1 A bill to be entitled
2 An act relating to Medicaid; amending s. 393.0661,
3 F.S.; revising dates requiring the Agency for Persons
4 with Disabilities, in conjunction with the Agency for
5 Health Care Administration, to develop a plan to
6 redesign a specified Medicaid waiver program under
7 certain conditions; revising the date by which such
8 plan must be submitted to the Legislature; revising
9 dates requiring the Agency for Persons with
10 Disabilities to provide monthly reports to the
11 Legislature and to implement a redesigned program;
12 amending s. 409.904, F.S.; requiring the Agency for
13 Health Care Administration to make payments for
14 Medicaid-covered services retroactive for a specified
15 period for certain eligible persons; reenacting s.
16 409.908(23), F.S., relating to provisions requiring
17 the agency to establish Medicaid reimbursement rates
18 for specified services; amending s. 409.908, F.S.;
19 authorizing the agency to receive funds from certain
20 entities to make Low Income Pool Program payments;
21 amending s. 409.911, F.S.; revising dates relating to
22 certain data used by the agency to calculate the
23 disproportionate share payment; amending s. 624.91,
24 F.S.; requiring an insurer or any provider of health
25 care services under a Florida Healthy Kids Corporation

26 contract to refund an amount to be deposited into a
27 specified fund under certain conditions; providing an
28 effective date.
29
30 Be It Enacted by the Legislature of the State of Florida:
31
32 Section 1. Subsection (10) of section 393.0661, Florida
33 Statutes, is amended to read:
34 393.0661 Home and community-based services delivery
35 system; comprehensive redesign.—The Legislature finds that the
36 home and community-based services delivery system for persons
37 with developmental disabilities and the availability of
38 appropriated funds are two of the critical elements in making
39 services available. Therefore, it is the intent of the
40 Legislature that the Agency for Persons with Disabilities shall
41 develop and implement a comprehensive redesign of the system.
42 (10) Implementation of Medicaid waiver programs and
43 services authorized under this chapter is limited by the funds
44 appropriated for the individual budgets pursuant to s. 393.0662
45 and the four-tiered waiver system pursuant to subsection (3).
46 Contracts with independent support coordinators and service
47 providers must include provisions requiring compliance with
48 agency cost containment initiatives. The agency shall implement
49 monitoring and accounting procedures necessary to track actual
50 expenditures and project future spending compared to available

51 appropriations for Medicaid waiver programs. When necessary
52 based on projected deficits, the agency must establish specific
53 corrective action plans that incorporate corrective actions of
54 contracted providers that are sufficient to align program
55 expenditures with annual appropriations. If deficits continue
56 during the 2018-2019 ~~2012-2013~~ fiscal year, the agency, in
57 conjunction with the Agency for Health Care Administration,
58 shall develop a plan to redesign the waiver program and submit
59 the plan to the President of the Senate and the Speaker of the
60 House of Representatives by September 30, 2019 ~~September 30,~~
61 ~~2013~~. At a minimum, the plan must include the following
62 elements:
63 (a) Budget predictability.—Agency budget recommendations
64 must include specific steps to restrict spending to budgeted
65 amounts based on alternatives to the iBudget and four-tiered
66 Medicaid waiver models.
67 (b) Services.—The agency shall identify core services that
68 are essential to provide for client health and safety and
69 recommend elimination of coverage for other services that are
70 not affordable based on available resources.
71 (c) Flexibility.—The redesign shall be responsive to
72 individual needs and to the extent possible encourage client
73 control over allocated resources for their needs.
74 (d) Support coordination services.—The plan shall modify
75 the manner of providing support coordination services to improve

76 management of service utilization and increase accountability
77 and responsiveness to agency priorities.
78 (e) Reporting.—The agency shall provide monthly reports to
79 the President of the Senate and the Speaker of the House of
80 Representatives on plan progress and development on July 31,
81 2019 ~~July 31, 2013~~, and August 31, 2019 ~~August 31, 2013~~.
82 (f) Implementation.—The implementation of a redesigned
83 program is subject to legislative approval and shall occur no
84 later than July 1, 2020 ~~July 1, 2014~~. The Agency for Health Care
85 Administration shall seek federal waivers as needed to implement
86 the redesigned plan approved by the Legislature.
87 Section 2. Subsection (12) is added to section 409.904,
88 Florida Statutes, to read:
89 409.904 Optional payments for eligible persons.—The agency
90 may make payments for medical assistance and related services on
91 behalf of the following persons who are determined to be
92 eligible subject to the income, assets, and categorical
93 eligibility tests set forth in federal and state law. Payment on
94 behalf of these Medicaid eligible persons is subject to the
95 availability of moneys and any limitations established by the
96 General Appropriations Act or chapter 216.
97 (12) Effective July 1, 2019, the agency shall make
98 payments for Medicaid-covered services:
99 (a) For eligible children and pregnant women, retroactive
100 for a period of no more than 90 days before the month in which

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

101 an application for Medicaid is submitted.
102 (b) For eligible nonpregnant adults, retroactive to the
103 first day of the month in which an application for Medicaid is
104 submitted.
105 Section 3. Notwithstanding the expiration date in section
106 19 of chapter 2018-10, Laws of Florida, subsection (23) of
107 section 409.908, Florida Statutes, is reenacted to read:
108 409.908 Reimbursement of Medicaid providers.—Subject to
109 specific appropriations, the agency shall reimburse Medicaid
110 providers, in accordance with state and federal law, according
111 to methodologies set forth in the rules of the agency and in
112 policy manuals and handbooks incorporated by reference therein.
113 These methodologies may include fee schedules, reimbursement
114 methods based on cost reporting, negotiated fees, competitive
115 bidding pursuant to s. 287.057, and other mechanisms the agency
116 considers efficient and effective for purchasing services or
117 goods on behalf of recipients. If a provider is reimbursed based
118 on cost reporting and submits a cost report late and that cost
119 report would have been used to set a lower reimbursement rate
120 for a rate semester, then the provider's rate for that semester
121 shall be retroactively calculated using the new cost report, and
122 full payment at the recalculated rate shall be effected
123 retroactively. Medicare-granted extensions for filing cost
124 reports, if applicable, shall also apply to Medicaid cost
125 reports. Payment for Medicaid compensable services made on

126 behalf of Medicaid eligible persons is subject to the
127 availability of moneys and any limitations or directions
128 provided for in the General Appropriations Act or chapter 216.
129 Further, nothing in this section shall be construed to prevent
130 or limit the agency from adjusting fees, reimbursement rates,
131 lengths of stay, number of visits, or number of services, or
132 making any other adjustments necessary to comply with the
133 availability of moneys and any limitations or directions
134 provided for in the General Appropriations Act, provided the
135 adjustment is consistent with legislative intent.
136 (23)(a) The agency shall establish rates at a level that
137 ensures no increase in statewide expenditures resulting from a
138 change in unit costs for county health departments effective
139 July 1, 2011. Reimbursement rates shall be as provided in the
140 General Appropriations Act.
141 (b)1. Base rate reimbursement for inpatient services under
142 a diagnosis-related group payment methodology shall be provided
143 in the General Appropriations Act.
144 2. Base rate reimbursement for outpatient services under
145 an enhanced ambulatory payment group methodology shall be
146 provided in the General Appropriations Act.
147 3. Prospective payment system reimbursement for nursing
148 home services shall be as provided in subsection (2) and in the
149 General Appropriations Act.
150 Section 4. Subsection (26) of section 409.908, Florida

151 Statutes, is amended to read:
152 409.908 Reimbursement of Medicaid providers.—Subject to
153 specific appropriations, the agency shall reimburse Medicaid
154 providers, in accordance with state and federal law, according
155 to methodologies set forth in the rules of the agency and in
156 policy manuals and handbooks incorporated by reference therein.
157 These methodologies may include fee schedules, reimbursement
158 methods based on cost reporting, negotiated fees, competitive
159 bidding pursuant to s. 287.057, and other mechanisms the agency
160 considers efficient and effective for purchasing services or
161 goods on behalf of recipients. If a provider is reimbursed based
162 on cost reporting and submits a cost report late and that cost
163 report would have been used to set a lower reimbursement rate
164 for a rate semester, then the provider's rate for that semester
165 shall be retroactively calculated using the new cost report, and
166 full payment at the recalculated rate shall be effected
167 retroactively. Medicare-granted extensions for filing cost
168 reports, if applicable, shall also apply to Medicaid cost
169 reports. Payment for Medicaid compensable services made on
170 behalf of Medicaid eligible persons is subject to the
171 availability of moneys and any limitations or directions
172 provided for in the General Appropriations Act or chapter 216.
173 Further, nothing in this section shall be construed to prevent
174 or limit the agency from adjusting fees, reimbursement rates,
175 lengths of stay, number of visits, or number of services, or

176 making any other adjustments necessary to comply with the
177 availability of moneys and any limitations or directions
178 provided for in the General Appropriations Act, provided the
179 adjustment is consistent with legislative intent.
180 (26) The agency may receive funds from state entities,
181 including, but not limited to, the Department of Health, local
182 governments, and other local political subdivisions, for the
183 purpose of making special exception payments and Low Income Pool
184 Program payments, including federal matching funds. Funds
185 received for this purpose shall be separately accounted for and
186 may not be commingled with other state or local funds in any
187 manner. The agency may certify all local governmental funds used
188 as state match under Title XIX of the Social Security Act to the
189 extent and in the manner authorized under the General
190 Appropriations Act and pursuant to an agreement between the
191 agency and the local governmental entity. In order for the
192 agency to certify such local governmental funds, a local
193 governmental entity must submit a final, executed letter of
194 agreement to the agency, which must be received by October 1 of
195 each fiscal year and provide the total amount of local
196 governmental funds authorized by the entity for that fiscal year
197 under the General Appropriations Act. The local governmental
198 entity shall use a certification form prescribed by the agency.
199 At a minimum, the certification form must identify the amount
200 being certified and describe the relationship between the

201 certifying local governmental entity and the local health care
202 provider. Local governmental funds outlined in the letters of
203 agreement must be received by the agency no later than October
204 31 of each fiscal year in which such funds are pledged, unless
205 an alternative plan is specifically approved by the agency.
206 Section 5. Subsection (2) of section 409.911, Florida
207 Statutes, is amended to read:
208 409.911 Disproportionate share program.—Subject to
209 specific allocations established within the General
210 Appropriations Act and any limitations established pursuant to
211 chapter 216, the agency shall distribute, pursuant to this
212 section, moneys to hospitals providing a disproportionate share
213 of Medicaid or charity care services by making quarterly
214 Medicaid payments as required. Notwithstanding the provisions of
215 s. 409.915, counties are exempt from contributing toward the
216 cost of this special reimbursement for hospitals serving a
217 disproportionate share of low-income patients.
218 (2) The Agency for Health Care Administration shall use
219 the following actual audited data to determine the Medicaid days
220 and charity care to be used in calculating the disproportionate
221 share payment:
222 (a) The average of the 2011, 2012, and 2013 ~~2010, 2011,~~
223 ~~and 2012~~ audited disproportionate share data to determine each
224 hospital's Medicaid days and charity care for the 2019-2020
225 ~~2018-2019~~ state fiscal year.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

226 (b) If the Agency for Health Care Administration does not
227 have the prescribed 3 years of audited disproportionate share
228 data as noted in paragraph (a) for a hospital, the agency shall
229 use the average of the years of the audited disproportionate
230 share data as noted in paragraph (a) which is available.
231 (c) In accordance with s. 1923(b) of the Social Security
232 Act, a hospital with a Medicaid inpatient utilization rate
233 greater than one standard deviation above the statewide mean or
234 a hospital with a low-income utilization rate of 25 percent or
235 greater shall qualify for reimbursement.
236 Section 6. Paragraph (b) of subsection (5) of section
237 624.91, Florida Statutes, is amended to read:
238 624.91 The Florida Healthy Kids Corporation Act.—
239 (5) CORPORATION AUTHORIZATION, DUTIES, POWERS.—
240 (b) The Florida Healthy Kids Corporation shall:
241 1. Arrange for the collection of any family, local
242 contributions, or employer payment or premium, in an amount to
243 be determined by the board of directors, to provide for payment
244 of premiums for comprehensive insurance coverage and for the
245 actual or estimated administrative expenses.
246 2. Arrange for the collection of any voluntary
247 contributions to provide for payment of Florida Kidcare program
248 premiums for children who are not eligible for medical
249 assistance under Title XIX or Title XXI of the Social Security
250 Act.

251 3. Subject to the provisions of s. 409.8134, accept
252 voluntary supplemental local match contributions that comply
253 with the requirements of Title XXI of the Social Security Act
254 for the purpose of providing additional Florida Kidcare coverage
255 in contributing counties under Title XXI.
256 4. Establish the administrative and accounting procedures
257 for the operation of the corporation.
258 5. Establish, with consultation from appropriate
259 professional organizations, standards for preventive health
260 services and providers and comprehensive insurance benefits
261 appropriate to children, provided that such standards for rural
262 areas shall not limit primary care providers to board-certified
263 pediatricians.
264 6. Determine eligibility for children seeking to
265 participate in the Title XXI-funded components of the Florida
266 Kidcare program consistent with the requirements specified in s.
267 409.814, as well as the non-Title-XXI-eligible children as
268 provided in subsection (3).
269 7. Establish procedures under which providers of local
270 match to, applicants to and participants in the program may have
271 grievances reviewed by an impartial body and reported to the
272 board of directors of the corporation.
273 8. Establish participation criteria and, if appropriate,
274 contract with an authorized insurer, health maintenance
275 organization, or third-party administrator to provide

276 administrative services to the corporation.
277 9. Establish enrollment criteria that include penalties or
278 waiting periods of 30 days for reinstatement of coverage upon
279 voluntary cancellation for nonpayment of family premiums.
280 10. Contract with authorized insurers or any provider of
281 health care services, meeting standards established by the
282 corporation, for the provision of comprehensive insurance
283 coverage to participants. Such standards shall include criteria
284 under which the corporation may contract with more than one
285 provider of health care services in program sites. Health plans
286 shall be selected through a competitive bid process. The Florida
287 Healthy Kids Corporation shall purchase goods and services in
288 the most cost-effective manner consistent with the delivery of
289 quality medical care. The maximum administrative cost for a
290 Florida Healthy Kids Corporation contract shall be 15 percent.
291 For health care contracts, the minimum medical loss ratio for a
292 Florida Healthy Kids Corporation contract shall be 85 percent.
293 For dental contracts, the remaining compensation to be paid to
294 the authorized insurer or provider under a Florida Healthy Kids
295 Corporation contract shall be no less than an amount which is 85
296 percent of premium; to the extent any contract provision does
297 not provide for this minimum compensation, this section shall
298 prevail. For an insurer or any provider of health care services
299 that achieves an annual medical loss ratio below 85 percent, the
300 Florida Healthy Kids Corporation shall validate the medical loss

301 ratio and calculate an amount to be refunded by the insurer or
302 any provider of health care services to the state which shall be
303 deposited into the General Revenue Fund unallocated. The health
304 plan selection criteria and scoring system, and the scoring
305 results, shall be available upon request for inspection after
306 the bids have been awarded.
307 11. Establish disenrollment criteria in the event local
308 matching funds are insufficient to cover enrollments.
309 12. Develop and implement a plan to publicize the Florida
310 Kidcare program, the eligibility requirements of the program,
311 and the procedures for enrollment in the program and to maintain
312 public awareness of the corporation and the program.
313 13. Secure staff necessary to properly administer the
314 corporation. Staff costs shall be funded from state and local
315 matching funds and such other private or public funds as become
316 available. The board of directors shall determine the number of
317 staff members necessary to administer the corporation.
318 14. In consultation with the partner agencies, provide a
319 report on the Florida Kidcare program annually to the Governor,
320 the Chief Financial Officer, the Commissioner of Education, the
321 President of the Senate, the Speaker of the House of
322 Representatives, and the Minority Leaders of the Senate and the
323 House of Representatives.
324 15. Provide information on a quarterly basis to the
325 Legislature and the Governor which compares the costs and

326 utilization of the full-pay enrolled population and the Title
327 XXI-subsidized enrolled population in the Florida Kidcare
328 program. The information, at a minimum, must include:
329 a. The monthly enrollment and expenditure for full-pay
330 enrollees in the Medikids and Florida Healthy Kids programs
331 compared to the Title XXI-subsidized enrolled population; and
332 b. The costs and utilization by service of the full-pay
333 enrollees in the Medikids and Florida Healthy Kids programs and
334 the Title XXI-subsidized enrolled population.
335 16. Establish benefit packages that conform to the
336 provisions of the Florida Kidcare program, as created in ss.
337 409.810-409.821.
338 Section 7. This act shall take effect July 1, 2019.