A bill to be entitled

An act relating to health care; terminating the Welfare Transition Trust Fund created within the Department of Health; providing for the disposition of balances in and revenues of the trust fund; requiring the department to pay any outstanding debts and obligations and requiring the Chief Financial Officer to close out and remove the terminated fund from state accounting systems; amending s. 20.435, F.S.; removing provisions relating to the Welfare Transition Trust Fund to conform to changes made by the act; amending s. 296.37, F.S.; revising the threshold dollar amount relating to a requirement that a resident of a certain health care facility contribute to his or her maintenance and support; amending s. 400.179, F.S.; decreasing the net cumulative threshold amount of specified fees collected by the Agency for Health Care Administration from certain nursing homes to maintain lease bonds; amending s. 408.061, F.S.; requiring nursing homes and their home offices to annually submit to the agency audited financial data and certain other information within a specified timeframe using a certain uniform system of financial reporting; amending s. 408.07, F.S.; providing definitions; amending s. 409.904, F.S.; revising dates relating to

a requirement that the agency make payments for Medicaid-covered services retroactive for a specified period for certain eligible persons; abrogating the future expiration of certain provisions; reenacting s. 409.908(23), F.S., relating to a requirement that the agency establish Medicaid reimbursement rates for specified services; amending s. 409.908, F.S.; authorizing the agency to receive funds from certain entities to make Low Income Pool Program payments; requiring certain providers to contract with Medicaid managed care plans as a condition of receiving certain funding; amending s. 409.911, F.S.; revising dates relating to certain data used by the agency to calculate the disproportionate share payment for hospitals; amending s. 409.9113, F.S.; revising dates relating to certain data used by the agency to calculate the disproportionate share payment for teaching hospitals; abrogating the future expiration of certain provisions; amending s. 409.9119, F.S.; revising dates relating to certain data used by the agency to calculate the disproportionate share payment for specialty hospitals for children; abrogating the future expiration of certain provisions; amending s. 409.966, F.S.; requiring the Secretary of Health Care Administration to make certain certifications

regarding prospective Medicaid managed care plans to the Governor and Legislature; providing that certification does not guarantee assignment of enrollees to a plan that fails to meet quality standards; amending ss. 409.977 and 409.984, F.S.; authorizing the agency to engage in certain enrollment assignment actions in the Medicaid managed medical assistance program and the long-term care managed care program under certain circumstances; amending s. 624.91, F.S.; requiring an insurer or any provider of health care services under a Florida Healthy Kids Corporation contract to refund an amount to be deposited into a specified fund under certain conditions; amending s. 945.602, F.S.; conforming provisions to changes made by the act; providing for a type two transfer of the State of Florida Correctional Medical Authority to the Department of Health; amending ss. 409.975 and 1011.52, F.S.; conforming cross-references; providing an effective date.

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

Section 1. (1) The Welfare Transition Trust Fund within the Department of Health, FLAIR number 64-2-401, is terminated.

(2) All current balances remaining in, and all revenues

of, the trust fund, shall be transferred to the Federal Grants Trust Fund, FLAIR number 64-2-261.

(3) The Department of Health shall pay any outstanding debts and obligations of the terminated fund as soon as practicable, and the Chief Financial Officer shall close out and remove the terminated fund from the various state accounting systems using generally accepted accounting principles concerning warrants outstanding, assets, and liabilities.

Section 2. Subsection (8) of section 20.435, Florida Statutes, is amended to read:

20.435 Department of Health; trust funds.—The following trust funds shall be administered by the Department of Health:

~~(8) Welfare Transition Trust Fund.~~

~~(a) The Welfare Transition Trust Fund is created within the Department of Health for the purposes of receiving federal funds under the Temporary Assistance for Needy Families Program. Trust fund moneys shall be used exclusively for the purpose of providing services to individuals eligible for Temporary Assistance for Needy Families pursuant to the requirements and limitations of part A of Title IV of the Social Security Act, as amended, or any other applicable federal requirement or limitation. Funds credited to the trust fund consist of those funds collected from the Temporary Assistance for Needy Families Block Grant.~~

~~(b) Notwithstanding the provisions of s. 216.301 and~~

~~pursuant to s. 216.351, any balance in the trust fund at the end of any fiscal year shall remain in the trust fund at the end of the year and shall be available for carrying out the purposes of the trust fund.~~

Section 3. Subsection (1) of section 296.37, Florida Statutes, is amended to read:

296.37 Residents; contribution to support.—

(1) Every resident of the home who receives a pension, compensation, or gratuity from the United States Government, or income from any other source of more than $130 ~~$105~~ per month, shall contribute to his or her maintenance and support while a resident of the home in accordance with a schedule of payment determined by the administrator and approved by the director. The total amount of such contributions shall be to the fullest extent possible but shall not exceed the actual cost of operating and maintaining the home.

Section 4. Upon the expiration and reversion of the amendment made to section 400.179, Florida Statutes, pursuant to section 29 of chapter 2019-116, Laws of Florida, paragraph (d) of subsection (2) of section 400.179, Florida Statutes, is amended to read:

400.179 Liability for Medicaid underpayments and overpayments.—

(2) Because any transfer of a nursing facility may expose the fact that Medicaid may have underpaid or overpaid the

transferor, and because in most instances, any such underpayment or overpayment can only be determined following a formal field audit, the liabilities for any such underpayments or overpayments shall be as follows:

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

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

2. A leasehold licensee may meet the requirements of subparagraph 1. by payment of a nonrefundable fee, paid at initial licensure, paid at the time of any subsequent change of ownership, and paid annually thereafter, in the amount of 1 percent of the total of 3 months' Medicaid payments to the facility computed on the basis of the preceding 12-month average Medicaid payments to the facility. If a preceding 12-month average is not available, projected Medicaid payments may be used. The fee shall be deposited into the Grants and Donations Trust Fund and shall be accounted for separately as a Medicaid nursing home overpayment account. These fees shall be used at the sole discretion of the agency to repay nursing home Medicaid overpayments or for enhanced payments to nursing facilities as

specified in the General Appropriations Act or other law. Payment of this fee shall not release the licensee from any liability for any Medicaid overpayments, nor shall payment bar the agency from seeking to recoup overpayments from the licensee and any other liable party. As a condition of exercising this lease bond alternative, licensees paying this fee must maintain an existing lease bond through the end of the 30-month term period of that bond. The agency is herein granted specific authority to promulgate all rules pertaining to the administration and management of this account, including withdrawals from the account, subject to federal review and approval. This provision shall take effect upon becoming law and shall apply to any leasehold license application. The financial viability of the Medicaid nursing home overpayment account shall be determined by the agency through annual review of the account balance and the amount of total outstanding, unpaid Medicaid overpayments owing from leasehold licensees to the agency as determined by final agency audits. By March 31 of each year, the agency shall assess the cumulative fees collected under this subparagraph, minus any amounts used to repay nursing home Medicaid overpayments and amounts transferred to contribute to the General Revenue Fund pursuant to s. 215.20. If the net cumulative collections, minus amounts utilized to repay nursing home Medicaid overpayments, exceed $10 ~~$25~~ million, the provisions of this subparagraph shall not apply for the

subsequent fiscal year.

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

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

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

6. Any failure of the nursing facility operator to acquire, maintain, renew annually, or provide proof to the agency shall be grounds for the agency to deny, revoke, and suspend the facility license to operate such facility and to take any further action, including, but not limited to, enjoining the facility, asserting a moratorium pursuant to part II of chapter 408, or applying for a receiver, deemed necessary to ensure compliance with this section and to safeguard and protect the health, safety, and welfare of the facility's residents. A lease agreement required as a condition of bond financing or refinancing under s. 154.213 by a health facilities

authority or required under s. 159.30 by a county or municipality is not a leasehold for purposes of this paragraph and is not subject to the bond requirement of this paragraph.

Section 5. Subsections (5) through (13) of section 408.061, Florida Statutes, are renumbered as subsections (7) through (15), respectively, subsection (4) is amended, and new subsections (5) and (6) are added to that section, to read:

408.061 Data collection; uniform systems of financial reporting; information relating to physician charges; confidential information; immunity.—

(4) Within 120 days after the end of its fiscal year, each health care facility, excluding continuing care facilities, and hospitals operated by state agencies~~, and nursing homes~~ as those terms are defined in s. 408.07, shall file with the agency, on forms adopted by the agency and based on the uniform system of financial reporting, its actual financial experience for that fiscal year, including expenditures, revenues, and statistical measures. Such data may be based on internal financial reports which are certified to be complete and accurate by the provider. However, hospitals' actual financial experience shall be their audited actual experience. Every nursing home shall submit to the agency, in a format designated by the agency, a statistical profile of the nursing home residents. The agency, in conjunction with the Department of Elderly Affairs and the Department of Health, shall review these statistical profiles

and develop recommendations for the types of residents who might more appropriately be placed in their homes or other noninstitutional settings.

(5) Within 120 days after the end of its fiscal year, each nursing home as defined in s. 408.07 shall file with the agency, on forms adopted by the agency and based on the uniform system of financial reporting, its actual financial experience for that fiscal year, including expenditures, revenues, and statistical measures. Such data may be based on internal financial reports which are certified to be complete and accurate by the chief financial officer of the nursing home. However, the nursing home's actual financial experience shall be its audited actual financial experience, as audited by an independent certified professional accountant. This audited actual experience shall include the fiscal year-end balance sheet, income statement, statement of cash flow, and statement of retained earnings and shall be submitted to the agency in addition to the information filed in the uniform system of financial reporting. The nursing home shall provide all necessary records for the independent certified professional accountant to form an opinion and complete an accurate audit report. The independent certified professional accountant's opinion and audit report shall accompany the financial statements submitted to the agency. The audited financial statements shall tie to the information submitted in the uniform system of financial reporting and a

crosswalk shall be submitted along with the audited financial statements.

(6) Within 120 days after the end of its fiscal year, the home office of each nursing home as defined in s. 408.07 shall file with the agency, on forms adopted by the agency and based on the uniform system of financial reporting, its actual financial experience for that fiscal year, including expenditures, revenues, and statistical measures. Such data may be based on internal financial reports which are certified to be complete and accurate by the chief financial officer of the nursing home. However, the home office's actual financial experience shall be its audited actual financial experience, as audited by an independent certified professional accountant. This audited actual experience shall include the fiscal year-end balance sheet, income statement, statement of cash flow, and statement of retained earnings and shall be submitted to the agency in addition to the information filed in the uniform system of financial reporting. The home office shall provide all necessary records for the independent certified professional accountant to form an opinion and complete an accurate audit report. The independent certified professional accountant's opinion and audit report shall accompany the financial statements submitted to the agency. The audited financial statements shall tie to the information submitted in the uniform system of financial reporting and a crosswalk shall be submitted

along with the audited financial statements.

Section 6. Subsections (19) through (27) of section 408.07, Florida Statutes, are renumbered as subsections (20) through (28), respectively, and subsections (28) through (44) are renumbered as subsections (30) through (46), and new subsections (19) and (29) are added to that section, to read:

408.07 Definitions.—As used in this chapter, with the exception of ss. 408.031-408.045, the term:

(19) "FNHURS" means the Florida Nursing Home Uniform Reporting System developed by the agency.

(29) "Home office" has the same meaning as provided in the Provider Reimbursement Manual, Part 1 (Centers for Medicare and Medicaid Services, Pub. 15-1), as that definition exists on the effective date of this act.

Section 7. Subsection (12) of section 409.904, Florida Statutes, is amended 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.

(12) Effective July 1, 2020 ~~July 1, 2019~~, the agency shall

make payments for ~~to~~ Medicaid-covered services:

(a) For eligible children and pregnant women, retroactive for a period of no more than 90 days before the month in which an application for Medicaid is submitted.

(b) For eligible nonpregnant adults, retroactive to the first day of the month in which an application for Medicaid is submitted.

~~This subsection expires July 1, 2020.~~

Section 8. Notwithstanding the expiration date in section 19 of chapter 2019-116, Laws of Florida, subsection (23) of section 409.908, Florida Statutes, is reenacted 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.

(23)(a) The agency shall establish rates at a level that ensures no increase in statewide expenditures resulting from a change in unit costs for county health departments effective July 1, 2011. Reimbursement rates shall be as provided in the General Appropriations Act.

(b)1. Base rate reimbursement for inpatient services under a diagnosis-related group payment methodology shall be provided in the General Appropriations Act.

2. Base rate reimbursement for outpatient services under an enhanced ambulatory payment group methodology shall be

provided in the General Appropriations Act.

3. Prospective payment system reimbursement for nursing home services shall be as provided in subsection (2) and in the General Appropriations Act.

Section 9. Upon the expiration and reversion of the amendment made to section 409.908, Florida Statutes, pursuant to section 21 of chapter 2019-116, Laws of Florida, subsection (26) of section 409.908, Florida Statutes, is amended 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.

(26) 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 and Low Income Pool Program payments, including federal matching funds. 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 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. Local governmental funds outlined in the letters of agreement must be received by the agency no later than October 31 of each fiscal year in which such funds are pledged, unless an alternative plan is specifically approved by the agency. To be eligible for low-income pool funding or other forms of supplemental payments funded by intergovernmental transfers, and in addition to any other applicable requirements, essential providers under s. 409.975(1)(a) and (1)(b)2. and 4. must contract with each managed care plan in their region and essential providers under s. 409.975(1)(b)1. and 3. must contract with each managed care plan in the state.

Section 10. Paragraph (a) of subsection (2) of section 409.911, Florida Statutes, is amended to read:

409.911 Disproportionate share program.—Subject to specific allocations established within the General Appropriations Act and any limitations established pursuant to chapter 216, the agency shall distribute, pursuant to this

section, moneys to hospitals providing a disproportionate share of Medicaid or charity care services by making quarterly Medicaid payments as required. Notwithstanding the provisions of s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients.

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

(a) The average of the 2012, 2013, and 2014 ~~2011, 2012, and 2013~~ audited disproportionate share data to determine each hospital's Medicaid days and charity care for the 2020-2021 ~~2019-2020~~ state fiscal year.

Section 11. Subsection (3) of section 409.9113, Florida Statutes, is amended to read:

409.9113 Disproportionate share program for teaching hospitals.—In addition to the payments made under s. 409.911, the agency shall make disproportionate share payments to teaching hospitals, as defined in s. 408.07, for their increased costs associated with medical education programs and for tertiary health care services provided to the indigent. This system of payments must conform to federal requirements and distribute funds in each fiscal year for which an appropriation is made by making quarterly Medicaid payments. Notwithstanding

s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients. The agency shall distribute the moneys provided in the General Appropriations Act to statutorily defined teaching hospitals and family practice teaching hospitals, as defined in s. 395.805, pursuant to this section. The funds provided for statutorily defined teaching hospitals shall be distributed as provided in the General Appropriations Act. The funds provided for family practice teaching hospitals shall be distributed equally among family practice teaching hospitals.

(3) Notwithstanding any provision of this section to the contrary, for the 2020-2021 ~~2019-2020~~ state fiscal year, the agency shall make disproportionate share payments to teaching hospitals, as defined in s. 408.07, as provided in the 2020-2021 ~~2019-2020~~ General Appropriations Act. ~~This subsection expires July 1, 2020.~~

Section 12. Subsection (4) of section 409.9119, Florida Statutes, is amended to read:

409.9119 Disproportionate share program for specialty hospitals for children.—In addition to the payments made under s. 409.911, the Agency for Health Care Administration shall develop and implement a system under which disproportionate share payments are made to those hospitals that are separately licensed by the state as specialty hospitals for children, have

a federal Centers for Medicare and Medicaid Services certification number in the 3300-3399 range, have Medicaid days that exceed 55 percent of their total days and Medicare days that are less than 5 percent of their total days, and were licensed on January 1, 2013, as specialty hospitals for children. This system of payments must conform to federal requirements and must distribute funds in each fiscal year for which an appropriation is made by making quarterly Medicaid payments. Notwithstanding s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals that serve a disproportionate share of low-income patients. The agency may make disproportionate share payments to specialty hospitals for children as provided for in the General Appropriations Act.

(4) Notwithstanding any provision of this section to the contrary, for the 2020-2021 ~~2019-2020~~ state fiscal year, for hospitals achieving full compliance under subsection (3), the agency shall make disproportionate share payments to specialty hospitals for children as provided in the 2020-2021 ~~2019-2020~~ General Appropriations Act. ~~This subsection expires July 1, 2020.~~

Section 13. Subsection (5) is added to section 409.966, Florida Statutes, to read:

409.966 Eligible plans; selection.—

(5) CERTIFICATION OF PLANS.—Before executing a contract

for a plan to operate in a specific region, the Secretary of Health Care Administration shall certify to the Governor, the President of the Senate, and the Speaker of the House of Representatives, that the plan has sufficiently documented its capability of providing quality services to Medicaid enrollees consistent with the agency's requirements. The secretary shall further certify that the agency's plan selection decisions and automatic assignment procedures will not systematically prevent the plan from achieving an enrollment level congruent with the plan's pro forma financial statement and determined by the agency to be reasonable and necessary for sustainable operations. Such certification does not guarantee assignment of enrollees to any plan that fails to meet quality standards.

Section 14. Subsection (1) of section 409.977, Florida Statutes, is amended to read:

409.977 Enrollment.—

(1) The agency shall automatically enroll into a managed care plan those Medicaid recipients who do not voluntarily choose a plan pursuant to s. 409.969. The agency shall automatically enroll recipients in plans that meet or exceed the performance or quality standards established pursuant to s. 409.967 and may not automatically enroll recipients in a plan that is deficient in those performance or quality standards. When a specialty plan is available to accommodate a specific condition or diagnosis of a recipient, the agency shall assign

the recipient to that plan. In the first year of the first contract term only, if a recipient was previously enrolled in a plan that is still available in the region, the agency shall automatically enroll the recipient in that plan unless an applicable specialty plan is available. Except as otherwise provided in this part, the agency may not engage in practices that are designed to favor one managed care plan over another, unless it is temporarily necessary to enable a new plan in a region to attain a sustainable enrollment level and accommodate the certification made by the Secretary of Health Care Administration pursuant to s. 409.966(5).

Section 15. Subsection (1) of section 409.984, Florida Statutes, is amended to read:

409.984 Enrollment in a long-term care managed care plan.—

(1) The agency shall automatically enroll into a long-term care managed care plan those Medicaid recipients who do not voluntarily choose a plan pursuant to s. 409.969. The agency shall automatically enroll recipients in plans that meet or exceed the performance or quality standards established pursuant to s. 409.967 and may not automatically enroll recipients in a plan that is deficient in those performance or quality standards. If a recipient is deemed dually eligible for Medicaid and Medicare services and is currently receiving Medicare services from an entity qualified under 42 C.F.R. part 422 as a Medicare Advantage Preferred Provider Organization, Medicare

Advantage Provider-sponsored Organization, or Medicare Advantage Special Needs Plan, the agency shall automatically enroll the recipient in such plan for Medicaid services if the plan is currently participating in the long-term care managed care program. Except as otherwise provided in this part, the agency may not engage in practices that are designed to favor one managed care plan over another, unless it is temporarily necessary to enable a new plan in a region to attain a sustainable enrollment level and accommodate the certification made by the Secretary of Health Care Administration pursuant to s. 409.966(5).

Section 16. Upon the expiration and reversion of the amendment made to section 624.91, Florida Statutes, pursuant to section 31 of chapter 2019-116, Laws of Florida, paragraph (b) of subsection (5) of section 624.91, Florida Statutes, is amended to read:

624.91 The Florida Healthy Kids Corporation Act.—

(5) CORPORATION AUTHORIZATION, DUTIES, POWERS.—

(b) The Florida Healthy Kids Corporation shall:

1. Arrange for the collection of any family, local contributions, or employer payment or premium, in an amount to be determined by the board of directors, to provide for payment of premiums for comprehensive insurance coverage and for the actual or estimated administrative expenses.

2. Arrange for the collection of any voluntary

contributions to provide for payment of Florida Kidcare program premiums for children who are not eligible for medical assistance under Title XIX or Title XXI of the Social Security Act.

3. Subject to the provisions of s. 409.8134, accept voluntary supplemental local match contributions that comply with the requirements of Title XXI of the Social Security Act for the purpose of providing additional Florida Kidcare coverage in contributing counties under Title XXI.

4. Establish the administrative and accounting procedures for the operation of the corporation.

5. Establish, with consultation from appropriate professional organizations, standards for preventive health services and providers and comprehensive insurance benefits appropriate to children, provided that such standards for rural areas shall not limit primary care providers to board-certified pediatricians.

6. Determine eligibility for children seeking to participate in the Title XXI-funded components of the Florida Kidcare program consistent with the requirements specified in s. 409.814, as well as the non-Title-XXI-eligible children as provided in subsection (3).

7. Establish procedures under which providers of local match to, applicants to and participants in the program may have grievances reviewed by an impartial body and reported to the

board of directors of the corporation.

8. Establish participation criteria and, if appropriate, contract with an authorized insurer, health maintenance organization, or third-party administrator to provide administrative services to the corporation.

9. Establish enrollment criteria that include penalties or waiting periods of 30 days for reinstatement of coverage upon voluntary cancellation for nonpayment of family premiums.

10. Contract with authorized insurers or any provider of health care services, meeting standards established by the corporation, for the provision of comprehensive insurance coverage to participants. Such standards shall include criteria under which the corporation may contract with more than one provider of health care services in program sites. Health plans shall be selected through a competitive bid process. The Florida Healthy Kids Corporation shall purchase goods and services in the most cost-effective manner consistent with the delivery of quality medical care. The maximum administrative cost for a Florida Healthy Kids Corporation contract shall be 15 percent. For health care contracts, the minimum medical loss ratio for a Florida Healthy Kids Corporation contract shall be 85 percent. For dental contracts, the remaining compensation to be paid to the authorized insurer or provider under a Florida Healthy Kids Corporation contract shall be no less than an amount which is 85 percent of premium; to the extent any contract provision does

not provide for this minimum compensation, this section shall prevail. For an insurer or any provider of health care services that achieves an annual medical loss ratio below 85 percent, the Florida Healthy Kids Corporation shall validate the medical loss ratio and calculate an amount to be refunded by the insurer or any provider of health care services to the state which shall be deposited into the General Revenue Fund unallocated. The health plan selection criteria and scoring system, and the scoring results, shall be available upon request for inspection after the bids have been awarded.

11. Establish disenrollment criteria in the event local matching funds are insufficient to cover enrollments.

12. Develop and implement a plan to publicize the Florida Kidcare program, the eligibility requirements of the program, and the procedures for enrollment in the program and to maintain public awareness of the corporation and the program.

13. Secure staff necessary to properly administer the corporation. Staff costs shall be funded from state and local matching funds and such other private or public funds as become available. The board of directors shall determine the number of staff members necessary to administer the corporation.

14. In consultation with the partner agencies, provide a report on the Florida Kidcare program annually to the Governor, the Chief Financial Officer, the Commissioner of Education, the President of the Senate, the Speaker of the House of

Representatives, and the Minority Leaders of the Senate and the House of Representatives.

15. Provide information on a quarterly basis to the Legislature and the Governor which compares the costs and utilization of the full-pay enrolled population and the Title XXI-subsidized enrolled population in the Florida Kidcare program. The information, at a minimum, must include:

a. The monthly enrollment and expenditure for full-pay enrollees in the Medikids and Florida Healthy Kids programs compared to the Title XXI-subsidized enrolled population; and

b. The costs and utilization by service of the full-pay enrollees in the Medikids and Florida Healthy Kids programs and the Title XXI-subsidized enrolled population.

16. Establish benefit packages that conform to the provisions of the Florida Kidcare program, as created in ss. 409.810-409.821.

Section 17. Subsection (1) of section 945.602, Florida Statutes, is amended to read:

945.602 State of Florida Correctional Medical Authority; creation; members.—

(1) There is created the State of Florida Correctional Medical Authority, which for administrative purposes shall be assigned to the Department of Health ~~Executive Office of the Governor~~. The governing board of the authority shall be composed of seven persons appointed by the Governor subject to

confirmation by the Senate. One member must be a member of the Florida Hospital Association, and one member must be a member of the Florida Medical Association. The authority shall contract with the Department of Health ~~Executive Office of the Governor~~ for the provision of administrative support services, including purchasing, personnel, general services, and budgetary matters. The authority is not subject to control, supervision, or direction by the Department of Health ~~Executive Office of the Governor~~ or the Department of Corrections. The authority shall annually elect one member to serve as chair. Members shall be appointed for terms of 4 years each. Each member may continue to serve upon the expiration of his or her term until a successor is duly appointed as provided in this section. Before entering upon his or her duties, each member of the authority shall take and subscribe to the oath or affirmation required by the State Constitution.

Section 18. All powers, duties, functions, records, offices, personnel, associated administrative support positions, property, pending issues, existing contracts, administrative authority, and administrative rules relating to the State of Florida Correctional Medical Authority in the Executive Office of the Governor are transferred by a type two transfer, as defined in s. 20.06(2), Florida Statutes, to the Department of Health.

Section 19. Paragraph (a) of subsection (1) of section

409.975, Florida Statutes, is 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(46) ~~s. 408.07(44)~~.

3. Hospitals that are trauma centers as defined in s. 395.4001(15).

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.

Section 20. Paragraph (e) of subsection (2) of section 1011.52, Florida Statutes, is amended to read:

1011.52 Appropriation to first accredited medical school.—

(2) In order for a medical school to qualify under this section and to be entitled to the benefits herein, such medical school:

(e) Must have in place an operating agreement with a government-owned hospital that is located in the same county as the medical school and that is a statutory teaching hospital as defined in s. 408.07(46) ~~s. 408.07(44)~~. The operating agreement must provide for the medical school to maintain the same level of affiliation with the hospital, including the level of services to indigent and charity care patients served by the hospital, which was in place in the prior fiscal year. Each year, documentation demonstrating that an operating agreement is in effect shall be submitted jointly to the Department of

Education by the hospital and the medical school prior to the payment of moneys from the annual appropriation.

Section 21. This act shall take effect July 1, 2020.