

1 A bill to be entitled
2 An act relating to Medicaid services; amending s.
3 395.602, F.S.; revising the definition of the term
4 "rural hospital" to delete sole community hospitals;
5 amending s. 409.904, F.S.; providing that certain
6 persons with AIDS are eligible for optional payments
7 for medical assistance and related services; amending
8 s. 409.906, F.S.; deleting a provision relating to
9 consolidation of waiver services to conform to changes
10 made by the act; amending s. 409.908, F.S.; deleting a
11 provision relating to reimbursement rate parameters
12 for certain Medicaid providers; authorizing the agency
13 to receive funds from certain governmental entities
14 for specified purposes; providing requirements for
15 letters of agreement executed by a local governmental
16 entity; amending s. 409.909, F.S.; revising the
17 definition of the term "Medicaid payments" to include
18 the outpatient enhanced ambulatory payment group for
19 purposes of the Statewide Medicaid Residency Program;
20 amending s. 409.911, F.S.; updating references to data
21 used for calculating disproportionate share program
22 payments to certain hospitals for the 2017-2018 fiscal
23 year; amending s. 409.979, F.S.; revising eligibility
24 criteria for certain long-term care services;
25 providing for certain home and community-based service

26 waiver participants to transition into the long-term
 27 care managed care program; requiring the agency to
 28 seek federal approval to terminate certain waiver
 29 programs; amending ss. 391.055, 393.0661, 409.968,
 30 427.0135, and 1011.70, F.S.; conforming cross-
 31 references; providing an effective date.

32

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

34

35 Section 1. Paragraph (e) of subsection (2) of section
 36 395.602, Florida Statutes, is amended to read:

37 395.602 Rural hospitals.—

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

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

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

44 2. An acute care hospital, in a county with a population
 45 density of up to 100 persons per square mile, which is at least
 46 30 minutes of travel time, on normally traveled roads under
 47 normal traffic conditions, from any other acute care hospital
 48 within the same county;

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

51 square mile;

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

54 4.5. A hospital with a service area that has a population
55 of up to 100 persons per square mile. As used in this
56 subparagraph, the term "service area" means the fewest number of
57 zip codes that account for 75 percent of the hospital's
58 discharges for the most recent 5-year period, based on
59 information available from the hospital inpatient discharge
60 database in the Florida Center for Health Information and
61 Transparency at the agency; or

62 ~~5.6.~~ A hospital designated as a critical access hospital,
63 as defined in s. 408.07.

64
65 Population densities used in this paragraph must be based upon
66 the most recently completed United States census. A hospital
67 that received funds under s. 409.9116 for a quarter beginning no
68 later than July 1, 2002, is deemed to have been and shall
69 continue to be a rural hospital from that date through June 30,
70 2021, if the hospital continues to have up to 100 licensed beds
71 and an emergency room. An acute care hospital that has not
72 previously been designated as a rural hospital and that meets
73 the criteria of this paragraph shall be granted such designation
74 upon application, including supporting documentation, to the
75 agency. A hospital that was licensed as a rural hospital during

76 | the 2010-2011 or 2011-2012 fiscal year shall continue to be a
 77 | rural hospital from the date of designation through June 30,
 78 | 2021, if the hospital continues to have up to 100 licensed beds
 79 | and an emergency room.

80 | Section 2. Subsection (11) is added to section 409.904,
 81 | Florida Statutes, to read:

82 | 409.904 Optional payments for eligible persons.—The agency
 83 | may make payments for medical assistance and related services on
 84 | behalf of the following persons who are determined to be
 85 | eligible subject to the income, assets, and categorical
 86 | eligibility tests set forth in federal and state law. Payment on
 87 | behalf of these Medicaid eligible persons is subject to the
 88 | availability of moneys and any limitations established by the
 89 | General Appropriations Act or chapter 216.

90 | (11) Subject to federal waiver approval, a person with
 91 | acquired immune deficiency syndrome (AIDS) who has an AIDS-
 92 | related opportunistic infection and is at risk of
 93 | hospitalization as determined by the agency or its designee, and
 94 | whose income is at or below 300 percent of the federal benefit
 95 | rate (FBR).

96 | Section 3. Paragraph (b) of subsection (13) of section
 97 | 409.906, Florida Statutes, is amended to read:

98 | 409.906 Optional Medicaid services.—Subject to specific
 99 | appropriations, the agency may make payments for services which
 100 | are optional to the state under Title XIX of the Social Security

101 Act and are furnished by Medicaid providers to recipients who
102 are determined to be eligible on the dates on which the services
103 were provided. Any optional service that is provided shall be
104 provided only when medically necessary and in accordance with
105 state and federal law. Optional services rendered by providers
106 in mobile units to Medicaid recipients may be restricted or
107 prohibited by the agency. Nothing in this section shall be
108 construed to prevent or limit the agency from adjusting fees,
109 reimbursement rates, lengths of stay, number of visits, or
110 number of services, or making any other adjustments necessary to
111 comply with the availability of moneys and any limitations or
112 directions provided for in the General Appropriations Act or
113 chapter 216. If necessary to safeguard the state's systems of
114 providing services to elderly and disabled persons and subject
115 to the notice and review provisions of s. 216.177, the Governor
116 may direct the Agency for Health Care Administration to amend
117 the Medicaid state plan to delete the optional Medicaid service
118 known as "Intermediate Care Facilities for the Developmentally
119 Disabled." Optional services may include:

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

121 ~~(b) The agency may consolidate types of services offered~~
122 ~~in the Aged and Disabled Waiver, the Channeling Waiver, the~~
123 ~~Project AIDS Care Waiver, and the Traumatic Brain and Spinal~~
124 ~~Cord Injury Waiver programs in order to group similar services~~
125 ~~under a single service, or continue a service upon evidence of~~

126 | ~~the need for including a particular service type in a particular~~
127 | ~~waiver. The agency is authorized to seek a Medicaid state plan~~
128 | ~~amendment or federal waiver approval to implement this policy.~~

129 | Section 4. Subsections (6) through (26) of section
130 | 409.908, Florida Statutes, are renumbered as subsections (5)
131 | through (25), respectively, present subsections (5) and (24) are
132 | amended, and a new subsection (26) is added to that section, to
133 | read:

134 | 409.908 Reimbursement of Medicaid providers.—Subject to
135 | specific appropriations, the agency shall reimburse Medicaid
136 | providers, in accordance with state and federal law, according
137 | to methodologies set forth in the rules of the agency and in
138 | policy manuals and handbooks incorporated by reference therein.
139 | These methodologies may include fee schedules, reimbursement
140 | methods based on cost reporting, negotiated fees, competitive
141 | bidding pursuant to s. 287.057, and other mechanisms the agency
142 | considers efficient and effective for purchasing services or
143 | goods on behalf of recipients. If a provider is reimbursed based
144 | on cost reporting and submits a cost report late and that cost
145 | report would have been used to set a lower reimbursement rate
146 | for a rate semester, then the provider's rate for that semester
147 | shall be retroactively calculated using the new cost report, and
148 | full payment at the recalculated rate shall be effected
149 | retroactively. Medicare-granted extensions for filing cost
150 | reports, if applicable, shall also apply to Medicaid cost

151 reports. Payment for Medicaid compensable services made on
152 behalf of Medicaid eligible persons is subject to the
153 availability of moneys and any limitations or directions
154 provided for in the General Appropriations Act or chapter 216.
155 Further, nothing in this section shall be construed to prevent
156 or limit the agency from adjusting fees, reimbursement rates,
157 lengths of stay, number of visits, or number of services, or
158 making any other adjustments necessary to comply with the
159 availability of moneys and any limitations or directions
160 provided for in the General Appropriations Act, provided the
161 adjustment is consistent with legislative intent.

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

165 (23)-(24)(a) The agency shall establish rates at a level
166 that ensures no increase in statewide expenditures resulting
167 from a change in unit costs effective July 1, 2011.
168 Reimbursement rates shall be as provided in the General
169 Appropriations Act.

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

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

176 (d)~~(e)~~ This subsection applies to the following provider
 177 types:

- 178 ~~1. Inpatient hospitals.~~
- 179 ~~2. Outpatient hospitals.~~
- 180 ~~1.3.~~ Nursing homes.
- 181 ~~2.4.~~ County health departments.
- 182 ~~5. Prepaid health plans.~~

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

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

201 amount of local governmental funds authorized by the entity for
 202 that fiscal year under the General Appropriations Act. The local
 203 governmental entity shall use a certification form prescribed by
 204 the agency. At a minimum, the certification form must identify
 205 the amount being certified and describe the relationship between
 206 the certifying local governmental entity and the local health
 207 care provider. Local governmental funds outlined in the letters
 208 of agreement must be received by the agency no later than
 209 October 31 of each fiscal year in which such funds are pledged,
 210 unless an alternative plan is specifically approved by the
 211 agency.

212 Section 5. Paragraph (b) of subsection (2) of section
 213 409.909, Florida Statutes, is amended to read:

214 409.909 Statewide Medicaid Residency Program.—

215 (2) On or before September 15 of each year, the agency
 216 shall calculate an allocation fraction to be used for
 217 distributing funds to participating hospitals. On or before the
 218 final business day of each quarter of a state fiscal year, the
 219 agency shall distribute to each participating hospital one-
 220 fourth of that hospital's annual allocation calculated under
 221 subsection (4). The allocation fraction for each participating
 222 hospital is based on the hospital's number of full-time
 223 equivalent residents and the amount of its Medicaid payments. As
 224 used in this section, the term:

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

226 | for reimbursing a hospital for direct inpatient services for the
227 | fiscal year in which the allocation fraction is calculated based
228 | on the hospital inpatient appropriation and the parameters for
229 | the inpatient diagnosis-related group base rate and the
230 | parameters for the outpatient enhanced ambulatory payment group
231 | rate, including applicable intergovernmental transfers,
232 | specified in the General Appropriations Act, as determined by
233 | the agency. Effective July 1, 2017, the term "Medicaid payments"
234 | means the estimated total payments for reimbursing a hospital
235 | for direct inpatient and outpatient services for the fiscal year
236 | in which the allocation fraction is calculated based on the
237 | hospital inpatient appropriation and outpatient appropriation
238 | and the parameters for the inpatient diagnosis-related group
239 | base rate and the parameters for the outpatient enhanced
240 | ambulatory payment group rate, including applicable
241 | intergovernmental transfers, specified in the General
242 | Appropriations Act, as determined by the agency.

243 | Section 6. Paragraph (a) of subsection (2) of section
244 | 409.911, Florida Statutes, is amended to read:

245 | 409.911 Disproportionate share program.—Subject to
246 | specific allocations established within the General
247 | Appropriations Act and any limitations established pursuant to
248 | chapter 216, the agency shall distribute, pursuant to this
249 | section, moneys to hospitals providing a disproportionate share
250 | of Medicaid or charity care services by making quarterly

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251 Medicaid payments as required. Notwithstanding the provisions of
252 s. 409.915, counties are exempt from contributing toward the
253 cost of this special reimbursement for hospitals serving a
254 disproportionate share of low-income patients.

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

259 (a) The average of the 2009, 2010, and 2011 ~~2007, 2008,~~
260 ~~and 2009~~ audited disproportionate share data to determine each
261 hospital's Medicaid days and charity care for the 2017-2018
262 ~~2015-2016~~ state fiscal year.

263 Section 7. Subsections (1) and (2) of section 409.979,
264 Florida Statutes, are amended to read:

265 409.979 Eligibility.—

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

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

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

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276 1. Nursing facility care as defined in s. 409.985(3); or
277 2. For individuals diagnosed as having cystic fibrosis,
278 hospital level of care.

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

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

292 1. Traumatic Brain and Spinal Cord Injury Waiver.
293 2. Adult Cystic Fibrosis Waiver.
294 3. Project AIDS Care Waiver.

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

300 Section 8. Subsection (3) of section 391.055, Florida

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301 Statutes, is amended to read:

302 391.055 Service delivery systems.—

303 (3) The Children's Medical Services network may contract
304 with school districts participating in the certified school
305 match program pursuant to ss. 409.908(21) ~~409.908(22)~~ and
306 1011.70 for the provision of school-based services, as provided
307 for in s. 409.9071, for Medicaid-eligible children who are
308 enrolled in the Children's Medical Services network.

309 Section 9. Subsection (7) of section 393.0661, Florida
310 Statutes, is amended to read:

311 393.0661 Home and community-based services delivery
312 system; comprehensive redesign.—The Legislature finds that the
313 home and community-based services delivery system for persons
314 with developmental disabilities and the availability of
315 appropriated funds are two of the critical elements in making
316 services available. Therefore, it is the intent of the
317 Legislature that the Agency for Persons with Disabilities shall
318 develop and implement a comprehensive redesign of the system.

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

321 Section 10. Paragraph (a) of subsection (4) of section
322 409.968, Florida Statutes, is amended to read:

323 409.968 Managed care plan payments.—

324 (4) (a) Subject to a specific appropriation and federal
325 approval under s. 409.906(13)(d) ~~409.906(13)(e)~~, the agency

326 shall establish a payment methodology to fund managed care plans
327 for flexible services for persons with severe mental illness and
328 substance use disorders, including, but not limited to,
329 temporary housing assistance. A managed care plan eligible for
330 these payments must do all of the following:

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

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

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

340 Section 11. Subsection (3) of section 427.0135, Florida
341 Statutes, is amended to read:

342 427.0135 Purchasing agencies; duties and
343 responsibilities.—Each purchasing agency, in carrying out the
344 policies and procedures of the commission, shall:

345 (3) Not procure transportation disadvantaged services
346 without initially negotiating with the commission, as provided
347 in s. 287.057(3)(e)12., or unless otherwise authorized by
348 statute. If the purchasing agency, after consultation with the
349 commission, determines that it cannot reach mutually acceptable
350 contract terms with the commission, the purchasing agency may

351 contract for the same transportation services provided in a more
352 cost-effective manner and of comparable or higher quality and
353 standards. The Medicaid agency shall implement this subsection
354 in a manner consistent with s. 409.908(18) ~~409.908(19)~~ and as
355 otherwise limited or directed by the General Appropriations Act.

356 Section 12. Subsections (1) and (5) of section 1011.70,
357 Florida Statutes, are amended to read:

358 1011.70 Medicaid certified school funding maximization.—

359 (1) Each school district, subject to the provisions of ss.
360 409.9071 and 409.908(21) ~~409.908(22)~~ and this section, is
361 authorized to certify funds provided for a category of required
362 Medicaid services termed "school-based services," which are
363 reimbursable under the federal Medicaid program. Such services
364 shall include, but not be limited to, physical, occupational,
365 and speech therapy services, behavioral health services, mental
366 health services, transportation services, Early Periodic
367 Screening, Diagnosis, and Treatment (EPSDT) administrative
368 outreach for the purpose of determining eligibility for
369 exceptional student education, and any other such services, for
370 the purpose of receiving federal Medicaid financial
371 participation. Certified school funding shall not be available
372 for the following services:

373 (a) Family planning.

374 (b) Immunizations.

375 (c) Prenatal care.

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376 (5) Lab schools, as authorized under s. 1002.32, shall be
377 authorized to participate in the Medicaid certified school match
378 program on the same basis as school districts subject to the
379 provisions of subsections (1)-(4) and ss. 409.9071 and
380 409.908(21) ~~409.908(22)~~.

381 Section 13. This act shall take effect July 1, 2017.