CHAPTER 2016-65

House Bill No. 5101

An act relating to health care services; amending s. 322.142, F.S.; authorizing the Department of Highway Safety and Motor Vehicles to provide the Agency for Health Care Administration with access to certain digital and photographic records; amending s. 409.9128, F.S.; conforming provisions to changes made by the act; amending s. 395.602, F.S.; revising the definition of "rural hospital" to include specified hospitals; amending 409.285, F.S.; requiring appeals related to Medicaid programs directly administered by the agency to be directed to the agency; providing requirements for appeals directed to the agency; providing an exemption from the uniform rules of procedure and from a requirement that certain proceedings be heard before an administrative law judge for specified hearings; requiring the agency to seek federal approval of its authority to oversee appeals; amending s. 409.811, F.S.; defining the term "lawfully residing child"; deleting the definition of the term "qualified alien"; conforming provisions to changes made by the act; amending s. 409.814, F.S.; revising eligibility for the Florida Kidcare program to conform to changes made by the act; specifying that undocumented immigrants are excluded from eligibility; amending s. 409.904, F.S.; providing eligibility for optional payments for medical assistance and related services for certain lawfully residing children; specifying that undocumented immigrants are excluded from eligibility; amending s. 409.905, F.S.; requiring the agency to implement a prospective payment system for such services by a specified date; removing a limitation on Medicaid reimbursement for certain hospital emergency services for certain recipients; deleting references to cost-based reimbursement methodology for outpatient services; amending s. 409.906, F.S.; directing the agency to seek federal approval to provide temporary housing assistance for certain persons; amending s. 393.063, F.S.; revising the definition of the term "developmental disability" to include Down syndrome and Phelan-McDermid syndrome; amending s. 393.063, F.S.; defining the term "Phelan-McDermid syndrome"; amending s. 393.065, F.S.; providing for the assignment of priority to clients waiting for waiver services; requiring an agency to allow a certain individual to receive such services if the individual's parent or legal guardian is an active-duty military service member; requiring the agency to send an annual letter to clients and their guardians or families; requiring the agency to allow a certain individual to receive such services if the individual has Phelan-McDermid syndrome; providing that certain agency action does not establish a right to a hearing or an administrative proceeding; amending s. 393.0662, F.S.; revising the allocations methodology that the agency is required to use to develop each client's iBudget; adding client needs that qualify as extraordinary needs, which may result in the approval of an increase in a client's allocated funds; providing for contingent effect; reenacting s. 393.067(15), F.S., relating to contracts between the agency

and licensed facilities; providing contingent abrogation of the scheduled expiration and reversion of amendments to s. 393.067(15), F.S., pursuant to s. 24 of chapter 2015-222, Laws of Florida; reenacting s. 393.18, F.S., relating to the comprehensive transitional education program; providing contingent abrogation of the scheduled expiration and reversion of amendments to s. 393.18, F.S., pursuant to s. 26 of chapter 2015-222, Laws of Florida; amending s. 409.907, F.S.; authorizing the agency to certify that a Medicaid provider is out of business; creating s. 409.9072, F.S.; directing the agency to pay private schools and charter schools that are Medicaid providers for specified school-based services under certain parameters; authorizing the agency to review a school that has applied to the program for capability requirements; amending s. 409.908, F.S.; limiting Medicaid reimbursement for certain types of hospitals; requiring the agency to implement a prospective payment system for ambulatory surgical centers; amending s. 409.909, F.S.; defining the term "qualifying institution" for purposes of the Statewide Medicaid Residency Program; conforming provisions of the statewide Medicaid program to the implementation of a prospective payment system; adding psychiatry to a list of primary care specialties under the Statewide Medicaid Residency Program; providing for annual updates to the statewide physician supply-and-demand deficit; amending s. 409.967, F.S.; defining the term "Medicaid rate" for determination of specified managed care plan payments for emergency services in compliance with federal law; requiring annual publication of fee schedules on the agency's website; amending s. 409.968, F.S.; directing the agency to establish a payment methodology for managed care plans providing housing assistance to specified persons; amending s. 409.975, F.S.; defining the term "essential provider"; providing for determination of Medicaid rates for emergency services paid by certain managed care plans; revising provisions relating to certain payment negotiations between managed care plans and hospitals; amending s. 624.91, F.S.; conforming provisions to changes made by the act; amending s. 641.513, F.S.; specifying parameters for payments by a health maintenance organization to a noncontracted provider of emergency services under certain circumstances; conforming provisions to changes made by the act; amending chapter 2012-33, Laws of Florida; authorizing a Program of All-inclusive Care for the Elderly (PACE) organization granted certain enrollee slots for frail elders residing in Broward County to use such slots for enrollees residing in Miami-Dade County; authorizing the agency to contract with an organization in Escambia County to provide services under the federal Program of All-inclusive Care for the Elderly in specified areas; exempting the organization from chapter 641, F.S., relating to health care service programs; authorizing Program of All-inclusive Care for the Elderly services in Clay, Duval, St. Johns, Baker and Nassau Counties, subject to federal approval; authorizing the agency to contract with not-for-profit organizations in Lake and Hillsborough Counties to offer hospice services via the Program of All-inclusive Care for the Elderly, subject to federal approval; amending ss. 391.055, 427.0135, 1002.385, and 1011.70, F.S.; conforming cross-references; providing effective dates.

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

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

322.142 Color photographic or digital imaged licenses.—

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

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

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

1. A justice or judge of this state;

2. An employee of the state courts system who works in a position that is designated in writing for access by the Chief Justice of the Supreme Court or a chief judge of a district or circuit court, or by his or her designee; or

3. A government employee who performs functions on behalf of the state courts system in a position that is designated in writing for access by the Chief Justice or a chief judge, or by his or her designee; or

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

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

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

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

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

409.9128 Requirements for providing emergency services and care.—

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

(a) The provider's charges;

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

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

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

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

395.602 Rural hospitals.—

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

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

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

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

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

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

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

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

Population densities used in this paragraph must be based upon the most recently completed United States census. A hospital that received funds

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

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

409.285 Opportunity for hearing and appeal.—

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

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

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

(2) Appeals related to Medicaid programs directly administered by the Agency for Health Care Administration, including appeals related to Florida's Statewide Medicaid Managed Care program and associated federal waivers, filed on or after March 1, 2017, must be directed to the agency in the manner and form prescribed by the agency. The department and the agency shall establish a transition process to transfer administration of these appeals from the department to the agency by March 1, 2017.

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

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

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

(3) Appeals related to Medicaid programs administered by the Agency for Persons with Disabilities are subject to s. 393.125.

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

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

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

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

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

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

409.814 Eligibility.—A child who has not reached 19 years of age whose family income is equal to or below 200 percent of the federal poverty level is eligible for the Florida Kidcare program as provided in this section. If an enrolled individual is determined to be ineligible for coverage, he or she must be immediately disenrolled from the respective Florida Kidcare program component.

(4) The following children are not eligible to receive Title XXI-funded premium assistance for health benefits coverage under the Florida Kidcare

program, except under Medicaid if the child would have been eligible for Medicaid under s. 409.903 or s. 409.904 as of June 1, 1997:

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

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

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

(8) A child who has not attained 19 years of age and who, notwithstanding s. 414.095(3), would be eligible for Medicaid under s. 409.903, except that the child is a lawfully residing child as defined in s. 409.811. This subsection does not extend eligibility for optional Medicaid payments or related services to an undocumented immigrant.

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

409.905 Mandatory Medicaid services.—The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law. Mandatory services rendered by providers in mobile units to Medicaid recipients may be restricted by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, number of services, or any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216.

(5) HOSPITAL INPATIENT SERVICES.—The agency shall pay for all covered services provided for the medical care and treatment of a recipient who is admitted as an inpatient by a licensed physician or dentist to a hospital licensed under part I of chapter 395. However, the agency shall limit the payment for inpatient hospital services for a Medicaid recipient 21 years of age or older to 45 days or the number of days necessary to comply with the General Appropriations Act. ~~Effective August 1, 2012, the agency shall limit~~

~~payment for hospital emergency department visits for a nonpregnant Medicaid recipient 21 years of age or older to six visits per fiscal year.~~

(a) The agency may implement reimbursement and utilization management reforms in order to comply with any limitations or directions in the General Appropriations Act, which may include, but are not limited to: prior authorization for inpatient psychiatric days; prior authorization for nonemergency hospital inpatient admissions for individuals 21 years of age and older; authorization of emergency and urgent-care admissions within 24 hours after admission; enhanced utilization and concurrent review programs for highly utilized services; reduction or elimination of covered days of service; adjusting reimbursement ceilings for variable costs; adjusting reimbursement ceilings for fixed and property costs; and implementing target rates of increase. The agency may limit prior authorization for hospital inpatient services to selected diagnosis-related groups, based on an analysis of the cost and potential for unnecessary hospitalizations represented by certain diagnoses. Admissions for normal delivery and newborns are exempt from requirements for prior authorization. In implementing the provisions of this section related to prior authorization, the agency shall ensure that the process for authorization is accessible 24 hours per day, 7 days per week and authorization is automatically granted when not denied within 4 hours after the request. Authorization procedures must include steps for review of denials. Upon implementing the prior authorization program for hospital inpatient services, the agency shall discontinue its hospital retrospective review program.

(b) A licensed hospital maintained primarily for the care and treatment of patients having mental disorders or mental diseases is not eligible to participate in the hospital inpatient portion of the Medicaid program except as provided in federal law. However, the department shall apply for a waiver, within 9 months after June 5, 1991, designed to provide hospitalization services for mental health reasons to children and adults in the most cost-effective and lowest cost setting possible. Such waiver shall include a request for the opportunity to pay for care in hospitals known under federal law as "institutions for mental disease" or "IMD's." The waiver proposal shall propose no additional aggregate cost to the state or Federal Government, and shall be conducted in Hillsborough County, Highlands County, Hardee County, Manatee County, and Polk County. The waiver proposal may incorporate competitive bidding for hospital services, comprehensive brokering, prepaid capitated arrangements, or other mechanisms deemed by the department to show promise in reducing the cost of acute care and increasing the effectiveness of preventive care. When developing the waiver proposal, the department shall take into account price, quality, accessibility, linkages of the hospital to community services and family support programs, plans of the hospital to ensure the earliest discharge possible, and the comprehensiveness of the mental health and other health care services offered by participating providers.

(c) The agency shall implement a prospective payment methodology for establishing reimbursement rates for inpatient hospital services. Rates shall

be calculated annually and take effect July 1 of each year. The methodology shall categorize each inpatient admission into a diagnosis-related group and assign a relative payment weight to the base rate according to the average relative amount of hospital resources used to treat a patient in a specific diagnosis-related group category. The agency may adopt the most recent relative weights calculated and made available by the Nationwide Inpatient Sample maintained by the Agency for Healthcare Research and Quality or may adopt alternative weights if the agency finds that Florida-specific weights deviate with statistical significance from national weights for high-volume diagnosis-related groups. The agency shall establish a single, uniform base rate for all hospitals unless specifically exempt pursuant to s. 409.908(1).

1. Adjustments may not be made to the rates after October 31 of the state fiscal year in which the rates take effect, except for cases of insufficient collections of intergovernmental transfers authorized under s. 409.908(1) or the General Appropriations Act. In such cases, the agency shall submit a budget amendment or amendments under chapter 216 requesting approval of rate reductions by amounts necessary for the aggregate reduction to equal the dollar amount of intergovernmental transfers not collected and the corresponding federal match. Notwithstanding the $1 million limitation on increases to an approved operating budget contained in ss. 216.181(11) and 216.292(3), a budget amendment exceeding that dollar amount is subject to notice and objection procedures set forth in s. 216.177.

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

(d) The agency shall implement a comprehensive utilization management program for hospital neonatal intensive care stays in certain high-volume participating hospitals, select counties, or statewide, and replace existing hospital inpatient utilization management programs for neonatal intensive care admissions. The program shall be designed to manage appropriate admissions and discharges for children being treated in neonatal intensive care units and must seek medically appropriate discharge to the child's home or other less costly treatment setting. The agency may competitively bid a contract for the selection of a qualified organization to provide neonatal intensive care utilization management services. The agency may seek federal waivers to implement this initiative.

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

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

409.905 Mandatory Medicaid services.—The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law. Mandatory services rendered by providers in mobile units to Medicaid recipients may be restricted by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, number of services, or any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216.

(6) HOSPITAL OUTPATIENT SERVICES.—

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

1. Adjustments may not be made to the rates after July 31 ~~October 31~~ of the state fiscal year in which the rates take effect~~, except for cases of insufficient collections of intergovernmental transfers authorized under s. 409.908(1) or the General Appropriations Act. In such cases, the agency shall submit a budget amendment or amendments under chapter 216 requesting approval of rate reductions by amounts necessary for the aggregate reduction to equal the dollar amount of intergovernmental transfers not collected and the corresponding federal match. Notwithstanding the $1 million limitation on increases to an approved operating budget under ss. 216.181(11) and 216.292(3), a budget amendment exceeding that dollar amount is subject to notice and objection procedures set forth in s. 216.177~~.

2. Errors in source data or calculations discovered after July 31 of each state fiscal year ~~October 31~~ must be reconciled in a subsequent rate period. However, the agency may not make any adjustment to a hospital's reimbursement more than 5 years after a hospital is notified of an audited rate established by the agency. The prohibition against adjustments more

than 5 years after notification is remedial and applies to actions by providers involving Medicaid claims for hospital services. Hospital reimbursement is subject to such limits or ceilings as may be established in law or described in the agency's hospital reimbursement plan. Specific exemptions to the limits or ceilings may be provided in the General Appropriations Act.

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

409.906 Optional Medicaid services.—Subject to specific appropriations, the agency may make payments for services which are optional to the state under Title XIX of the Social Security Act and are furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any optional service that is provided shall be provided only when medically necessary and in accordance with state and federal law. Optional services rendered by providers in mobile units to Medicaid recipients may be restricted or prohibited by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. If necessary to safeguard the state's systems of providing services to elderly and disabled persons and subject to the notice and review provisions of s. 216.177, the Governor may direct the Agency for Health Care Administration to amend the Medicaid state plan to delete the optional Medicaid service known as "Intermediate Care Facilities for the Developmentally Disabled." Optional services may include:

(13) HOME AND COMMUNITY-BASED SERVICES.—

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

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

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

(9) "Developmental disability" means a disorder or syndrome that is attributable to intellectual disability, cerebral palsy, autism, spina bifida, Down syndrome, Phelan-McDermid syndrome, or Prader-Willi syndrome; that manifests before the age of 18; and that constitutes a substantial handicap that can reasonably be expected to continue indefinitely.

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

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

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

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

393.065 Application and eligibility determination.—

(5) Except as otherwise directed by law, beginning July 1, 2010, The agency shall assign and provide priority to clients waiting for waiver services in the following order:

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

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

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

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

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

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

For individuals who are at least 18 years but not yet 22 years of age and who are eligible under sub-subparagraph 1.b., the agency shall provide waiver services, including residential habilitation, and the community-based care lead agency shall fund room and board at the rate established in s. 409.145(4) and provide case management and related services as defined in s. 409.986(3)(e). Individuals may receive both waiver services and services

under s. 39.6251. Services may not duplicate services available through the Medicaid state plan.

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

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

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

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

(9)~~(7)~~ The agency and the Agency for Health Care Administration may adopt rules specifying application procedures, criteria associated with the waiting list ~~wait list~~ categories, procedures for administering the waiting ~~wait~~ list, including tools for prioritizing waiver enrollment within categories, and eligibility criteria as needed to administer this section.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

393.067 Facility licensure.—

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

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

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

(1) Comprehensive transitional education programs shall include a minimum of two component centers or units, one of which shall be an intensive treatment and educational center or a transitional training and educational center, which provides services to persons with maladaptive behaviors in the following sequential order:

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

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

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

(d) Alternative living center.—This component is a residential unit providing an educational and family living environment for persons with maladaptive behaviors in a moderately unrestricted setting. Residential staff shall be required for this component.

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

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

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

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

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

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

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

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

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

(1) Subject to a specific appropriation by the Legislature, the agency shall reimburse private schools as defined in s. 1002.01 and schools designated as charter schools under s. 1002.33 which are Medicaid providers for school-based services pursuant to the rehabilitative services option provided under 42 U.S.C. s. 1396d(a)(13) to children younger than 21 years of age with specified disabilities who are eligible for both Medicaid and part B or part H of the Individuals with Disabilities Education Act (IDEA) or the exceptional student education program, or who have an individualized educational plan.

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

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

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

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

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

(3) The types of school-based services for which schools may be reimbursed under this section are those included in s. 1011.70(1). Private schools and charter schools may not be reimbursed by the agency for providing services that are excluded by that subsection.

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

(5) For reimbursements to private schools and charter schools under this section, the agency shall apply the reimbursement schedule developed under s. 409.9071(5). Health care practitioners engaged by a school to provide services under this section must be enrolled as Medicaid providers and meet the qualifications specified under 42 C.F.R. s. 440.110, as applicable. Each school's continued participation in providing Medicaid services under this

section is contingent upon the school providing to the agency an annual accounting of how the Medicaid reimbursements are used.

(6) For Medicaid provider agreements issued under this section, the agency's and the school's confidentiality is waived in relation to the state's efforts to control Medicaid fraud. The agency and the school shall provide any information or documents relating to this section to the Medicaid Fraud Control Unit in the Department of Legal Affairs, upon request, pursuant to the Attorney General's authority under s. 409.920.

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

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

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

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

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

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

a. State-owned psychiatric hospitals.

b. Newborn hearing screening services.

c. Transplant services for which the agency has established a global fee.

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

e. Class III psychiatric hospitals.

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

The agency may receive funds from state entities, including, but not limited to, the Department of Health, local governments, and other local political subdivisions, for the purpose of making special exception payments, including federal matching funds, through the Medicaid inpatient reimbursement methodologies. Funds received for this purpose shall be separately accounted for and may not be commingled with other state or local funds in any manner. The agency may certify all local governmental funds used as state match under Title XIX of the Social Security Act, to the extent and in the manner authorized under the General Appropriations Act and pursuant to an agreement between the agency and the local governmental entity. In order for the agency to certify such local governmental funds, a local governmental entity must submit a final, executed letter of agreement to the agency, which must be received by October 1 of each fiscal year and provide the total amount of local governmental funds authorized by the entity for that fiscal year under this paragraph, paragraph (b), or the General Appropriations Act. The local governmental entity shall use a certification form prescribed by the agency. At a minimum, the certification form must identify the amount being certified and describe the relationship between the certifying local governmental entity and the local health care provider. The agency shall prepare an annual statement of impact which documents the specific activities undertaken during the previous fiscal year pursuant to this paragraph, to be submitted to the Legislature annually by January 1.

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

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

409.909 Statewide Medicaid Residency Program.—

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

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

1. Family medicine;

2. General internal medicine;

3. General pediatrics;

4. Preventive medicine;

5. Geriatric medicine;

6. Osteopathic general practice;

7. Obstetrics and gynecology;

8. Emergency medicine; ~~and~~

9. General surgery; and

10. Psychiatry.

(b) "Medicaid payments" means the estimated total payments for reimbursing a hospital for direct inpatient services for the fiscal year in which the allocation fraction is calculated based on the hospital inpatient

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

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

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

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

Where:

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

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

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

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

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

(4) A hospital's and qualifying institution's annual allocation shall be calculated by multiplying the funds appropriated for the Statewide Medicaid Residency Program in the General Appropriations Act by that hospital's and qualifying institution's allocation fraction. If the calculation results in an annual allocation that exceeds two times the average per FTE resident amount for all hospitals and qualifying institutions, the hospital's and qualifying institution's annual allocation shall be reduced to a sum equaling no more than two times the average per FTE resident. The funds calculated for that hospital and qualifying institution in excess of two times the average per FTE resident amount for all hospitals and qualifying institutions shall be redistributed to participating hospitals and qualifying institutions whose annual allocation does not exceed two times the average per FTE resident

amount for all hospitals and qualifying institutions, using the same methodology and payment schedule specified in this section.

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

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

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

409.967 Managed care plan accountability.—

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

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

1. The provider's charges;

2. The usual and customary provider charges for similar services in the community where the services were provided;

3. The charge mutually agreed to by the entity and the provider within 60 days after submittal of the claim; or

4. The Medicaid rate, which, for the purposes of this paragraph, means the amount the provider would collect from the agency on a fee-for-service basis, less any amounts for the indirect costs of medical education and the direct costs of graduate medical education that are otherwise included in the agency's fee-for-service payment, as required under 42 U.S.C. s. 1396u-2(b)(2)(D) ~~the agency would have paid on the most recent October 1st~~. For the purpose of establishing the amounts specified in this subparagraph, the agency shall publish on its website annually, or more frequently as needed, the applicable fee-for-service fee schedules and their effective dates, less any amounts for indirect costs of medical education and direct costs of graduate medical education that are otherwise included in the agency's fee-for-service payments.

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

409.968 Managed care plan payments.—

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

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

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

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

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

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

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

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

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

1. Federally qualified health centers.

2. Statutory teaching hospitals as defined in s. 408.07(45).

3. Hospitals that are trauma centers as defined in s. 395.4001(14).

4. Hospitals located at least 25 miles from any other hospital with similar services.

Managed care plans that have not contracted with all essential providers in the region as of the first date of recipient enrollment, or with whom an essential provider has terminated its contract, must negotiate in good faith with such essential providers for 1 year or until an agreement is reached, whichever is first. Payments for services rendered by a nonparticipating essential provider shall be made at the applicable Medicaid rate as of the first day of the contract between the agency and the plan. A rate schedule for all essential providers shall be attached to the contract between the agency and the plan. After 1 year, managed care plans that are unable to contract with essential providers shall notify the agency and propose an alternative arrangement for securing the essential services for Medicaid enrollees. The arrangement must rely on contracts with other participating providers, regardless of whether those providers are located within the same region as the nonparticipating essential service provider. If the alternative arrangement is approved by the agency, payments to nonparticipating essential providers after the date of the agency's approval shall equal 90 percent of the

applicable Medicaid rate. Except for payment for emergency services, if the alternative arrangement is not approved by the agency, payment to nonparticipating essential providers shall equal 110 percent of the applicable Medicaid rate.

(b) Certain providers are statewide resources and essential providers for all managed care plans in all regions. All managed care plans must include these essential providers in their networks. Statewide essential providers include:

1. Faculty plans of Florida medical schools.

2. Regional perinatal intensive care centers as defined in s. 383.16(2).

3. Hospitals licensed as specialty children's hospitals as defined in s. 395.002(28).

4. Accredited and integrated systems serving medically complex children which comprise ~~that are comprised of~~ separately licensed, but commonly owned, health care providers delivering at least the following services: medical group home, in-home and outpatient nursing care and therapies, pharmacy services, durable medical equipment, and Prescribed Pediatric Extended Care.

Managed care plans that have not contracted with all statewide essential providers in all regions as of the first date of recipient enrollment must continue to negotiate in good faith. Payments to physicians on the faculty of nonparticipating Florida medical schools shall be made at the applicable Medicaid rate. Payments for services rendered by regional perinatal intensive care centers shall be made at the applicable Medicaid rate as of the first day of the contract between the agency and the plan. Except for payments for emergency services, payments to nonparticipating specialty children's hospitals shall equal the highest rate established by contract between that provider and any other Medicaid managed care plan.

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

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

(e)~~(d)~~ Each managed care plan must offer a network contract to each home medical equipment and supplies provider in the region which meets

quality and fraud prevention and detection standards established by the plan and which agrees to accept the lowest price previously negotiated between the plan and another such provider.

(6) PROVIDER PAYMENT.—Managed care plans and hospitals shall negotiate mutually acceptable rates, methods, and terms of payment. ~~For rates, methods, and terms of payment negotiated after the contract between the agency and the plan is executed, plans shall pay hospitals, at a minimum, the rate the agency would have paid on the first day of the contract between the provider and the plan.~~ Such payments to hospitals may not exceed 120 percent of the rate the agency would have paid on the first day of the contract between the provider and the plan, unless specifically approved by the agency. Payment rates may be updated periodically.

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

624.91 The Florida Healthy Kids Corporation Act.—

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

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

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

641.513 Requirements for providing emergency services and care.—

(6) Reimbursement for services under this section provided to subscribers who are Medicaid recipients by a provider for whom no contract exists between the provider and the health maintenance organization shall be determined under chapter 409. ~~the lesser of:~~

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

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

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

~~(d) The Medicaid rate.~~

(7) Reimbursement for services under this section provided to subscribers who are enrolled in a health maintenance organization pursuant to s.

624.91 by a provider for whom no contract exists between the provider and the health maintenance organization shall be the lesser of:

(a) The provider's charges;

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

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

(d) The Medicaid rate.

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

Section 18. Notwithstanding s. 430.707, Florida Statutes, and subject to federal approval of an additional site for the Program of All-Inclusive Care for the Elderly (PACE), the Agency for Health Care Administration shall contract with a current PACE organization authorized to provide PACE services in Southeast Florida to develop and operate a PACE program in Broward County to serve frail elders who reside in Broward County or Miami-Dade County. The organization shall be exempt from chapter 641, Florida Statutes. The agency, in consultation with the Department of Elderly Affairs and subject to an appropriation, shall approve up to 150 initial enrollee slots in the Broward program established by the organization.

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

Section 28. Subject to federal approval of the application to be a site for the Program of All-inclusive Care for the Elderly (PACE), the Agency for Health Care Administration shall contract with a not-for-profit organization that has been jointly formed by a lead agency that has been designated pursuant to s. 430.205, Florida Statutes, and by a not-for-profit hospice provider that has been licensed for more than 30 years to serve individuals and families in Clay, Duval, St. Johns, Baker, and Nassau Counties. The not-for-profit organization shall leverage existing community-based care

providers and health care organizations to provide PACE services to frail elders who reside in Clay, Duval, St. Johns, Baker, and Nassau Counties. The organization is exempt from the requirements of chapter 641, Florida Statutes. The agency, in consultation with the Department of Elderly Affairs and subject to the appropriation of funds by the Legislature, shall approve up to 300 initial enrollees in the Program of All-inclusive Care for the Elderly established by the organization to serve frail elders who reside in Clay, Duval, St. Johns, Baker, and Nassau Counties.

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

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

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

391.055 Service delivery systems.—

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

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

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

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

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

1002.385 Florida personal learning scholarship accounts.—

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

(d) "Disability" means, for a student in kindergarten to grade 12, autism, as defined in s. 393.063(3); cerebral palsy, as defined in s. 393.063(4); Down syndrome, as defined in s. 393.063(13); an intellectual disability, as defined in s. 393.063(21); Phelan-McDermid syndrome, as defined in s. 393.063(25); Prader-Willi syndrome, as defined in s. 393.063(26) ~~393.063(25)~~; or spina bifida, as defined in s. 393.063(37) ~~393.063(36)~~; for a student in kindergarten, being a high-risk child, as defined in s. 393.063(20)(a); and Williams syndrome.

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

1011.70 Medicaid certified school funding maximization.—

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

(a) Family planning.

(b) Immunizations.

(c) Prenatal care.

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

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

Approved by the Governor March 17, 2016.

Filed in Office Secretary of State March 17, 2016.