
63 patient's home; deleting a provision relating to
64 reimbursement rate parameters for certain Medicaid
65 providers; authorizing the agency to receive funds
66 from certain governmental entities for specified
67 purposes; providing requirements for letters of
68 agreement executed by a local governmental entity;
69 amending s. 409.9082, F.S.; revising the uses of
70 quality assessment and federal matching funds to
71 include the partial funding of the quality incentive
72 payment program for nursing facilities that exceed
73 quality benchmarks; amending s. 409.909, F.S.;

74 providing that the agency shall make payments and
75 distribute funds to qualifying institutions in
76 addition to hospitals under the Statewide Medicaid
77 Residency Program; amending s. 409.911, F.S.; updating
78 obsolete language; amending s. 409.9119, F.S.;

79 revising criteria for the participation of hospitals
80 in the disproportionate share program for specialty
81 hospitals for children; amending s. 409.913, F.S.;

82 removing a requirement that the agency provide each
83 Medicaid recipient with an explanation of benefits;
84 authorizing the agency to provide an explanation of
85 benefits to a sample of Medicaid recipients or their
86 representatives; amending s. 409.975, F.S.;

87 authorizing, rather than requiring, a managed care

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88 plan to offer a network contract to certain medical
89 equipment and supplies providers in the region;
90 amending s. 409.979, F.S.; expanding eligibility for
91 long-term care services to include hospital level of
92 care for certain individuals diagnosed with cystic
93 fibrosis; revising eligibility for certain Medicaid
94 recipients in the long-term care managed care program;
95 amending s. 409.983, F.S.; eliminating the requirement
96 that the agency consider facility costs adjusted for
97 inflation and other factors in the establishment of
98 certain payment rates for nursing facilities; amending
99 s. 409.901, F.S.; revising the definition of the term
100 "third party"; amending s. 409.910, F.S.; revising
101 provisions relating to responsibility for Medicaid
102 payments in settlement proceedings; extending period
103 of time for filing a claim of lien filed for purposes
104 of third-party liability; extending the period of time
105 within which the agency is authorized to pursue
106 certain causes of action; revising procedures for a
107 recipient to contest the amount payable to the agency
108 when federal law limits reimbursement under certain
109 circumstances; requiring certain entities responsible
110 for payment of claims to provide certain records and
111 information and respond to requests for payment of
112 claims within a specified timeframe as a condition of
113 doing business in the state; providing circumstances
114 under which such parties are obligated to pay claims;
115 deleting provisions relating to cooperative agreements
116 between the agency, the Office of Insurance

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117 Regulation, and the Department of Revenue; requiring
118 the agency to contract with a specified not-for-profit
119 organization, a not-for-profit agency serving elders,
120 and a not-for-profit hospice in Leon County to be a
121 site for the Program for All-inclusive Care for the
122 Elderly (PACE), subject to federal approval of the
123 application site; authorizing PACE to serve eligible
124 enrollees in Gadsden, Jefferson, Leon, and Wakulla
125 Counties; requiring the agency, in consultation with
126 the department, to approve a certain number of initial
127 enrollees in PACE at the new site, subject to an
128 appropriation; amending s. 17 of chapter 2011-61, Laws
129 of Florida; requiring the agency, in consultation with
130 the department, to approve a certain number of initial
131 enrollees in PACE to serve frail elders who reside in
132 certain counties; amending s. 29 of chapter 2016-65,
133 Laws of Florida; requiring the agency, in consultation
134 with the department, to approve a certain number of
135 enrollees in the PACE established to serve frail
136 elders who reside in Hospice Service Area 7C;
137 requiring the agency, in consultation with the
138 department, to approve a certain number of initial
139 enrollees in PACE at the new site, subject to certain
140 conditions; amending ss. 391.055, 393.0661, 409.968,
141 427.0135, and 1011.70, F.S.; conforming cross-
142 references; providing appropriations; providing
143 effective dates.

144
145 Be It Enacted by the Legislature of the State of Florida:

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147 Section 1. Paragraph (c) of subsection (2) of section
148 210.20, Florida Statutes, is amended to read:

149 210.20 Employees and assistants; distribution of funds.—

150 (2) As collections are received by the division from such
151 cigarette taxes, it shall pay the same into a trust fund in the
152 State Treasury designated "Cigarette Tax Collection Trust Fund"
153 which shall be paid and distributed as follows:

154 (c) Beginning July 1, 2017 ~~2013~~, and continuing through
155 June 30, 2033, the division shall from month to month certify to
156 the Chief Financial Officer the amount derived from the
157 cigarette tax imposed by s. 210.02, less the service charges
158 provided for in s. 215.20 and less 0.9 percent of the amount
159 derived from the cigarette tax imposed by s. 210.02, which shall
160 be deposited into the Alcoholic Beverage and Tobacco Trust Fund,
161 specifying an amount equal to 1 percent of the net collections,
162 not to exceed \$3 million annually, and that amount shall be
163 deposited into the Biomedical Research Trust Fund in the
164 Department of Health. These funds are appropriated annually ~~in~~
165 ~~an amount not to exceed \$3 million~~ from the Biomedical Research
166 Trust Fund for the advancement of cures for cancers afflicting
167 pediatric populations through basic or applied research,
168 including, but not limited to, clinical trials and nontoxic drug
169 discovery. These funds are not included in the calculation for
170 the distribution of funds pursuant to s. 381.915; however, these
171 funds shall be distributed to cancer centers participating in
172 the Florida Consortium of National Cancer Institute Centers
173 Program in the same proportion as is allocated to each cancer
174 center in accordance with s. 381.915 and are in addition to any

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175 funds distributed pursuant to that section ~~Department of Health~~
176 ~~and the Sanford-Burnham Medical Research Institute to work in~~
177 ~~conjunction for the purpose of establishing activities and grant~~
178 ~~opportunities in relation to biomedical research.~~

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

181 381.922 William G. "Bill" Bankhead, Jr., and David Coley
182 Cancer Research Program.—

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

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

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

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

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

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

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

203 e. Facilitating the technical coordination, business

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204 development, and support of intellectual property as it relates
205 to the advancement of cancer research; and

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

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

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

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

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

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

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

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

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

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

232 (c) There is established within the program the Live Like

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233 Bella Initiative. The purpose of the initiative is to advance
234 progress toward curing pediatric cancer by awarding grants
235 through the peer-reviewed, competitive process established under
236 subsection (3). This paragraph is subject to the annual
237 appropriation of funds by the Legislature.

238 Section 3. Paragraph (a) of subsection (10) of section
239 394.9082, Florida Statutes, is republished, paragraph (b) of
240 that subsection is amended, and paragraph (f) is added to that
241 subsection, to read:

242 394.9082 Behavioral health managing entities.—

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

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

261 (b) A managing entity shall require providers specified in

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262 paragraph (a) to submit data, in real time or at least daily, to
263 the managing entity for:

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

267 2. All admissions and discharges of clients receiving
268 substance abuse services in an addictions receiving facility or
269 detoxification facility pursuant to parts IV and V of chapter
270 397 who qualify as indigent.

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

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

281 Section 4. Paragraph (e) of subsection (2) of section
282 395.602, Florida Statutes, is amended to read:

283 395.602 Rural hospitals.—

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

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

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

290 2. An acute care hospital, in a county with a population

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291 density of up to 100 persons per square mile, which is at least
292 30 minutes of travel time, on normally traveled roads under
293 normal traffic conditions, from any other acute care hospital
294 within the same county;

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

298 4. A hospital classified as a sole community hospital under
299 42 C.F.R. s. 412.92, regardless of the number of ~~which has up to~~
300 ~~175~~ licensed beds;

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

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

310

311 Population densities used in this paragraph must be based upon
312 the most recently completed United States census. A hospital
313 that received funds under s. 409.9116 for a quarter beginning no
314 later than July 1, 2002, is deemed to have been and shall
315 continue to be a rural hospital from that date through June 30,
316 2021, if the hospital continues to have up to 100 licensed beds
317 and an emergency room. An acute care hospital that has not
318 previously been designated as a rural hospital and that meets
319 the criteria of this paragraph shall be granted such designation

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320 upon application, including supporting documentation, to the
321 agency. A hospital that was licensed as a rural hospital during
322 the 2010-2011 or 2011-2012 fiscal year shall continue to be a
323 rural hospital from the date of designation through June 30,
324 2021, if the hospital continues to have up to 100 licensed beds
325 and an emergency room.

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

329 400.179 Liability for Medicaid underpayments and
330 overpayments.—

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

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

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

345 2. A leasehold licensee may meet the requirements of
346 subparagraph 1. by payment of a nonrefundable fee, paid at
347 initial licensure, paid at the time of any subsequent change of
348 ownership, and paid annually thereafter, in the amount of 1

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349 percent of the total of 3 months' Medicaid payments to the
350 facility computed on the basis of the preceding 12-month average
351 Medicaid payments to the facility. If a preceding 12-month
352 average is not available, projected Medicaid payments may be
353 used. The fee shall be deposited into the Grants and Donations
354 Trust Fund and shall be accounted for separately as a Medicaid
355 nursing home overpayment account. These fees shall be used at
356 the sole discretion of the agency to repay nursing home Medicaid
357 overpayments or for enhanced payments to nursing facilities as
358 specified in the General Appropriations Act or other law.

359 Payment of this fee shall not release the licensee from any
360 liability for any Medicaid overpayments, nor shall payment bar
361 the agency from seeking to recoup overpayments from the licensee
362 and any other liable party. As a condition of exercising this
363 lease bond alternative, licensees paying this fee must maintain
364 an existing lease bond through the end of the 30-month term
365 period of that bond. The agency is herein granted specific
366 authority to promulgate all rules pertaining to the
367 administration and management of this account, including
368 withdrawals from the account, subject to federal review and
369 approval. This provision shall take effect upon becoming law and
370 shall apply to any leasehold license application. The financial
371 viability of the Medicaid nursing home overpayment account shall
372 be determined by the agency through annual review of the account
373 balance and the amount of total outstanding, unpaid Medicaid
374 overpayments owing from leasehold licensees to the agency as
375 determined by final agency audits. By March 31 of each year, the
376 agency shall assess the cumulative fees collected under this
377 subparagraph, minus any amounts used to repay nursing home

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378 Medicaid overpayments and amounts transferred to contribute to
379 the General Revenue Fund pursuant to s. 215.20. If the net
380 cumulative collections, minus amounts utilized to repay nursing
381 home Medicaid overpayments, exceed \$25 million, the provisions
382 of this subparagraph shall not apply for the subsequent fiscal
383 year.

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

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

393 5. It shall be the responsibility of all nursing facility
394 operators, operating the facility as a leasehold, to renew the
395 30-month bond and to provide proof of such renewal to the agency
396 annually.

397 6. Any failure of the nursing facility operator to acquire,
398 maintain, renew annually, or provide proof to the agency shall
399 be grounds for the agency to deny, revoke, and suspend the
400 facility license to operate such facility and to take any
401 further action, including, but not limited to, enjoining the
402 facility, asserting a moratorium pursuant to part II of chapter
403 408, or applying for a receiver, deemed necessary to ensure
404 compliance with this section and to safeguard and protect the
405 health, safety, and welfare of the facility's residents. A lease
406 agreement required as a condition of bond financing or

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407 refinancing under s. 154.213 by a health facilities authority or
408 required under s. 159.30 by a county or municipality is not a
409 leasehold for purposes of this paragraph and is not subject to
410 the bond requirement of this paragraph.

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

413 409.904 Optional payments for eligible persons.—The agency
414 may make payments for medical assistance and related services on
415 behalf of the following persons who are determined to be
416 eligible subject to the income, assets, and categorical
417 eligibility tests set forth in federal and state law. Payment on
418 behalf of these Medicaid eligible persons is subject to the
419 availability of moneys and any limitations established by the
420 General Appropriations Act or chapter 216.

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

426 Section 7. Paragraph (b) of subsection (13) of section
427 409.906, Florida Statutes, is amended to read:

428 409.906 Optional Medicaid services.—Subject to specific
429 appropriations, the agency may make payments for services which
430 are optional to the state under Title XIX of the Social Security
431 Act and are furnished by Medicaid providers to recipients who
432 are determined to be eligible on the dates on which the services
433 were provided. Any optional service that is provided shall be
434 provided only when medically necessary and in accordance with
435 state and federal law. Optional services rendered by providers

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436 in mobile units to Medicaid recipients may be restricted or
437 prohibited by the agency. Nothing in this section shall be
438 construed to prevent or limit the agency from adjusting fees,
439 reimbursement rates, lengths of stay, number of visits, or
440 number of services, or making any other adjustments necessary to
441 comply with the availability of moneys and any limitations or
442 directions provided for in the General Appropriations Act or
443 chapter 216. If necessary to safeguard the state's systems of
444 providing services to elderly and disabled persons and subject
445 to the notice and review provisions of s. 216.177, the Governor
446 may direct the Agency for Health Care Administration to amend
447 the Medicaid state plan to delete the optional Medicaid service
448 known as "Intermediate Care Facilities for the Developmentally
449 Disabled." Optional services may include:

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

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

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

461 409.908 Reimbursement of Medicaid providers.—Subject to
462 specific appropriations, the agency shall reimburse Medicaid
463 providers, in accordance with state and federal law, according
464 to methodologies set forth in the rules of the agency and in

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465 policy manuals and handbooks incorporated by reference therein.
466 These methodologies may include fee schedules, reimbursement
467 methods based on cost reporting, negotiated fees, competitive
468 bidding pursuant to s. 287.057, and other mechanisms the agency
469 considers efficient and effective for purchasing services or
470 goods on behalf of recipients. If a provider is reimbursed based
471 on cost reporting and submits a cost report late and that cost
472 report would have been used to set a lower reimbursement rate
473 for a rate semester, then the provider's rate for that semester
474 shall be retroactively calculated using the new cost report, and
475 full payment at the recalculated rate shall be effected
476 retroactively. Medicare-granted extensions for filing cost
477 reports, if applicable, shall also apply to Medicaid cost
478 reports. Payment for Medicaid compensable services made on
479 behalf of Medicaid eligible persons is subject to the
480 availability of moneys and any limitations or directions
481 provided for in the General Appropriations Act or chapter 216.
482 Further, nothing in this section shall be construed to prevent
483 or limit the agency from adjusting fees, reimbursement rates,
484 lengths of stay, number of visits, or number of services, or
485 making any other adjustments necessary to comply with the
486 availability of moneys and any limitations or directions
487 provided for in the General Appropriations Act, provided the
488 adjustment is consistent with legislative intent.

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

493 2. Unless otherwise limited or directed in the General

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494 Appropriations Act, reimbursement to hospitals licensed under
495 part I of chapter 395 for the provision of swing-bed nursing
496 home services must be made on the basis of the average statewide
497 nursing home payment, and reimbursement to a hospital licensed
498 under part I of chapter 395 for the provision of skilled nursing
499 services must be made on the basis of the average nursing home
500 payment for those services in the county in which the hospital
501 is located. When a hospital is located in a county that does not
502 have any community nursing homes, reimbursement shall be
503 determined by averaging the nursing home payments in counties
504 that surround the county in which the hospital is located.
505 Reimbursement to hospitals, including Medicaid payment of
506 Medicare copayments, for skilled nursing services shall be
507 limited to 30 days, unless a prior authorization has been
508 obtained from the agency. Medicaid reimbursement may be extended
509 by the agency beyond 30 days, and approval must be based upon
510 verification by the patient's physician that the patient
511 requires short-term rehabilitative and recuperative services
512 only, in which case an extension of no more than 15 days may be
513 approved. Reimbursement to a hospital licensed under part I of
514 chapter 395 for the temporary provision of skilled nursing
515 services to nursing home residents who have been displaced as
516 the result of a natural disaster or other emergency may not
517 exceed the average county nursing home payment for those
518 services in the county in which the hospital is located and is
519 limited to the period of time which the agency considers
520 necessary for continued placement of the nursing home residents
521 in the hospital.

522 (b) Subject to any limitations or directions in the General

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523 Appropriations Act, the agency shall establish and implement a
524 state Title XIX Long-Term Care Reimbursement Plan for nursing
525 home care in order to provide care and services in conformance
526 with the applicable state and federal laws, rules, regulations,
527 and quality and safety standards and to ensure that individuals
528 eligible for medical assistance have reasonable geographic
529 access to such care.

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

548 a. Peer Groups, including:

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

551 (II) South-SMMC Regions 10-11, plus Palm Beach and

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552 Okeechobee Counties.

553 b. Percentage of Median Costs based on the cost reports

554 used for September 2016 rate setting:

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

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

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

558 c. Floors:

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

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

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

562 d. Pass-through Payments...Real Estate and Personal Property

563 Taxes and Property Insurance.

564 e. Quality Incentive Program Payment Pool.....6 percent of

565 September 2016 non-property related payments of included

566 facilities.

567 f. Quality Score Threshold to Quality for Quality Incentive

568 Payment.....20th percentile of included facilities.

569 g. Fair Rental Value System Payment Parameters:

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

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

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

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

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

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

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

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

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

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

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

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

583 2. The direct care subcomponent shall include salaries and
584 benefits of direct care staff providing nursing services
585 including registered nurses, licensed practical nurses, and
586 certified nursing assistants who deliver care directly to
587 residents in the nursing home facility, allowable therapy costs,
588 and dietary costs. This excludes nursing administration, staff
589 development, the staffing coordinator, and the administrative
590 portion of the minimum data set and care plan coordinators. The
591 direct care subcomponent also includes medically necessary
592 dental care, vision care, hearing care, and podiatric care.

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

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

604 5. Every fourth year, the agency shall rebase nursing home
605 prospective payment rates to reflect changes in cost based on
606 the most recently audited cost report for each participating
607 provider ~~In order to offset the cost of general and professional~~
608 ~~liability insurance, the agency shall amend the plan to allow~~
609 ~~for interim rate adjustments to reflect increases in the cost of~~

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610 ~~general or professional liability insurance for nursing homes.~~
611 ~~This provision shall be implemented to the extent existing~~
612 ~~appropriations are available.~~

613 6. A direct care supplemental payment may be made to
614 providers whose direct care hours per patient day are above the
615 80th percentile and who provide Medicaid services to a larger
616 percentage of Medicaid patients than the state average.

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

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

633
634 It is the intent of the Legislature that the reimbursement plan
635 achieve the goal of providing access to health care for nursing
636 home residents who require large amounts of care while
637 encouraging diversion services as an alternative to nursing home
638 care for residents who can be served within the community. The

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639 agency shall base the establishment of any maximum rate of
640 payment, whether overall or component, on the available moneys
641 as provided for in the General Appropriations Act. The agency
642 may base the maximum rate of payment on the results of
643 scientifically valid analysis and conclusions derived from
644 objective statistical data pertinent to the particular maximum
645 rate of payment.

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

651 409.908 Reimbursement of Medicaid providers.—Subject to
652 specific appropriations, the agency shall reimburse Medicaid
653 providers, in accordance with state and federal law, according
654 to methodologies set forth in the rules of the agency and in
655 policy manuals and handbooks incorporated by reference therein.
656 These methodologies may include fee schedules, reimbursement
657 methods based on cost reporting, negotiated fees, competitive
658 bidding pursuant to s. 287.057, and other mechanisms the agency
659 considers efficient and effective for purchasing services or
660 goods on behalf of recipients. If a provider is reimbursed based
661 on cost reporting and submits a cost report late and that cost
662 report would have been used to set a lower reimbursement rate
663 for a rate semester, then the provider's rate for that semester
664 shall be retroactively calculated using the new cost report, and
665 full payment at the recalculated rate shall be effected
666 retroactively. Medicare-granted extensions for filing cost
667 reports, if applicable, shall also apply to Medicaid cost

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668 reports. Payment for Medicaid compensable services made on
669 behalf of Medicaid eligible persons is subject to the
670 availability of moneys and any limitations or directions
671 provided for in the General Appropriations Act or chapter 216.
672 Further, nothing in this section shall be construed to prevent
673 or limit the agency from adjusting fees, reimbursement rates,
674 lengths of stay, number of visits, or number of services, or
675 making any other adjustments necessary to comply with the
676 availability of moneys and any limitations or directions
677 provided for in the General Appropriations Act, provided the
678 adjustment is consistent with legislative intent.

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

682 (13) ~~(14)~~ Medicare premiums for persons eligible for both
683 Medicare and Medicaid coverage shall be paid at the rates
684 established by Title XVIII of the Social Security Act. For
685 Medicare services rendered to Medicaid-eligible persons,
686 Medicaid shall pay Medicare deductibles and coinsurance as
687 follows:

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

691 (b) Medicaid will pay no portion of Medicare deductibles
692 and coinsurance when payment that Medicare has made for the
693 service equals or exceeds what Medicaid would have paid if it
694 had been the sole payor. The combined payment of Medicare and
695 Medicaid shall not exceed the amount Medicaid would have paid
696 had it been the sole payor. The Legislature finds that there has

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697 been confusion regarding the reimbursement for services rendered
698 to dually eligible Medicare beneficiaries. Accordingly, the
699 Legislature clarifies that it has always been the intent of the
700 Legislature before and after 1991 that, in reimbursing in
701 accordance with fees established by Title XVIII for premiums,
702 deductibles, and coinsurance for Medicare services rendered by
703 physicians to Medicaid eligible persons, physicians be
704 reimbursed at the lesser of the amount billed by the physician
705 or the Medicaid maximum allowable fee established by the Agency
706 for Health Care Administration, as is permitted by federal law.
707 It has never been the intent of the Legislature with regard to
708 such services rendered by physicians that Medicaid be required
709 to provide any payment for deductibles, coinsurance, or
710 copayments for Medicare cost sharing, or any expenses incurred
711 relating thereto, in excess of the payment amount provided for
712 under the State Medicaid plan for such service. This payment
713 methodology is applicable even in those situations in which the
714 payment for Medicare cost sharing for a qualified Medicare
715 beneficiary with respect to an item or service is reduced or
716 eliminated. This expression of the Legislature is in
717 clarification of existing law and shall apply to payment for,
718 and with respect to provider agreements with respect to, items
719 or services furnished on or after the effective date of this
720 act. This paragraph applies to payment by Medicaid for items and
721 services furnished before the effective date of this act if such
722 payment is the subject of a lawsuit that is based on the
723 provisions of this section, and that is pending as of, or is
724 initiated after, the effective date of this act.

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

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

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

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

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

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

752 (23)~~(24)~~(a) The agency shall establish rates at a level
753 that ensures no increase in statewide expenditures resulting
754 from a change in unit costs effective July 1, 2011.

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755 Reimbursement rates shall be as provided in the General
756 Appropriations Act.

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

760 (c) Base rate reimbursement for outpatient services under
761 an enhanced ambulatory payment group methodology shall be
762 provided in the General Appropriations Act.

763 (d)~~(e)~~ This subsection applies to the following provider
764 types:

765 ~~1. Inpatient hospitals.~~

766 ~~2. Outpatient hospitals.~~

767 ~~1.3.~~ Nursing homes.

768 ~~2.4.~~ County health departments.

769 ~~5. Prepaid health plans.~~

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

772 (26) The agency may receive funds from state entities,
773 including, but not limited to, the Department of Health, local
774 governments, and other local political subdivisions, for the
775 purpose of making special exception payments, including federal
776 matching funds. Funds received for this purpose shall be
777 separately accounted for and may not be commingled with other
778 state or local funds in any manner. The agency may certify all
779 local governmental funds used as state match under Title XIX of
780 the Social Security Act to the extent and in the manner
781 authorized under the General Appropriations Act and pursuant to
782 an agreement between the agency and the local governmental
783 entity. In order for the agency to certify such local

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784 governmental funds, a local governmental entity must submit a
785 final, executed letter of agreement to the agency, which must be
786 received by October 1 of each fiscal year and provide the total
787 amount of local governmental funds authorized by the entity for
788 that fiscal year under the General Appropriations Act. The local
789 governmental entity shall use a certification form prescribed by
790 the agency. At a minimum, the certification form must identify
791 the amount being certified and describe the relationship between
792 the certifying local governmental entity and the local health
793 care provider. Local governmental funds outlined in the letters
794 of agreement must be received by the agency no later than
795 October 31 of each fiscal year in which such funds are pledged,
796 unless an alternative plan is specifically approved by the
797 agency.

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

800 409.9082 Quality assessment on nursing home facility
801 providers; exemptions; purpose; federal approval required;
802 remedies.—

803 (4) The purpose of the nursing home facility quality
804 assessment is to ensure continued quality of care. Collected
805 assessment funds shall be used to obtain federal financial
806 participation through the Medicaid program to make Medicaid
807 payments for nursing home facility services up to the amount of
808 nursing home facility Medicaid rates as calculated in accordance
809 with the approved state Medicaid plan in effect on December 31,
810 2007. The quality assessment and federal matching funds shall be
811 used exclusively for the following purposes and in the following
812 order of priority:

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

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

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

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

827 409.909 Statewide Medicaid Residency Program.—

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

840 (2) On or before September 15 of each year, the agency
841 shall calculate an allocation fraction to be used for

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842 distributing funds to participating hospitals and to qualifying
843 institutions as defined in paragraph (2) (c). On or before the
844 final business day of each quarter of a state fiscal year, the
845 agency shall distribute to each participating hospital one-
846 fourth of that hospital's annual allocation calculated under
847 subsection (4). The allocation fraction for each participating
848 hospital is based on the hospital's number of full-time
849 equivalent residents and the amount of its Medicaid payments. As
850 used in this section, the term:

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

- 866 1. Family medicine;
- 867 2. General internal medicine;
- 868 3. General pediatrics;
- 869 4. Preventive medicine;
- 870 5. Geriatric medicine;

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- 871 6. Osteopathic general practice;
872 7. Obstetrics and gynecology;
873 8. Emergency medicine;
874 9. General surgery; and
875 10. Psychiatry.

876 (b) "Medicaid payments" means the estimated total payments
877 for reimbursing a hospital for direct inpatient services for the
878 fiscal year in which the allocation fraction is calculated based
879 on the hospital inpatient appropriation and the parameters for
880 the inpatient diagnosis-related group base rate and the
881 parameters for the outpatient enhanced ambulatory payment group
882 rate, including applicable intergovernmental transfers,
883 specified in the General Appropriations Act, as determined by
884 the agency. Effective July 1, 2017, the term "Medicaid payments"
885 means the estimated total payments for reimbursing a hospital
886 and qualifying institutions as defined in paragraph (2) (c) for
887 direct inpatient and outpatient services for the fiscal year in
888 which the allocation fraction is calculated based on the
889 hospital inpatient appropriation and outpatient appropriation
890 and the parameters for the inpatient diagnosis-related group
891 base rate and the parameters for the outpatient enhanced
892 ambulatory payment group rate, including applicable
893 intergovernmental transfers, specified in the General
894 Appropriations Act, as determined by the agency.

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

898 (d) "Resident" means a medical intern, fellow, or resident
899 enrolled in a program accredited by the Accreditation Council

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900 for Graduate Medical Education, the American Association of
901 Colleges of Osteopathic Medicine, or the American Osteopathic
902 Association at the beginning of the state fiscal year during
903 which the allocation fraction is calculated, as reported by the
904 hospital to the agency.

905 (3) The agency shall use the following formula to calculate
906 a participating hospital's and qualifying institution's
907 allocation fraction:

908

$$909 \text{ HAF} = [0.9 \times (\text{HFTE}/\text{TFTE})] + [0.1 \times (\text{HMP}/\text{TMP})]$$

910

911 Where:

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

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

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

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

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

922

923 (4) A hospital's and qualifying institution's annual
924 allocation shall be calculated by multiplying the funds
925 appropriated for the Statewide Medicaid Residency Program in the
926 General Appropriations Act by that hospital's and qualifying
927 institution's allocation fraction. If the calculation results in
928 an annual allocation that exceeds two times the average per FTE

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929 resident amount for all hospitals and qualifying institutions,
930 the hospital's and qualifying institution's annual allocation
931 shall be reduced to a sum equaling no more than two times the
932 average per FTE resident. The funds calculated for that hospital
933 and qualifying institution in excess of two times the average
934 per FTE resident amount for all hospitals and qualifying
935 institutions shall be redistributed to participating hospitals
936 and qualifying institutions whose annual allocation does not
937 exceed two times the average per FTE resident amount for all
938 hospitals and qualifying institutions, using the same
939 methodology and payment schedule specified in this section.

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

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958 across all newly created resident positions in physician
959 specialties in statewide supply-and-demand deficit.

960 (a) Hospitals and qualifying institutions as defined in
961 paragraph (2) (c) applying for a startup bonus must submit to the
962 agency by March 1 their Accreditation Council for Graduate
963 Medical Education or Osteopathic Postdoctoral Training
964 Institution approval validating the new resident positions
965 approved on or after March 2 of the prior fiscal year through
966 March 1 of the current fiscal year for the physician specialties
967 identified in a statewide supply-and-demand deficit as provided
968 in the current fiscal year's General Appropriations Act. An
969 applicant hospital or qualifying institution as defined in
970 paragraph (2) (c) may validate a change in the number of
971 residents by comparing the number in the prior period
972 Accreditation Council for Graduate Medical Education or
973 Osteopathic Postdoctoral Training Institution approval to the
974 number in the current year.

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

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

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987 Appropriations Act.

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

992 (6) Beginning in the 2015-2016 state fiscal year, the
993 agency shall reconcile each participating hospital's total
994 number of FTE residents calculated for the state fiscal year 2
995 years before with its most recently available Medicare cost
996 reports covering the same time period. Reconciled FTE counts
997 shall be prorated according to the portion of the state fiscal
998 year covered by a Medicare cost report. Using the same
999 definitions, methodology, and payment schedule specified in this
1000 section, the reconciliation shall apply any differences in
1001 annual allocations calculated under subsection (4) to the
1002 current year's annual allocations.

1003 (7) The agency may adopt rules to administer this section.

1004 Section 12. Paragraph (a) of subsection (2) of section
1005 409.911, Florida Statutes, is amended, and paragraph (b) of that
1006 subsection is republished, to read:

1007 409.911 Disproportionate share program.—Subject to specific
1008 allocations established within the General Appropriations Act
1009 and any limitations established pursuant to chapter 216, the
1010 agency shall distribute, pursuant to this section, moneys to
1011 hospitals providing a disproportionate share of Medicaid or
1012 charity care services by making quarterly Medicaid payments as
1013 required. Notwithstanding the provisions of s. 409.915, counties
1014 are exempt from contributing toward the cost of this special
1015 reimbursement for hospitals serving a disproportionate share of

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1016 low-income patients.

1017 (2) The Agency for Health Care Administration shall use the
1018 following actual audited data to determine the Medicaid days and
1019 charity care to be used in calculating the disproportionate
1020 share payment:

1021 (a) The average of the 2009, 2010, and 2011 ~~2007, 2008, and~~
1022 ~~2009~~ audited disproportionate share data to determine each
1023 hospital's Medicaid days and charity care for the 2017-2018
1024 ~~2015-2016~~ state fiscal year.

1025 (b) If the Agency for Health Care Administration does not
1026 have the prescribed 3 years of audited disproportionate share
1027 data as noted in paragraph (a) for a hospital, the agency shall
1028 use the average of the years of the audited disproportionate
1029 share data as noted in paragraph (a) which is available.

1030 Section 13. Section 409.9119, Florida Statutes, is amended
1031 to read:

1032 409.9119 Disproportionate share program for specialty
1033 hospitals for children.—In addition to the payments made under
1034 s. 409.911, the Agency for Health Care Administration shall
1035 develop and implement a system under which disproportionate
1036 share payments are made to those hospitals that are separately
1037 licensed by the state as specialty hospitals for children, have
1038 a federal Centers for Medicare and Medicaid Services
1039 certification number in the 3300-3399 range, have Medicaid days
1040 that exceed 55 percent of their total days and Medicare days
1041 that are less than 5 percent of their total days, and were
1042 licensed on January 1, 2013 ~~January 1, 2000~~, as specialty
1043 hospitals for children. This system of payments must conform to
1044 federal requirements and must distribute funds in each fiscal

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1045 year for which an appropriation is made by making quarterly
 1046 Medicaid payments. Notwithstanding s. 409.915, counties are
 1047 exempt from contributing toward the cost of this special
 1048 reimbursement for hospitals that serve a disproportionate share
 1049 of low-income patients. The agency may make disproportionate
 1050 share payments to specialty hospitals for children as provided
 1051 for in the General Appropriations Act.

1052 (1) Unless specified in the General Appropriations Act, the
 1053 agency shall use the following formula to calculate the total
 1054 amount earned for hospitals that participate in the specialty
 1055 hospital for children disproportionate share program:

$$1056 \qquad \qquad \qquad 1057 \qquad \qquad \qquad \text{TAE} = \text{DSR} \times \text{BMPD} \times \text{MD}$$

1058
 1059 Where:

1060 TAE = total amount earned by a specialty hospital for
 1061 children.

1062 DSR = disproportionate share rate.

1063 BMPD = base Medicaid per diem.

1064 MD = Medicaid days.

1065
 1066 (2) The agency shall calculate the total additional payment
 1067 for hospitals that participate in the specialty hospital for
 1068 children disproportionate share program as follows:

$$1069 \qquad \qquad \qquad 1070 \qquad \qquad \qquad \text{TAP} = (\text{TAE} \times \text{TA}) \div \text{STAE}$$

1071
 1072 Where:

1073 TAP = total additional payment for a specialty hospital for

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1074 children.

1075 TAE = total amount earned by a specialty hospital for
1076 children.

1077 TA = total appropriation for the specialty hospital for
1078 children disproportionate share program.

1079 STAE = sum of total amount earned by each hospital that
1080 participates in the specialty hospital for children
1081 disproportionate share program.

1082

1083 (3) A hospital may not receive any payments under this
1084 section until it achieves full compliance with the applicable
1085 rules of the agency. A hospital that is not in compliance for
1086 two or more consecutive quarters may not receive its share of
1087 the funds. Any forfeited funds must be distributed to the
1088 remaining participating specialty hospitals for children that
1089 are in compliance.

1090 (4) Notwithstanding any provision of this section to the
1091 contrary, for the 2017-2018 ~~2016-2017~~ state fiscal year, for
1092 hospitals achieving full compliance under subsection (3), the
1093 agency shall make disproportionate share payments to specialty
1094 hospitals for children as provided in the 2017-2018 ~~2016-2017~~
1095 General Appropriations Act. This subsection expires July 1, 2018
1096 ~~2017~~.

1097 Section 14. Subsection (36) of section 409.913, Florida
1098 Statutes, is amended to read:

1099 409.913 Oversight of the integrity of the Medicaid
1100 program.—The agency shall operate a program to oversee the
1101 activities of Florida Medicaid recipients, and providers and
1102 their representatives, to ensure that fraudulent and abusive

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1103 behavior and neglect of recipients occur to the minimum extent
1104 possible, and to recover overpayments and impose sanctions as
1105 appropriate. Beginning January 1, 2003, and each year
1106 thereafter, the agency and the Medicaid Fraud Control Unit of
1107 the Department of Legal Affairs shall submit a joint report to
1108 the Legislature documenting the effectiveness of the state's
1109 efforts to control Medicaid fraud and abuse and to recover
1110 Medicaid overpayments during the previous fiscal year. The
1111 report must describe the number of cases opened and investigated
1112 each year; the sources of the cases opened; the disposition of
1113 the cases closed each year; the amount of overpayments alleged
1114 in preliminary and final audit letters; the number and amount of
1115 fines or penalties imposed; any reductions in overpayment
1116 amounts negotiated in settlement agreements or by other means;
1117 the amount of final agency determinations of overpayments; the
1118 amount deducted from federal claiming as a result of
1119 overpayments; the amount of overpayments recovered each year;
1120 the amount of cost of investigation recovered each year; the
1121 average length of time to collect from the time the case was
1122 opened until the overpayment is paid in full; the amount
1123 determined as uncollectible and the portion of the uncollectible
1124 amount subsequently reclaimed from the Federal Government; the
1125 number of providers, by type, that are terminated from
1126 participation in the Medicaid program as a result of fraud and
1127 abuse; and all costs associated with discovering and prosecuting
1128 cases of Medicaid overpayments and making recoveries in such
1129 cases. The report must also document actions taken to prevent
1130 overpayments and the number of providers prevented from
1131 enrolling in or reenrolling in the Medicaid program as a result

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1132 of documented Medicaid fraud and abuse and must include policy
1133 recommendations necessary to prevent or recover overpayments and
1134 changes necessary to prevent and detect Medicaid fraud. All
1135 policy recommendations in the report must include a detailed
1136 fiscal analysis, including, but not limited to, implementation
1137 costs, estimated savings to the Medicaid program, and the return
1138 on investment. The agency must submit the policy recommendations
1139 and fiscal analyses in the report to the appropriate estimating
1140 conference, pursuant to s. 216.137, by February 15 of each year.
1141 The agency and the Medicaid Fraud Control Unit of the Department
1142 of Legal Affairs each must include detailed unit-specific
1143 performance standards, benchmarks, and metrics in the report,
1144 including projected cost savings to the state Medicaid program
1145 during the following fiscal year.

1146 (36) ~~At least three times a year,~~ The agency may ~~shall~~
1147 provide to a sample of each Medicaid recipients recipient or
1148 their representatives through the distribution of explanations
1149 his or her representative an explanation of benefits information
1150 about services reimbursed by the Medicaid program for goods and
1151 services to such recipients, including in the form of a letter
1152 that is mailed to the most recent address of the recipient on
1153 the record with the Department of Children and Families. The
1154 explanation of benefits must include the patient's name, the
1155 name of the health care provider and the address of the location
1156 where the service was provided, a description of all services
1157 billed to Medicaid in terminology that should be understood by a
1158 reasonable person, and information on how to report
1159 inappropriate or incorrect billing to the agency or other law
1160 enforcement entities for review or investigation. At least once

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1161 ~~a year, the letter also must include~~ information on how to
1162 report criminal Medicaid fraud ~~to~~, the Medicaid Fraud Control
1163 Unit's toll-free hotline number, and information about the
1164 rewards available under s. 409.9203. The explanation of benefits
1165 may not be mailed for Medicaid independent laboratory services
1166 as described in s. 409.905(7) or for Medicaid certified match
1167 services as described in ss. 409.9071 and 1011.70.

1168 Section 15. Paragraph (e) of subsection (1) of section
1169 409.975, Florida Statutes, is amended, to read:

1170 409.975 Managed care plan accountability.—In addition to
1171 the requirements of s. 409.967, plans and providers
1172 participating in the managed medical assistance program shall
1173 comply with the requirements of this section.

1174 (1) PROVIDER NETWORKS.—Managed care plans must develop and
1175 maintain provider networks that meet the medical needs of their
1176 enrollees in accordance with standards established pursuant to
1177 s. 409.967(2)(c). Except as provided in this section, managed
1178 care plans may limit the providers in their networks based on
1179 credentials, quality indicators, and price.

1180 (e) Each managed care plan may ~~must~~ offer a network
1181 contract to each home medical equipment and supplies provider in
1182 the region which meets quality and fraud prevention and
1183 detection standards established by the plan and which agrees to
1184 accept the lowest price previously negotiated between the plan
1185 and another such provider.

1186 Section 16. Subsections (1) and (2) of section 409.979,
1187 Florida Statutes, are amended to read:

1188 409.979 Eligibility.—

1189 (1) PREREQUISITE CRITERIA FOR ELIGIBILITY.—Medicaid

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1190 recipients who meet all of the following criteria are eligible
1191 to receive long-term care services and must receive long-term
1192 care services by participating in the long-term care managed
1193 care program. The recipient must be:

1194 (a) Sixty-five years of age or older, or age 18 or older
1195 and eligible for Medicaid by reason of a disability.

1196 (b) Determined by the Comprehensive Assessment Review and
1197 Evaluation for Long-Term Care Services (CARES) preadmission
1198 screening program to require:

1199 1. Nursing facility care as defined in s. 409.985(3); or
1200 2. Hospital level of care, for individuals diagnosed with
1201 cystic fibrosis.

1202 (2) ENROLLMENT OFFERS.—Subject to the availability of
1203 funds, the Department of Elderly Affairs shall make offers for
1204 enrollment to eligible individuals based on a wait-list
1205 prioritization. Before making enrollment offers, the agency and
1206 the Department of Elderly Affairs shall determine that
1207 sufficient funds exist to support additional enrollment into
1208 plans.

1209 (a) A Medicaid recipient enrolled in one of the following
1210 Medicaid home and community-based services waiver programs who
1211 meets the eligibility criteria established in subsection (1) is
1212 eligible to participate in the long-term care managed care
1213 program and must be transitioned into the long-term care managed
1214 care program by January 1, 2018:

1215 1. Traumatic Brain and Spinal Cord Injury Waiver.

1216 2. Adult Cystic Fibrosis Waiver.

1217 3. Project AIDS Care Waiver.

1218 (b) The agency shall seek federal approval to terminate the

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1219 Traumatic Brain and Spinal Cord Injury Waiver, the Adult Cystic
1220 Fibrosis Waiver, and the Project AIDS Care Waiver once all
1221 eligible Medicaid recipients have transitioned into the long-
1222 term care managed care program.

1223 Section 17. Effective October 1, 2018, subsection (6) of
1224 section 409.983, Florida Statutes, is amended to read:

1225 409.983 Long-term care managed care plan payment.—In
1226 addition to the payment provisions of s. 409.968, the agency
1227 shall provide payment to plans in the long-term care managed
1228 care program pursuant to this section.

1229 (6) The agency shall establish nursing-facility-specific
1230 payment rates for each licensed nursing home ~~based on facility~~
1231 ~~costs adjusted for inflation and other factors~~ as authorized in
1232 the General Appropriations Act. Payments to long-term care
1233 managed care plans shall be reconciled, as necessary, to
1234 reimburse actual payments to nursing facilities resulting from
1235 changes in nursing home per diem rates, but may not be
1236 reconciled to actual days experienced by the long-term care
1237 managed care plans.

1238 Section 18. Subsection (27) of section 409.901, Florida
1239 Statutes, is amended to read:

1240 409.901 Definitions; ss. 409.901-409.920.—As used in ss.
1241 409.901-409.920, except as otherwise specifically provided, the
1242 term:

1243 (27) "Third party" means an individual, entity, or program,
1244 excluding Medicaid, that is, may be, could be, should be, or has
1245 been liable for all or part of the cost of medical services
1246 related to any medical assistance covered by Medicaid. A third
1247 party includes a third-party administrator; ~~or~~ a pharmacy

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1248 benefits manager; a health insurer; a self-insured plan; a group
1249 health plan, as defined in s. 607(1) of the Employee Retirement
1250 Income Security Act of 1974; a service benefit plan; a managed
1251 care organization; liability insurance, including self-
1252 insurance; no-fault insurance; workers' compensation laws or
1253 plans; or other parties that are, by statute, contract, or
1254 agreement, legally responsible for payment of a claim for a
1255 health care item or service.

1256 Section 19. Subsection (4), paragraph (c) of subsection
1257 (6), paragraph (h) of subsection (11), subsection (16),
1258 paragraph (b) of subsection (17), and subsection (20) of section
1259 409.910, Florida Statutes, are amended to read:

1260 409.910 Responsibility for payments on behalf of Medicaid-
1261 eligible persons when other parties are liable.-

1262 (4) After the agency has provided medical assistance under
1263 the Medicaid program, it shall seek ~~recovery of~~ reimbursement
1264 from third-party benefits to the limit of legal liability and
1265 for the full amount of third-party benefits, but not in excess
1266 of the amount of medical assistance paid by Medicaid, as to:

1267 (a) Claims for which the agency has a waiver pursuant to
1268 federal law; or

1269 (b) Situations in which the agency learns of the existence
1270 of a liable third party or in which third-party benefits are
1271 discovered or become available after medical assistance has been
1272 provided by Medicaid.

1273 (6) When the agency provides, pays for, or becomes liable
1274 for medical care under the Medicaid program, it has the
1275 following rights, as to which the agency may assert independent
1276 principles of law, which shall nevertheless be construed

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1277 together to provide the greatest recovery from third-party
1278 benefits:

1279 (c) The agency is entitled to, and has, an automatic lien
1280 for the full amount of medical assistance provided by Medicaid
1281 to or on behalf of the recipient for medical care furnished as a
1282 result of any covered injury or illness for which a third party
1283 is or may be liable, upon the collateral, as defined in s.
1284 409.901.

1285 1. The lien attaches automatically when a recipient first
1286 receives treatment for which the agency may be obligated to
1287 provide medical assistance under the Medicaid program. The lien
1288 is perfected automatically at the time of attachment.

1289 2. The agency is authorized to file a verified claim of
1290 lien. The claim of lien shall be signed by an authorized
1291 employee of the agency, and shall be verified as to the
1292 employee's knowledge and belief. The claim of lien may be filed
1293 and recorded with the clerk of the circuit court in the
1294 recipient's last known county of residence or in any county
1295 deemed appropriate by the agency. The claim of lien, to the
1296 extent known by the agency, shall contain:

1297 a. The name and last known address of the person to whom
1298 medical care was furnished.

1299 b. The date of injury.

1300 c. The period for which medical assistance was provided.

1301 d. The amount of medical assistance provided or paid, or
1302 for which Medicaid is otherwise liable.

1303 e. The names and addresses of all persons claimed by the
1304 recipient to be liable for the covered injuries or illness.

1305 3. The filing of the claim of lien pursuant to this section

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1306 shall be notice thereof to all persons.

1307 4. If the claim of lien is filed within 3 years ~~1 year~~
1308 after the later of the date when the last item of medical care
1309 relative to a specific covered injury or illness was paid, or
1310 the date of discovery by the agency of the liability of any
1311 third party, or the date of discovery of a cause of action
1312 against a third party brought by a recipient or his or her legal
1313 representative, record notice shall relate back to the time of
1314 attachment of the lien.

1315 5. If the claim of lien is filed after 3 years ~~1 year~~ after
1316 the later of the events specified in subparagraph 4., notice
1317 shall be effective as of the date of filing.

1318 6. Only one claim of lien need be filed to provide notice
1319 as set forth in this paragraph and shall provide sufficient
1320 notice as to any additional or after-paid amount of medical
1321 assistance provided by Medicaid for any specific covered injury
1322 or illness. The agency may, in its discretion, file additional,
1323 amended, or substitute claims of lien at any time after the
1324 initial filing, until the agency has been repaid the full amount
1325 of medical assistance provided by Medicaid or otherwise has
1326 released the liable parties and recipient.

1327 7. No release or satisfaction of any cause of action, suit,
1328 claim, counterclaim, demand, judgment, settlement, or settlement
1329 agreement shall be valid or effectual as against a lien created
1330 under this paragraph, unless the agency joins in the release or
1331 satisfaction or executes a release of the lien. An acceptance of
1332 a release or satisfaction of any cause of action, suit, claim,
1333 counterclaim, demand, or judgment and any settlement of any of
1334 the foregoing in the absence of a release or satisfaction of a

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1335 lien created under this paragraph shall prima facie constitute
1336 an impairment of the lien, and the agency is entitled to recover
1337 damages on account of such impairment. In an action on account
1338 of impairment of a lien, the agency may recover from the person
1339 accepting the release or satisfaction or making the settlement
1340 the full amount of medical assistance provided by Medicaid.
1341 Nothing in this section shall be construed as creating a lien or
1342 other obligation on the part of an insurer which in good faith
1343 has paid a claim pursuant to its contract without knowledge or
1344 actual notice that the agency has provided medical assistance
1345 for the recipient related to a particular covered injury or
1346 illness. However, notice or knowledge that an insured is, or has
1347 been a Medicaid recipient within 1 year from the date of service
1348 for which a claim is being paid creates a duty to inquire on the
1349 part of the insurer as to any injury or illness for which the
1350 insurer intends or is otherwise required to pay benefits.

1351 8. The lack of a properly filed claim of lien shall not
1352 affect the agency's assignment or subrogation rights provided in
1353 this subsection, nor shall it affect the existence of the lien,
1354 but only the effective date of notice as provided in
1355 subparagraph 5.

1356 9. The lien created by this paragraph is a first lien and
1357 superior to the liens and charges of any provider, and shall
1358 exist for a period of 7 years, if recorded, after the date of
1359 recording; and shall exist for a period of 7 years after the
1360 date of attachment, if not recorded. If recorded, the lien may
1361 be extended for one additional period of 7 years by rerecording
1362 the claim of lien within the 90-day period preceding the
1363 expiration of the lien.

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1364 10. The clerk of the circuit court for each county in the
1365 state shall endorse on a claim of lien filed under this
1366 paragraph the date and hour of filing and shall record the claim
1367 of lien in the official records of the county as for other
1368 records received for filing. The clerk shall receive as his or
1369 her fee for filing and recording any claim of lien or release of
1370 lien under this paragraph the total sum of \$2. Any fee required
1371 to be paid by the agency shall not be required to be paid in
1372 advance of filing and recording, but may be billed to the agency
1373 after filing and recording of the claim of lien or release of
1374 lien.

1375 11. After satisfaction of any lien recorded under this
1376 paragraph, the agency shall, within 60 days after satisfaction,
1377 either file with the appropriate clerk of the circuit court or
1378 mail to any appropriate party, or counsel representing such
1379 party, if represented, a satisfaction of lien in a form
1380 acceptable for filing in Florida.

1381 (11) The agency may, as a matter of right, in order to
1382 enforce its rights under this section, institute, intervene in,
1383 or join any legal or administrative proceeding in its own name
1384 in one or more of the following capacities: individually, as
1385 subrogee of the recipient, as assignee of the recipient, or as
1386 lienholder of the collateral.

1387 (h) Except as otherwise provided in this section, actions
1388 to enforce the rights of the agency under this section shall be
1389 commenced within 6 ~~5~~ years after the date a cause of action
1390 accrues, with the period running from the later of the date of
1391 discovery by the agency of a case filed by a recipient or his or
1392 her legal representative, or of discovery of any judgment,

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1393 award, or settlement contemplated in this section, or of
1394 discovery of facts giving rise to a cause of action under this
1395 section. Nothing in this paragraph affects or prevents a
1396 proceeding to enforce a lien during the existence of the lien as
1397 set forth in subparagraph (6)(c)9.

1398 (16) Any transfer or encumbrance of any right, title, or
1399 interest to which the agency has a right pursuant to this
1400 section, with the intent, likelihood, or practical effect of
1401 defeating, hindering, or reducing reimbursement to recovery by
1402 the agency for ~~reimbursement~~ of medical assistance provided by
1403 Medicaid, shall be deemed to be a fraudulent conveyance, and
1404 such transfer or encumbrance shall be void and of no effect
1405 against the claim of the agency, unless the transfer was for
1406 adequate consideration and the proceeds of the transfer are
1407 reimbursed in full to the agency, but not in excess of the
1408 amount of medical assistance provided by Medicaid.

1409 (17)

1410 (b) If federal law limits the agency to reimbursement from
1411 the recovered medical expense damages, a recipient, or his or
1412 her legal representative, may contest the amount designated as
1413 recovered medical expense damages payable to the agency pursuant
1414 to the formula specified in paragraph (11)(f) by filing a
1415 petition under chapter 120 within 21 days after the date of
1416 payment of funds to the agency or after the date of placing the
1417 full amount of the third-party benefits in the trust account for
1418 the benefit of the agency pursuant to paragraph (a). The
1419 petition shall be filed with the Division of Administrative
1420 Hearings. For purposes of chapter 120, the payment of funds to
1421 the agency or the placement of the full amount of the third-

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1422 party benefits in the trust account for the benefit of the
1423 agency constitutes final agency action and notice thereof. Final
1424 order authority for the proceedings specified in this subsection
1425 rests with the Division of Administrative Hearings. This
1426 procedure is the exclusive method for challenging the amount of
1427 third-party benefits payable to the agency. In order to
1428 successfully challenge the amount designated as recovered
1429 medical expenses payable to the agency, the recipient must
1430 prove, by clear and convincing evidence, that the a lesser
1431 portion of the total recovery which should be allocated as
1432 reimbursement for past and future medical expenses is less than
1433 the amount calculated by the agency pursuant to the formula set
1434 forth in paragraph (11)(f). Alternatively, the recipient must
1435 prove by clear and convincing evidence ~~or~~ that Medicaid provided
1436 a lesser amount of medical assistance than that asserted by the
1437 agency.

1438 (20) (a) Entities providing health insurance as defined in
1439 s. 624.603, health maintenance organizations and prepaid health
1440 clinics as defined in chapter 641, and, on behalf of their
1441 clients, third-party administrators, ~~and~~ pharmacy benefits
1442 managers, and any other third parties, as defined in s.
1443 409.901(27), which are legally responsible for payment of a
1444 claim for a health care item or service as a condition of doing
1445 business in the state or providing coverage to residents of this
1446 state, shall provide such records and information as are
1447 necessary to accomplish the purpose of this section, unless such
1448 requirement results in an unreasonable burden.

1449 (b) An entity must respond to a request for payment with
1450 payment on the claim, a written request for additional

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1451 information with which to process the claim, or a written reason
1452 for denial of the claim within 90 working days after receipt of
1453 written proof of loss or claim for payment for a health care
1454 item or service provided to a Medicaid recipient who is covered
1455 by the entity. Failure to pay or deny a claim within 140 days
1456 after receipt of the claim creates an uncontestable obligation
1457 to pay the claim.

1458 ~~(a) The director of the agency and the Director of the~~
1459 ~~Office of Insurance Regulation of the Financial Services~~
1460 ~~Commission shall enter into a cooperative agreement for~~
1461 ~~requesting and obtaining information necessary to effect the~~
1462 ~~purpose and objective of this section.~~

1463 ~~1. The agency shall request only that information necessary~~
1464 ~~to determine whether health insurance as defined pursuant to s.~~
1465 ~~624.603, or those health services provided pursuant to chapter~~
1466 ~~641, could be, should be, or have been claimed and paid with~~
1467 ~~respect to items of medical care and services furnished to any~~
1468 ~~person eligible for services under this section.~~

1469 ~~2. All information obtained pursuant to subparagraph 1. is~~
1470 ~~confidential and exempt from s. 119.07(1). The agency shall~~
1471 ~~provide the information obtained pursuant to subparagraph 1. to~~
1472 ~~the Department of Revenue for purposes of administering the~~
1473 ~~state Title IV-D program. The agency and the Department of~~
1474 ~~Revenue shall enter into a cooperative agreement for purposes of~~
1475 ~~implementing this requirement.~~

1476 ~~3. The cooperative agreement or rules adopted under this~~
1477 ~~subsection may include financial arrangements to reimburse the~~
1478 ~~reporting entities for reasonable costs or a portion thereof~~
1479 ~~incurred in furnishing the requested information. Neither the~~

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1480 ~~cooperative agreement nor the rules shall require the automation~~
1481 ~~of manual processes to provide the requested information.~~

1482 ~~(b) The agency and the Financial Services Commission~~
1483 ~~jointly shall adopt rules for the development and administration~~
1484 ~~of the cooperative agreement. The rules shall include the~~
1485 ~~following:~~

1486 ~~1. A method for identifying those entities subject to~~
1487 ~~furnishing information under the cooperative agreement.~~

1488 ~~2. A method for furnishing requested information.~~

1489 ~~3. Procedures for requesting exemption from the cooperative~~
1490 ~~agreement based on an unreasonable burden to the reporting~~
1491 ~~entity.~~

1492 Section 20. Notwithstanding section 27 of chapter 2016-65,
1493 Laws of Florida, and subject to federal approval of the
1494 application to be a site for the Program of All-inclusive Care
1495 for the Elderly (PACE), the Agency for Health Care
1496 Administration shall contract with a not-for-profit
1497 organization, formed by a partnership with a not-for-profit
1498 hospital, a not-for-profit agency serving elders, and a not-for-
1499 profit hospice in Leon County. The not-for-profit PACE shall
1500 serve eligible PACE enrollees in Gadsden, Jefferson, Leon, and
1501 Wakulla Counties. The Agency for Health Care Administration, in
1502 consultation with the Department of Elderly Affairs and subject
1503 to an appropriation, shall approve up to 300 initial enrollees
1504 for the additional PACE site.

1505 Section 21. Section 17 of chapter 2011-61, Laws of Florida,
1506 is amended to read:

1507 Section 17. Notwithstanding s. 430.707, Florida Statutes,
1508 and subject to federal approval of the application to be a site

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1509 for the Program of All-inclusive Care for the Elderly, the
1510 Agency for Health Care Administration shall contract with one
1511 private health care organization, the sole member of which is a
1512 private, not-for-profit corporation that owns and manages health
1513 care organizations which provide comprehensive long-term care
1514 services, including nursing home, assisted living, independent
1515 housing, home care, adult day care, and care management, with a
1516 board-certified, trained geriatrician as the medical director.
1517 This organization shall provide these services to frail and
1518 elderly persons who reside in Indian River, Martin, Okeechobee,
1519 Palm Beach, and St. Lucie Counties ~~County~~. The organization is
1520 exempt from the requirements of chapter 641, Florida Statutes.
1521 The agency, in consultation with the Department of Elderly
1522 Affairs and subject to an appropriation, shall approve up to 150
1523 initial enrollees who reside in Palm Beach County and up to 150
1524 initial enrollees who reside in Martin County in the Program of
1525 All-inclusive Care for the Elderly established by this
1526 organization to serve elderly persons ~~who reside in Palm Beach~~
1527 ~~County~~.

1528 Section 22. Section 29 of chapter 2016-65, Laws of Florida,
1529 is amended to read:

1530 Section 29. Subject to federal approval of the application
1531 to be a site for the Program of All-inclusive Care for the
1532 Elderly (PACE), the Agency for Health Care Administration shall
1533 contract with one private, not-for-profit hospice organization
1534 located in Lake County which operates health care organizations
1535 licensed in Hospice Areas 7B and 3E and which provides
1536 comprehensive services, including hospice and palliative care,
1537 to frail elders who reside in these service areas. The

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1538 organization is exempt from the requirements of chapter 641,
1539 Florida Statutes. The agency, in consultation with the
1540 Department of Elderly Affairs and subject to the appropriation
1541 of funds by the Legislature, shall approve up to 150 initial
1542 enrollees in the Program of All-inclusive Care for the Elderly
1543 established by the organization to serve frail elders who reside
1544 in Hospice Service Areas 7B and 3E. The agency, in consultation
1545 with the department and subject to an appropriation, shall
1546 approve up to 150 enrollees in the Program of All-inclusive Care
1547 for the Elderly established by this organization to serve frail
1548 elders who reside in Hospice Service Area 7C.

1549 Section 23. Subsection (3) of section 391.055, Florida
1550 Statutes, is amended to read:

1551 391.055 Service delivery systems.—

1552 (3) The Children's Medical Services network may contract
1553 with school districts participating in the certified school
1554 match program pursuant to ss. 409.908(21) ~~409.908(22)~~ and
1555 1011.70 for the provision of school-based services, as provided
1556 for in s. 409.9071, for Medicaid-eligible children who are
1557 enrolled in the Children's Medical Services network.

1558 Section 24. Subsection (7) of section 393.0661, Florida
1559 Statutes, is amended to read:

1560 393.0661 Home and community-based services delivery system;
1561 comprehensive redesign.—The Legislature finds that the home and
1562 community-based services delivery system for persons with
1563 developmental disabilities and the availability of appropriated
1564 funds are two of the critical elements in making services
1565 available. Therefore, it is the intent of the Legislature that
1566 the Agency for Persons with Disabilities shall develop and

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1567 implement a comprehensive redesign of the system.

1568 (7) The agency shall collect premiums or cost sharing
1569 pursuant to s. 409.906(13)(c) ~~409.906(13)(d)~~.

1570 Section 25. Paragraph (a) of subsection (4) of section
1571 409.968, Florida Statutes, is amended to read:

1572 409.968 Managed care plan payments.—

1573 (4)(a) Subject to a specific appropriation and federal
1574 approval under s. 409.906(13)(d) ~~409.906(13)(e)~~, the agency
1575 shall establish a payment methodology to fund managed care plans
1576 for flexible services for persons with severe mental illness and
1577 substance use disorders, including, but not limited to,
1578 temporary housing assistance. A managed care plan eligible for
1579 these payments must do all of the following:

1580 1. Participate as a specialty plan for severe mental
1581 illness or substance use disorders or participate in counties
1582 designated by the General Appropriations Act;

1583 2. Include providers of behavioral health services pursuant
1584 to chapters 394 and 397 in the managed care plan's provider
1585 network; and

1586 3. Document a capability to provide housing assistance
1587 through agreements with housing providers, relationships with
1588 local housing coalitions, and other appropriate arrangements.

1589 Section 26. Subsection (3) of section 427.0135, Florida
1590 Statutes, is amended to read:

1591 427.0135 Purchasing agencies; duties and responsibilities.—
1592 Each purchasing agency, in carrying out the policies and
1593 procedures of the commission, shall:

1594 (3) Not procure transportation disadvantaged services
1595 without initially negotiating with the commission, as provided

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1596 in s. 287.057(3)(e)12., or unless otherwise authorized by
1597 statute. If the purchasing agency, after consultation with the
1598 commission, determines that it cannot reach mutually acceptable
1599 contract terms with the commission, the purchasing agency may
1600 contract for the same transportation services provided in a more
1601 cost-effective manner and of comparable or higher quality and
1602 standards. The Medicaid agency shall implement this subsection
1603 in a manner consistent with s. 409.908(18) ~~409.908(19)~~ and as
1604 otherwise limited or directed by the General Appropriations Act.

1605 Section 27. Subsections (1) and (5) of section 1011.70,
1606 Florida Statutes, are amended to read:

1607 1011.70 Medicaid certified school funding maximization.—

1608 (1) Each school district, subject to the provisions of ss.
1609 409.9071 and 409.908(21) ~~409.908(22)~~ and this section, is
1610 authorized to certify funds provided for a category of required
1611 Medicaid services termed "school-based services," which are
1612 reimbursable under the federal Medicaid program. Such services
1613 shall include, but not be limited to, physical, occupational,
1614 and speech therapy services, behavioral health services, mental
1615 health services, transportation services, Early Periodic
1616 Screening, Diagnosis, and Treatment (EPSDT) administrative
1617 outreach for the purpose of determining eligibility for
1618 exceptional student education, and any other such services, for
1619 the purpose of receiving federal Medicaid financial
1620 participation. Certified school funding shall not be available
1621 for the following services:

- 1622 (a) Family planning.
- 1623 (b) Immunizations.
- 1624 (c) Prenatal care.

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1625 (5) Lab schools, as authorized under s. 1002.32, shall be
1626 authorized to participate in the Medicaid certified school match
1627 program on the same basis as school districts subject to the
1628 provisions of subsections (1)-(4) and ss. 409.9071 and
1629 409.908(21) ~~409.908(22)~~.

1630 Section 28. For the 2017-2018 fiscal year, \$578,918,460 in
1631 nonrecurring funds from the Grants and Donations Trust Fund and
1632 \$924,467,313 in nonrecurring funds from the Medical Care Trust
1633 Fund are appropriated to the Agency for Health Care
1634 Administration for the purpose of implementing a Low-Income Pool
1635 Program. These funds shall be held in reserve. Subject to the
1636 federal approval of the final terms and conditions of the Low-
1637 Income Pool, the Agency for Health Care Administration shall
1638 submit a budget amendment requesting release of the funds held
1639 in reserve pursuant to chapter 216, Florida Statutes. If the
1640 chair and vice chair of the Legislative Budget Commission or the
1641 President of the Senate and the Speaker of the House of
1642 Representatives object in writing to a proposed amendment within
1643 14 days after notification, the Governor shall void the action.
1644 In addition to the proposed amendment, the agency must submit:
1645 the Reimbursement and Funding Methodology Document, as specified
1646 in the terms and conditions, which documents permissible Low-
1647 Income Pool expenditures; a proposed distribution model by
1648 entity; and a proposed listing of entities contributing
1649 Intergovernmental Transfers to support the state match required.
1650 Low-Income Pool payments to providers under this section are
1651 contingent upon the nonfederal share being provided through
1652 intergovernmental transfers in the Grants and Donations Trust
1653 Fund. In the event the funds are not available in the Grants and

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1654 Donations Trust Fund, the State of Florida is not obligated to
1655 make payments under this section. This section expires July 1,
1656 2018.

1657 Section 29. For the 2017-2018 fiscal year, \$94,414,800 in
1658 nonrecurring funds from the Grants and Donations Trust Fund and
1659 \$151,585,200 in nonrecurring funds from the Medical Care Trust
1660 Funds are appropriated to the Agency for Health Care
1661 Administration to continue medical school faculty physician
1662 supplemental payments. These funds shall be held in reserve.
1663 These funds shall be used to continue supplemental payments for
1664 services provided by doctors of medicine and osteopathy, as well
1665 as other licensed health care practitioners acting under the
1666 supervision of those doctors, who are employed by or under
1667 contract with a medical school in Florida. These funds may also
1668 be used for pass-through, sub-capitation, differential fee, or
1669 directed lump sum payments for doctors of medicine and
1670 osteopathy, as well as other licensed health care practitioners
1671 acting under the supervision of those doctors, who are employed
1672 by or under contract with a medical school in Florida. Subject
1673 to federal approval to continue the supplemental and/or pass-
1674 through, sub-capitation, differential fee, or directed lump sum
1675 payments, the Agency for Health Care Administration may submit a
1676 budget amendment requesting release of the funds held in reserve
1677 pursuant to the provisions of chapter 216, Florida Statutes. If
1678 the chair and vice chair of the Legislative Budget Commission or
1679 the President of the Senate and the Speaker of the House of
1680 Representatives object in writing to a proposed amendment within
1681 14 days following notification, the Governor shall void the
1682 action. The amendment shall include the federal approvals, a

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1683 proposed distribution model by entity, and a proposed listing of
1684 entities contributing Intergovernmental Transfers to support the
1685 state match required. Payments to providers under this section
1686 are contingent upon the nonfederal share being provided through
1687 intergovernmental transfers in the Grants and Donations Trust
1688 Fund. In the event the funds are not available in the Grants and
1689 Donations Trust Fund, the State of Florida is not obligated to
1690 make payments under this section. This section expires July 1,
1691 2018.

1692 Section 30. Except as otherwise expressly provided in this
1693 act, this act shall take effect July 1, 2017.