Conference Committee on
House Health Care Appropriations/
Senate Health and Human Services Appropriations

House Offer #1
Medicaid Conforming Bill

Tuesday, June 9, 2015
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212 Knott

HOUSE HEALTH CARE APPROPRIATIONS / SENATE HEALTH AND HUMAN SERVICES APPROPRIATIONS
MEDICAID CONFORMING BILL – FISCAL YEAR 2015-16

	House Bill 9-A	House Offer #1	SB 2508-A
1	**Section 1.** (s. 395.602(2)(e), F.S.) Revises definition of "rural hospital" by deleting the provision allowing a hospital to qualify as a rural hospital by being classified as a sole community hospital having up to 340 licensed beds. Also extends expiration date of certain rural hospitals until July 2021 instead of July 2015.	**Identical**	**Section 1.** (s. 395.602(2)(e), F.S.) Revises definition of "rural hospital" by deleting the provision allowing a hospital to qualify as a rural hospital by being classified as a sole community hospital having up to 340 licensed beds. Also extends expiration date of certain rural hospitals until July 2021 instead of July 2015.
2		**Pending LIP Proposal**	**Section 2.** (s. 409.908(1), F.S.) Effective upon becoming law, consolidates authority for AHCA to accept and use IGTs for hospital IP and OP rates into new paragraph under parameters of current law. Also directs AHCA to seek waiver authority to use IGTs for the general advancement of Medicaid, both in FFS and SMMC, in ways that incent IGT donations and that do not penalize IGT-donating providers when Medicaid cost limits are calculated.
3	**Section 2.** (s. 409.908(23), F.S.) Removes ICF/DDs from the list of providers for which AHCA is required to set rates at levels that ensure no increase in statewide expenditures resulting from changes in unit costs.	**Identical**	**Section 3.** (s. 409.908(23), F.S.) Removes ICF/DDs from the list of providers for which AHCA is required to set rates at levels that ensure no increase in statewide expenditures resulting from changes in unit costs.
4		**Pending LIP Proposal**	**Section 4.** (s. 409.909, F.S.) Revises several parameters of the Statewide Medicaid Residency Program (SMRP) and creates a GME startup bonus program to incent hospitals to target physician shortage specialties when bringing new residency slots online.
5	**Section 3, part 1.** (s. 409.911(2)(a), F.S.) Revises and updates the years of data that AHCA uses to measure hospitals' Medicaid and charity care for the DSH programs, so that the average of the audited data from 2006, 2007, and 2008 is used.	**Senate**	**Section 5.** (s. 409.911(2)(a), F.S.) Revises and updates the years of data that AHCA uses to measure hospitals' Medicaid and charity care for the DSH programs, so that the average of the audited data from 2007, 2008, and 2009 is used.
6	**Section 3, part 2.** (s. 409.911(4)(d), F.S.) Extends for another year the provision that any non-state-owned or operated hospital that was eligible for public-hospital DSH payments on July 1, 2011, remains eligible for public-hospital DSH during the 2015-2016 fiscal year. Under current law, that provision is limited to the current fiscal year.	**House**	
7	**Section 4.** (s. 409.967, F.S.) Revises provisions of Statewide Medicaid Managed Care. For the Achieved Savings Rebate, provides that funds returned to the state by managed care plans will be transferred into GR unallocated. For Medical Loss Ratio, provides that funds donated to the state by managed care plans will be deposited into the Grants and Donations Trust Fund.	**House**	

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8	**Section 5.** (s. 409.975(4)(a), F.S.) Repeals provision within Statewide Medicaid Managed Care for AHCA to support MOMCARE with certified public expenditures of GR appropriated for Healthy Start services and any earned federal match.	**House**	
9	**Section 6.** (s. 409.983(6), F.S.) Provides that LTC managed care plans will have their "pass-through" nursing home payments reconciled based on changes in NH per diem rates, not on NH bed-days experienced by the plans.	**Identical**	**Section 7.** (s. 409.983(6), F.S.) Provides that LTC managed care plans will have their "pass-through" nursing home payments reconciled based on changes in NH per diem rates, not on NH bed-days experienced by the plans.
10	**Section 7.** Repeals s. 409.97, F.S.	**Identical**	**Section 6.** Repeals s. 409.97, F.S.
11	**Section 8.** Creates a undesignated section of law to prohibit AHCA from partnering with any other state or territory for Medicaid fiscal agent operations and that FMMIS is to be used for Florida only, effective upon the bill becoming law. Effective upon this act becoming a law, the Agency for Health Care Administration (AHCA) may partner with any other state or territory for the purposes of providing Medicaid fiscal agent operations only if any resulting agreement or contract provides for termination if the State of Florida decides it is not in the best interest of the state. Any such agreement or contract shall not impact Florida's current Medicaid Management Information System and each state or territory shall deal directly with the federal Centers for Medicaid and Medicare Services independently regarding any billing and or matching requirements.	**Modified**	
12		**Senate**	**Section 8.** (s. 408.07(43), F.S.) Corrects a cross-reference pertaining to the change in the definition of rural hospital under Section 1 of the bill.
13		**House**	**Sections 9 through 25, 27, and 28** pertain to the creation of the Florida Health Insurance Affordability Exchange program, which is also contained in CS/SB 7044.
14		**Senate**	**Section 26.** (s. 18, ch. 2012-33, LOF) Amends authorization granted in 2012 for a PACE organization to expand into Broward County with up to 150 PACE slots. The bill allows those Broward slots to also be used in Miami-Dade County.
15	**Section 9.** Except as otherwise provided, the bill takes effect July 1, 2015.	**Identical**	**Section 29.** Except as otherwise provided, the bill takes effect July 1, 2015.

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16	**New Section.** (s.409.9082(2), F.S.) Revises the date by which the Agency shall collect the quality assessment imposed upon each nursing home from the 15th to the 20th of each month.	**New**	
17	**New Section.** If any law amended by this act was also amended by a law enacted at the 2015 Regular Session of the Legislature, such laws shall be construed as if they had been enacted at the same session of the Legislature, and full effect shall be given to each if possible.	**New**	
18	**New Section.** (s.393.067(15), F.S.) Provides that effective July 1, 2015, the requirements of the subsection shall not apply to facilities with fifty percent or greater Medicaid care.	**New**	
19	**New Section.** (s.393.18(5), F.S.) Provides that comprehensive transitional education programs initially licensed after July 1, 2015, with fifty percent or greater Medicaid care, the total number of persons who are being provided with services may not exceed 15 residents.	**New**	
20	**New Section.** (s.409.908(1)(e), F.S.) Clarifies existing law related to reimbursement provisions, provider notification requirements, and the administrative challenge process for Medicaid inpatient and outpatient hospital rates.	**New**	

MEDICAID CONFORMING BILL

PROPOSED NEW LANGUAGE

ROW 16

Section 4. Subsection (2) of section 409.9082, Florida Statutes, is amended to read:

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

(2) A quality assessment is imposed upon each nursing home facility. The aggregated amount of assessments for all nursing home facilities in a given year shall be an amount not exceeding the maximum percentage allowed under federal law of the total aggregate net patient service revenue of assessed facilities. The agency shall calculate the quality assessment rate annually on a per-resident-day basis, exclusive of those resident days funded by the Medicare program, as reported by the facilities. The per-resident-day assessment rate must be uniform except as prescribed in subsection (3). Each facility shall report monthly to the agency its total number of resident days, exclusive of Medicare Part A resident days, and remit an amount equal to the assessment rate times the reported number of days. The agency shall collect, and each facility shall pay, the quality assessment each month. The agency shall collect the assessment from nursing home facility providers by the 20th ~~15th~~ day of the next succeeding calendar month. The agency shall notify providers of the quality assessment and provide a standardized form to complete and submit with payments. The collection of the nursing home facility quality assessment shall commence no sooner than 5 days after the agency's initial payment of the Medicaid rates containing the elements prescribed in subsection (4). Nursing home facilities may not create a separate line-item charge for the purpose of passing the assessment through to residents.

MEDICAID CONFORMING
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ORIGINAL YEAR

A bill to be entitled

An act relating to ; providing an effective date.

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

Section 1. Subsection (15) of section 393.067, Florida Statutes, is amended to read:

393.067 Facility licensure.—

(15) The agency is not required to contract with new facilities licensed after October 1, 1989, pursuant to this chapter. Pursuant to chapter 287, the agency shall continue to contract within available resources for residential services with facilities licensed prior to October 1, 1989, if such facilities comply with the provisions of this chapter and all other applicable laws and regulations. Effective July 1, 2015, the requirements of this subsection shall not apply to facilities with fifty percent or greater Medicaid care.

Section 2. Subsections (5) and (6) of section 393.18, Florida Statutes, are amended 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.

(5) For comprehensive transitional education programs initially licensed after July 1, 2015 with fifty percent or greater Medicaid care, the total number of persons who are being provided with services may not in any instance exceed 15 residents.

~~(5) Licensure is authorized for comprehensive transitional education programs which by July 1, 1989:~~

~~(a) Were in actual operation; or~~

~~(b) Owned a fee simple interest in real property for which a county or city government has approved zoning allowing for the placement of the facilities described in this subsection, and have registered an intent with the agency to operate a comprehensive transitional education program. However, nothing prohibits the assignment by such a registrant to another entity at a different site within the state, if there is compliance~~

~~with the criteria of this program and local zoning requirements and each residential facility within the component centers or units of the program authorized under this paragraph does not exceed a capacity of 15 persons.~~

~~(6) Notwithstanding subsection (5), in order to maximize federal revenues and provide for children needing special behavioral services, the agency may authorize the licensure of a facility that:~~

~~(a) Provides residential services for children who have developmental disabilities along with intensive behavioral problems as defined by the agency; and~~

~~(b) As of July 1, 2010, serve children who were served by the child welfare system and who have an open case in the automated child welfare system of the Department of Children and Families.~~

~~The facility must be in compliance with all program criteria and local zoning requirements and may not exceed a capacity of 15 children.~~

Section 3. This act shall take effect July 1, 2015.

MEDICAID CONFORMING BILL
PROPOSED NEW LANGUAGE
ROW 20

(e)1. Pursuant to chapter 120, the agency shall furnish to providers written notice of the audited hospital cost-based per diem reimbursement rate for inpatient and outpatient care established by the agency. The written notice constitutes final agency action. A substantially affected provider seeking to correct or adjust the calculation of the audited hospital cost-based per diem reimbursement rate for inpatient and outpatient care, other than a challenge to the methodologies set forth in the rules of the agency and in reimbursement plans incorporated by reference therein used to calculate the reimbursement rate for inpatient and outpatient care, may request an administrative hearing to challenge the final agency action by filing a petition with the agency within 180 days after receipt of the written notice by the provider. The petition must include all documentation supporting the challenge upon which the provider intends to rely at the administrative hearing and may not be amended or supplemented except as authorized under uniform rules adopted pursuant to s. 120.54(5). The failure to timely file a petition in compliance with this subparagraph is deemed conclusive acceptance of the audited hospital cost-based per diem reimbursement rate for inpatient and outpatient care established by the agency.

2. Any challenge to the methodologies set forth in the rules of the agency and in reimbursement plans incorporated by reference therein used to calculate the

reimbursement rate for inpatient and outpatient care can only be applied retroactive for a period of three years from the date of the challenge.

3. This paragraph applies to any challenge to final agency action which seeks the correction or adjustment of a provider's audited hospital cost-based per diem reimbursement rate for inpatient and outpatient care and to any challenge to the methodologies set forth in the rules of the agency and in reimbursement plans incorporated by reference therein used to calculate the reimbursement rate for inpatient and outpatient care, including any right to challenge which arose before July 1, 2015. A correction or adjustment of an audited hospital cost-based per diem reimbursement rate for inpatient and outpatient care which is required by an administrative order or appellate decision:

a. Must be reconciled in the first rate period after the order or decision becomes final;

b. May not be the basis for any challenge to correct or adjust hospital rates required to be paid by any Medicaid managed care provider pursuant to part IV of chapter 409.

4. The agency may not be compelled by an administrative body or a court to pay additional compensation to a hospital relating to the establishment of audited hospital cost-based per diem reimbursement rates by the agency or for remedies relating to such rates, unless an appropriation has been made by law for the exclusive, specific purpose of paying such additional compensation. As used in this subparagraph, the term "appropriation made by law" has the same meaning as provided in s. 11.066.

4. Any period of time specified in this paragraph is not tolled by the pendency of any administrative or appellate proceeding.

5. The exclusive means to challenge a written notice of audited hospital cost-based per diem reimbursement rate for inpatient and outpatient care for the purpose of correcting or adjusting such rate or to challenge, before, on, or after July 1, 2015, or to challenge the methodologies set forth in the rules of the agency and in reimbursement plans incorporated by reference therein used to calculate the reimbursement rate for inpatient and outpatient care is through an administrative proceeding pursuant to chapter 120.

Section 2. For the purpose of incorporating the amendment made by this act to section 409.908, Florida Statutes, in a reference thereto, section 383.18, Florida Statutes, is reenacted to read:

383.18 Contracts; conditions.—Participation in the regional perinatal intensive care centers program under ss. 383.15-383.19 is contingent upon the department entering into a contract with a provider. The contract shall provide that patients will receive services from the center and that parents or guardians of patients who participate in the program and who are in compliance with Medicaid eligibility requirements as determined by the department are not additionally charged for treatment and care which has been contracted for by the department. Financial eligibility for the program is based on the Medicaid income guidelines for pregnant women and for children under 1 year of age. Funding shall be provided in accordance with ss. 383.19 and 409.908.

Section 3. For the purpose of incorporating the amendment made by this act to section 409.908, Florida Statutes, in a reference thereto, subsection (4) of section 409.8132, Florida Statutes, is reenacted to read:

409.8132 Medikids program component.—

(4) APPLICABILITY OF LAWS RELATING TO MEDICAID.—The

provisions of ss. 409.902, 409.905, 409.906, 409.907, 409.908, 409.912, 409.9121, 409.9122, 409.9123, 409.9124, 409.9127, 409.9128, 409.913, 409.916, 409.919, 409.920, and 409.9205 apply to the administration of the Medikids program component of the Florida Kidcare program, except that s. 409.9122 applies to Medikids as modified by the provisions of subsection (7).

Section 4. For the purpose of incorporating the amendment made by this act to section 409.908, Florida Statutes, in references thereto, paragraph (c) of subsection (5) and paragraph (b) of subsection (6) of section 409.905, Florida Statutes, are reenacted 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.

(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.

(6) HOSPITAL OUTPATIENT SERVICES.—

(b) The agency shall implement a methodology for establishing base reimbursement rates for outpatient services for each hospital based on allowable costs, as defined by the agency. Rates shall be calculated annually and take effect July 1 of each year based on the most recent complete and accurate cost report submitted by each hospital.

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 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 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 5. The amendment made by this act to s. 409.908, Florida Statutes, is remedial in nature, confirms and clarifies existing law, and applies to all proceedings pending on or commenced after this act takes effect.