

20212518e1

1                   A bill to be entitled  
2     An act relating to health care; amending s. 296.37,  
3     F.S.; revising the amount of money residents of a  
4     veterans' nursing home must receive monthly before  
5     being required to contribute to their maintenance and  
6     support; reenacting s. 400.179(2)(d), F.S., relating  
7     to liability for Medicaid underpayments and  
8     overpayments; amending s. 408.061, F.S.; requiring  
9     nursing homes and their home offices to annually  
10    submit to the Agency for Health Care Administration  
11    certain information within a specified timeframe;  
12    amending s. 408.07, F.S.; defining the terms "FNHURS"  
13    and "home office"; amending s. 409.903, F.S.; revising  
14    the postpartum Medicaid eligibility period for  
15    pregnant women; amending s. 409.904, F.S.; deleting  
16    the effective date and the expiration date of a  
17    provision requiring the agency to make payments to  
18    Medicaid-covered services; reenacting s. 409.908(23),  
19    F.S., relating to reimbursement of Medicaid providers;  
20    amending s. 409.908, F.S.; authorizing the agency to  
21    receive funds to be used for Low Income Pool Program  
22    payments; requiring certain essential providers to  
23    offer to contract with certain managed care plans to  
24    be eligible for low-income pool funding; requiring the  
25    agency to evaluate contract negotiations and withhold  
26    supplemental payments under certain circumstances;  
27    requiring the agency to notify and afford hearing  
28    rights to providers under certain circumstances;  
29    amending s. 409.911, F.S.; revising the years of

20212518e1

30 audited disproportionate share data the agency must  
31 use for calculating an average for purposes of  
32 calculating disproportionate share payments;  
33 authorizing the agency to use data available for a  
34 hospital; conforming provisions to changes made by the  
35 act; revising the requirement that the agency  
36 distribute moneys to hospitals providing a  
37 disproportionate share of Medicaid or charity care  
38 services, as provided in the General Appropriations  
39 Act, to apply to each fiscal year, rather than a  
40 specified fiscal year; deleting the expiration date of  
41 such requirement; amending s. 409.9113, F.S.; revising  
42 the requirement that the agency make disproportionate  
43 share payments to teaching hospitals, as provided in  
44 the General Appropriations Act, to apply to each  
45 fiscal year, rather than a specified fiscal year;  
46 deleting the expiration date of such requirement;  
47 amending s. 409.9119, F.S.; revising the requirement  
48 that the agency make disproportionate share payments  
49 to certain specialty hospitals for children to apply  
50 to each fiscal year, rather than a specified fiscal  
51 year; deleting the expiration date of such  
52 requirement; amending s. 409.975, F.S.; conforming a  
53 cross-reference; amending s. 430.502, F.S.; revising  
54 the name of a memory disorder clinic in Pensacola;  
55 reenacting s. 624.91(5)(b), F.S., relating to The  
56 Florida Healthy Kids Corporation Act; amending s.  
57 1011.52, F.S.; conforming a cross-reference; requiring  
58 the agency to contract with organizations for the

20212518e1

59 provision of elder care services in specified counties  
60 if certain conditions are met; requiring the agency to  
61 contract with hospitals for the provision of elder  
62 care services in specified counties if certain  
63 conditions are met; authorizing an organization  
64 providing elder care services in specified counties to  
65 provide elder care services in additional specified  
66 counties if certain conditions are met; authorizing  
67 the consolidation of organizations providing elder  
68 care services in specified counties; authorizing an  
69 organization to provide elder care services with the  
70 consolidation if certain criteria are met; authorizing  
71 an organization to provide elder care services in  
72 specified counties if certain criteria are met;  
73 providing an effective date.  
74

75 Be It Enacted by the Legislature of the State of Florida:  
76

77 Section 1. Subsections (1) and (3) of section 296.37,  
78 Florida Statutes, are amended to read:

79 296.37 Residents; contribution to support.-

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

20212518e1

88 operating and maintaining the home.

89 ~~(3) Notwithstanding subsection (1), each resident of the~~  
90 ~~home who receives a pension, compensation, or gratuity from the~~  
91 ~~United States Government, or income from any other source, of~~  
92 ~~more than \$130 per month shall contribute to his or her~~  
93 ~~maintenance and support while a resident of the home in~~  
94 ~~accordance with a payment schedule determined by the~~  
95 ~~administrator and approved by the director. The total amount of~~  
96 ~~such contributions shall be to the fullest extent possible, but,~~  
97 ~~in no case, shall exceed the actual cost of operating and~~  
98 ~~maintaining the home. This subsection expires July 1, 2021.~~

99 Section 2. Notwithstanding the expiration date in section  
100 51 of chapter 2020-114, Laws of Florida, paragraph (d) of  
101 subsection (2) of section 400.179, Florida Statutes, is  
102 reenacted to read:

103 400.179 Liability for Medicaid underpayments and  
104 overpayments.—

105 (2) Because any transfer of a nursing facility may expose  
106 the fact that Medicaid may have underpaid or overpaid the  
107 transferor, and because in most instances, any such underpayment  
108 or overpayment can only be determined following a formal field  
109 audit, the liabilities for any such underpayments or  
110 overpayments shall be as follows:

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

113 1. The transferee shall, as a condition to being issued a  
114 license by the agency, acquire, maintain, and provide proof to  
115 the agency of a bond with a term of 30 months, renewable  
116 annually, in an amount not less than the total of 3 months'

20212518e1

117 Medicaid payments to the facility computed on the basis of the  
118 preceding 12-month average Medicaid payments to the facility.

119       2. A leasehold licensee may meet the requirements of  
120 subparagraph 1. by payment of a nonrefundable fee, paid at  
121 initial licensure, paid at the time of any subsequent change of  
122 ownership, and paid annually thereafter, in the amount of 1  
123 percent of the total of 3 months' Medicaid payments to the  
124 facility computed on the basis of the preceding 12-month average  
125 Medicaid payments to the facility. If a preceding 12-month  
126 average is not available, projected Medicaid payments may be  
127 used. The fee shall be deposited into the Grants and Donations  
128 Trust Fund and shall be accounted for separately as a Medicaid  
129 nursing home overpayment account. These fees shall be used at  
130 the sole discretion of the agency to repay nursing home Medicaid  
131 overpayments or for enhanced payments to nursing facilities as  
132 specified in the General Appropriations Act or other law.  
133 Payment of this fee shall not release the licensee from any  
134 liability for any Medicaid overpayments, nor shall payment bar  
135 the agency from seeking to recoup overpayments from the licensee  
136 and any other liable party. As a condition of exercising this  
137 lease bond alternative, licensees paying this fee must maintain  
138 an existing lease bond through the end of the 30-month term  
139 period of that bond. The agency is herein granted specific  
140 authority to promulgate all rules pertaining to the  
141 administration and management of this account, including  
142 withdrawals from the account, subject to federal review and  
143 approval. This provision shall take effect upon becoming law and  
144 shall apply to any leasehold license application. The financial  
145 viability of the Medicaid nursing home overpayment account shall

20212518e1

146 be determined by the agency through annual review of the account  
147 balance and the amount of total outstanding, unpaid Medicaid  
148 overpayments owing from leasehold licensees to the agency as  
149 determined by final agency audits. By March 31 of each year, the  
150 agency shall assess the cumulative fees collected under this  
151 subparagraph, minus any amounts used to repay nursing home  
152 Medicaid overpayments and amounts transferred to contribute to  
153 the General Revenue Fund pursuant to s. 215.20. If the net  
154 cumulative collections, minus amounts utilized to repay nursing  
155 home Medicaid overpayments, exceed \$10 million, the provisions  
156 of this subparagraph shall not apply for the subsequent fiscal  
157 year.

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

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

167 5. It shall be the responsibility of all nursing facility  
168 operators, operating the facility as a leasehold, to renew the  
169 30-month bond and to provide proof of such renewal to the agency  
170 annually.

171 6. Any failure of the nursing facility operator to acquire,  
172 maintain, renew annually, or provide proof to the agency shall  
173 be grounds for the agency to deny, revoke, and suspend the  
174 facility license to operate such facility and to take any

20212518e1

175 further action, including, but not limited to, enjoining the  
176 facility, asserting a moratorium pursuant to part II of chapter  
177 408, or applying for a receiver, deemed necessary to ensure  
178 compliance with this section and to safeguard and protect the  
179 health, safety, and welfare of the facility's residents. A lease  
180 agreement required as a condition of bond financing or  
181 refinancing under s. 154.213 by a health facilities authority or  
182 required under s. 159.30 by a county or municipality is not a  
183 leasehold for purposes of this paragraph and is not subject to  
184 the bond requirement of this paragraph.

185 Section 3. Present subsections (5) through (13) of section  
186 408.061, Florida Statutes, are redesignated as subsections (7)  
187 through (15), respectively, subsection (4) is amended, and new  
188 subsections (5) and (6) are added to that section, to read:

189 408.061 Data collection; uniform systems of financial  
190 reporting; information relating to physician charges;  
191 confidential information; immunity.—

192 (4) Within 120 days after the end of its fiscal year, each  
193 health care facility, excluding continuing care facilities, and  
194 hospitals operated by state agencies, ~~and nursing homes~~ as those  
195 terms are defined in s. 408.07, shall file with the agency, on  
196 forms adopted by the agency and based on the uniform system of  
197 financial reporting, its actual financial experience for that  
198 fiscal year, including expenditures, revenues, and statistical  
199 measures. Such data may be based on internal financial reports  
200 which are certified to be complete and accurate by the provider.  
201 However, hospitals' actual financial experience shall be their  
202 audited actual experience. Every nursing home shall submit to  
203 the agency, in a format designated by the agency, a statistical

20212518e1

204 profile of the nursing home residents. The agency, in  
205 conjunction with the Department of Elderly Affairs and the  
206 Department of Health, shall review these statistical profiles  
207 and develop recommendations for the types of residents who might  
208 more appropriately be placed in their homes or other  
209 noninstitutional settings.

210 (5) Within 120 days after the end of its fiscal year, each  
211 nursing home as defined in s. 408.07 shall file with the agency,  
212 on forms adopted by the agency and based on the uniform system  
213 of financial reporting, its actual financial experience for that  
214 fiscal year, including expenditures, revenues, and statistical  
215 measures. Such data may be based on internal financial reports  
216 that are certified to be complete and accurate by the chief  
217 financial officer of the nursing home. This actual experience  
218 must include the fiscal year-end balance sheet, income  
219 statement, statement of cash flow, and statement of retained  
220 earnings and must be submitted to the agency in addition to the  
221 information filed in the uniform system of financial reporting.  
222 The financial statements must tie to the information submitted  
223 in the uniform system of financial reporting, and a crosswalk  
224 must be submitted along with the financial statements.

225 (6) Within 120 days after the end of its fiscal year, the  
226 home office of each nursing home as defined in s. 408.07 shall  
227 file with the agency, on forms adopted by the agency and based  
228 on the uniform system of financial reporting, its actual  
229 financial experience for that fiscal year, including  
230 expenditures, revenues, and statistical measures. Such data may  
231 be based on internal financial reports that are certified to be  
232 complete and accurate by the chief financial officer of the



20212518e1

233 nursing home. This actual experience must include the fiscal  
234 year-end balance sheet, income statement, statement of cash  
235 flow, and statement of retained earnings and must be submitted  
236 to the agency in addition to the information filed in the  
237 uniform system of financial reporting. The financial statements  
238 must tie to the information submitted in the uniform system of  
239 financial reporting, and a crosswalk must be submitted along  
240 with the audited financial statements.

241 Section 4. Present subsections (19) through (27) of section  
242 408.07, Florida Statutes, are redesignated as subsections (20)  
243 through (28), respectively, and present subsections (28) through  
244 (44) are redesignated as subsections (30) through (46),  
245 respectively, and new subsections (19) and (29) are added to  
246 that section, to read:

247 408.07 Definitions.—As used in this chapter, with the  
248 exception of ss. 408.031-408.045, the term:

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

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

255 Section 5. Subsection (5) of section 409.903, Florida  
256 Statutes, is amended to read:

257 409.903 Mandatory payments for eligible persons.—The agency  
258 shall make payments for medical assistance and related services  
259 on behalf of the following persons who the department, or the  
260 Social Security Administration by contract with the Department  
261 of Children and Families, determines to be eligible, subject to

20212518e1

262 the income, assets, and categorical eligibility tests set forth  
263 in federal and state law. Payment on behalf of these Medicaid  
264 eligible persons is subject to the availability of moneys and  
265 any limitations established by the General Appropriations Act or  
266 chapter 216.

267 (5) A pregnant woman for the duration of her pregnancy and  
268 for the postpartum period consisting of the 12-month period  
269 beginning on the last day of her pregnancy ~~as defined in federal~~  
270 ~~law and rule~~, or a child under age 1, if either is living in a  
271 family that has an income that ~~which~~ is at or ~~below 150 percent~~  
272 ~~of the most current federal poverty level, or, effective January~~  
273 ~~1, 1992, that has an income which is at or~~ below 185 percent of  
274 the most current federal poverty level. Such a person is not  
275 subject to an assets test. Further, a pregnant woman who applies  
276 for eligibility for the Medicaid program through a qualified  
277 Medicaid provider must be offered the opportunity, subject to  
278 federal rules, to be made presumptively eligible for the  
279 Medicaid program.

280 Section 6. Subsection (12) of section 409.904, Florida  
281 Statutes, is amended to read:

282 409.904 Optional payments for eligible persons.—The agency  
283 may make payments for medical assistance and related services on  
284 behalf of the following persons who are determined to be  
285 eligible subject to the income, assets, and categorical  
286 eligibility tests set forth in federal and state law. Payment on  
287 behalf of these Medicaid eligible persons is subject to the  
288 availability of moneys and any limitations established by the  
289 General Appropriations Act or chapter 216.

290 (12) ~~Effective July 1, 2020,~~ The agency shall make payments

20212518e1

291 to Medicaid-covered services:

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

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

298

299 ~~This subsection expires July 1, 2021.~~

300 Section 7. Notwithstanding the expiration date in section  
301 13 of chapter 2020-114, Laws of Florida, subsection (23) of  
302 section 409.908, Florida Statutes, is reenacted to read:

303 409.908 Reimbursement of Medicaid providers.—Subject to  
304 specific appropriations, the agency shall reimburse Medicaid  
305 providers, in accordance with state and federal law, according  
306 to methodologies set forth in the rules of the agency and in  
307 policy manuals and handbooks incorporated by reference therein.  
308 These methodologies may include fee schedules, reimbursement  
309 methods based on cost reporting, negotiated fees, competitive  
310 bidding pursuant to s. 287.057, and other mechanisms the agency  
311 considers efficient and effective for purchasing services or  
312 goods on behalf of recipients. If a provider is reimbursed based  
313 on cost reporting and submits a cost report late and that cost  
314 report would have been used to set a lower reimbursement rate  
315 for a rate semester, then the provider's rate for that semester  
316 shall be retroactively calculated using the new cost report, and  
317 full payment at the recalculated rate shall be effected  
318 retroactively. Medicare-granted extensions for filing cost  
319 reports, if applicable, shall also apply to Medicaid cost

20212518e1

320 reports. Payment for Medicaid compensable services made on  
321 behalf of Medicaid eligible persons is subject to the  
322 availability of moneys and any limitations or directions  
323 provided for in the General Appropriations Act or chapter 216.  
324 Further, nothing in this section shall be construed to prevent  
325 or limit the agency from adjusting fees, reimbursement rates,  
326 lengths of stay, number of visits, or number of services, or  
327 making any other adjustments necessary to comply with the  
328 availability of moneys and any limitations or directions  
329 provided for in the General Appropriations Act, provided the  
330 adjustment is consistent with legislative intent.

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

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

339 2. Base rate reimbursement for outpatient services under an  
340 enhanced ambulatory payment group methodology shall be provided  
341 in the General Appropriations Act.

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

345 Section 8. Upon the expiration and reversion of the  
346 amendments made to section 409.908, Florida Statutes, pursuant  
347 to section 15 of chapter 2020-114, Laws of Florida, subsection  
348 (26) of section 409.908, Florida Statutes, is amended to read:

20212518e1

349 409.908 Reimbursement of Medicaid providers.—Subject to  
350 specific appropriations, the agency shall reimburse Medicaid  
351 providers, in accordance with state and federal law, according  
352 to methodologies set forth in the rules of the agency and in  
353 policy manuals and handbooks incorporated by reference therein.  
354 These methodologies may include fee schedules, reimbursement  
355 methods based on cost reporting, negotiated fees, competitive  
356 bidding pursuant to s. 287.057, and other mechanisms the agency  
357 considers efficient and effective for purchasing services or  
358 goods on behalf of recipients. If a provider is reimbursed based  
359 on cost reporting and submits a cost report late and that cost  
360 report would have been used to set a lower reimbursement rate  
361 for a rate semester, then the provider's rate for that semester  
362 shall be retroactively calculated using the new cost report, and  
363 full payment at the recalculated rate shall be effected  
364 retroactively. Medicare-granted extensions for filing cost  
365 reports, if applicable, shall also apply to Medicaid cost  
366 reports. Payment for Medicaid compensable services made on  
367 behalf of Medicaid eligible persons is subject to the  
368 availability of moneys and any limitations or directions  
369 provided for in the General Appropriations Act or chapter 216.  
370 Further, nothing in this section shall be construed to prevent  
371 or limit the agency from adjusting fees, reimbursement rates,  
372 lengths of stay, number of visits, or number of services, or  
373 making any other adjustments necessary to comply with the  
374 availability of moneys and any limitations or directions  
375 provided for in the General Appropriations Act, provided the  
376 adjustment is consistent with legislative intent.

377 (26) The agency may receive funds from state entities,

20212518e1

378 including, but not limited to, the Department of Health, local  
379 governments, and other local political subdivisions, for the  
380 purpose of making special exception payments and Low Income Pool  
381 Program payments, including federal matching funds. Funds  
382 received for this purpose shall be separately accounted for and  
383 may not be commingled with other state or local funds in any  
384 manner. The agency may certify all local governmental funds used  
385 as state match under Title XIX of the Social Security Act to the  
386 extent and in the manner authorized under the General  
387 Appropriations Act and pursuant to an agreement between the  
388 agency and the local governmental entity. In order for the  
389 agency to certify such local governmental funds, a local  
390 governmental entity must submit a final, executed letter of  
391 agreement to the agency, which must be received by October 1 of  
392 each fiscal year and provide the total amount of local  
393 governmental funds authorized by the entity for that fiscal year  
394 under the General Appropriations Act. The local governmental  
395 entity shall use a certification form prescribed by the agency.  
396 At a minimum, the certification form must identify the amount  
397 being certified and describe the relationship between the  
398 certifying local governmental entity and the local health care  
399 provider. Local governmental funds outlined in the letters of  
400 agreement must be received by the agency no later than October  
401 31 of each fiscal year in which such funds are pledged, unless  
402 an alternative plan is specifically approved by the agency. To  
403 be eligible for low-income pool funding or other forms of  
404 supplemental payments funded by intergovernmental transfers, and  
405 in addition to any other applicable requirements, essential  
406 providers identified in s. 409.975(1)(a)2. must offer to

20212518e1

407 contract with each managed care plan in their region and  
408 essential providers identified in s. 409.975(1)(b)1. and 3. must  
409 offer to contract with each managed care plan in the state.  
410 Before releasing such supplemental payments, in the event the  
411 parties have not executed network contracts, the agency shall  
412 evaluate the parties' efforts to complete negotiations. If such  
413 efforts continue to fail, the agency must withhold such  
414 supplemental payments beginning in the third quarter of the  
415 fiscal year if it determines that, based upon the totality of  
416 the circumstances, the essential provider has negotiated with  
417 the managed care plan in bad faith. If the agency determines  
418 that an essential provider has negotiated in bad faith, it must  
419 notify the essential provider at least 90 days in advance of the  
420 start of the third quarter of the fiscal year and afford the  
421 essential provider hearing rights in accordance with chapter  
422 120.

423 Section 9. Subsections (2), (3), and (10) of section  
424 409.911, Florida Statutes, are amended to read:

425 409.911 Disproportionate share program.—Subject to specific  
426 allocations established within the General Appropriations Act  
427 and any limitations established pursuant to chapter 216, the  
428 agency shall distribute, pursuant to this section, moneys to  
429 hospitals providing a disproportionate share of Medicaid or  
430 charity care services by making quarterly Medicaid payments as  
431 required. Notwithstanding the provisions of s. 409.915, counties  
432 are exempt from contributing toward the cost of this special  
433 reimbursement for hospitals serving a disproportionate share of  
434 low-income patients.

435 (2) The Agency for Health Care Administration shall use the

20212518e1

436 following actual audited data to determine the Medicaid days and  
437 charity care to be used in calculating the disproportionate  
438 share payment:

439 (a) The average of the 3 most recent years of 2012, 2013,  
440 ~~and 2014~~ audited disproportionate share data available for a  
441 hospital to determine each hospital's Medicaid days and charity  
442 care for each ~~the 2020-2021~~ state fiscal year.

443 (b) ~~If the Agency for Health Care Administration does not~~  
444 ~~have the prescribed 3 years of audited disproportionate share~~  
445 ~~data as noted in paragraph (a) for a hospital, the agency shall~~  
446 ~~use the average of the years of the audited disproportionate~~  
447 ~~share data as noted in paragraph (a) which is available.~~

448 ~~(c)~~ In accordance with s. 1923(b) of the Social Security  
449 Act, a hospital with a Medicaid inpatient utilization rate  
450 greater than one standard deviation above the statewide mean or  
451 a hospital with a low-income utilization rate of 25 percent or  
452 greater shall qualify for reimbursement.

453 (3) Hospitals that qualify for a disproportionate share  
454 payment solely under paragraph (2) (b) ~~(2) (c)~~ shall have their  
455 payment calculated in accordance with the following formulas:

456  
457 
$$\text{DSHP} = (\text{HMD}/\text{TMSD}) \times \$1 \text{ million}$$

458  
459 Where:

460 DSHP = disproportionate share hospital payment.

461 HMD = hospital Medicaid days.

462 TSD = total state Medicaid days.

463

464 Any funds not allocated to hospitals qualifying under this



20212518e1

465 section shall be redistributed to the non-state government owned  
466 or operated hospitals with greater than 3,100 Medicaid days.

467 (10) Notwithstanding any provision of this section to the  
468 contrary, for each ~~the 2020-2021~~ state fiscal year, the agency  
469 shall distribute moneys to hospitals providing a  
470 disproportionate share of Medicaid or charity care services as  
471 provided in the ~~2020-2021~~ General Appropriations Act. ~~This~~  
472 ~~subsection expires July 1, 2021.~~

473 Section 10. Subsection (3) of section 409.9113, Florida  
474 Statutes, is amended to read:

475 409.9113 Disproportionate share program for teaching  
476 hospitals.—In addition to the payments made under s. 409.911,  
477 the agency shall make disproportionate share payments to  
478 teaching hospitals, as defined in s. 408.07, for their increased  
479 costs associated with medical education programs and for  
480 tertiary health care services provided to the indigent. This  
481 system of payments must conform to federal requirements and  
482 distribute funds in each fiscal year for which an appropriation  
483 is made by making quarterly Medicaid payments. Notwithstanding  
484 s. 409.915, counties are exempt from contributing toward the  
485 cost of this special reimbursement for hospitals serving a  
486 disproportionate share of low-income patients. The agency shall  
487 distribute the moneys provided in the General Appropriations Act  
488 to statutorily defined teaching hospitals and family practice  
489 teaching hospitals, as defined in s. 395.805, pursuant to this  
490 section. The funds provided for statutorily defined teaching  
491 hospitals shall be distributed as provided in the General  
492 Appropriations Act. The funds provided for family practice  
493 teaching hospitals shall be distributed equally among family

20212518e1

494 practice teaching hospitals.

495 (3) Notwithstanding any provision of this section to the  
496 contrary, for each ~~the 2020-2021~~ state fiscal year, the agency  
497 shall make disproportionate share payments to teaching  
498 hospitals, as defined in s. 408.07, as provided in the ~~2020-2021~~  
499 General Appropriations Act. ~~This subsection expires July 1,~~  
500 ~~2021.~~

501 Section 11. Subsection (4) of section 409.9119, Florida  
502 Statutes, is amended to read:

503 409.9119 Disproportionate share program for specialty  
504 hospitals for children.—In addition to the payments made under  
505 s. 409.911, the Agency for Health Care Administration shall  
506 develop and implement a system under which disproportionate  
507 share payments are made to those hospitals that are separately  
508 licensed by the state as specialty hospitals for children, have  
509 a federal Centers for Medicare and Medicaid Services  
510 certification number in the 3300-3399 range, have Medicaid days  
511 that exceed 55 percent of their total days and Medicare days  
512 that are less than 5 percent of their total days, and were  
513 licensed on January 1, 2013, as specialty hospitals for  
514 children. This system of payments must conform to federal  
515 requirements and must distribute funds in each fiscal year for  
516 which an appropriation is made by making quarterly Medicaid  
517 payments. Notwithstanding s. 409.915, counties are exempt from  
518 contributing toward the cost of this special reimbursement for  
519 hospitals that serve a disproportionate share of low-income  
520 patients. The agency may make disproportionate share payments to  
521 specialty hospitals for children as provided for in the General  
522 Appropriations Act.

20212518e1

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

529 Section 12. Paragraph (a) of subsection (1) of section  
530 409.975, Florida Statutes, is amended to read:

531 409.975 Managed care plan accountability.—In addition to  
532 the requirements of s. 409.967, plans and providers  
533 participating in the managed medical assistance program shall  
534 comply with the requirements of this section.

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

541 (a) Plans must include all providers in the region that are  
542 classified by the agency as essential Medicaid providers, unless  
543 the agency approves, in writing, an alternative arrangement for  
544 securing the types of services offered by the essential  
545 providers. Providers are essential for serving Medicaid  
546 enrollees if they offer services that are not available from any  
547 other provider within a reasonable access standard, or if they  
548 provided a substantial share of the total units of a particular  
549 service used by Medicaid patients within the region during the  
550 last 3 years and the combined capacity of other service  
551 providers in the region is insufficient to meet the total needs

20212518e1

552 of the Medicaid patients. The agency may not classify physicians  
553 and other practitioners as essential providers. The agency, at a  
554 minimum, shall determine which providers in the following  
555 categories are essential Medicaid providers:

- 556 1. Federally qualified health centers.
- 557 2. Statutory teaching hospitals as defined in s. 408.07(46)  
558 ~~s. 408.07(44)~~.
- 559 3. Hospitals that are trauma centers as defined in s.  
560 395.4001(15).
- 561 4. Hospitals located at least 25 miles from any other  
562 hospital with similar services.

563  
564 Managed care plans that have not contracted with all essential  
565 providers in the region as of the first date of recipient  
566 enrollment, or with whom an essential provider has terminated  
567 its contract, must negotiate in good faith with such essential  
568 providers for 1 year or until an agreement is reached, whichever  
569 is first. Payments for services rendered by a nonparticipating  
570 essential provider shall be made at the applicable Medicaid rate  
571 as of the first day of the contract between the agency and the  
572 plan. A rate schedule for all essential providers shall be  
573 attached to the contract between the agency and the plan. After  
574 1 year, managed care plans that are unable to contract with  
575 essential providers shall notify the agency and propose an  
576 alternative arrangement for securing the essential services for  
577 Medicaid enrollees. The arrangement must rely on contracts with  
578 other participating providers, regardless of whether those  
579 providers are located within the same region as the  
580 nonparticipating essential service provider. If the alternative

20212518e1

581 arrangement is approved by the agency, payments to  
582 nonparticipating essential providers after the date of the  
583 agency's approval shall equal 90 percent of the applicable  
584 Medicaid rate. Except for payment for emergency services, if the  
585 alternative arrangement is not approved by the agency, payment  
586 to nonparticipating essential providers shall equal 110 percent  
587 of the applicable Medicaid rate.

588 Section 13. Subsection (1) of section 430.502, Florida  
589 Statutes, is amended to read:

590 430.502 Alzheimer's disease; memory disorder clinics and  
591 day care and respite care programs.—

592 (1) There is established:

593 (a) A memory disorder clinic at each of the three medical  
594 schools in this state;

595 (b) A memory disorder clinic at a major private nonprofit  
596 research-oriented teaching hospital, and may fund a memory  
597 disorder clinic at any of the other affiliated teaching  
598 hospitals;

599 (c) A memory disorder clinic at the Mayo Clinic in  
600 Jacksonville;

601 (d) A memory disorder clinic at the ~~West Florida Regional~~  
602 Medical Center Clinic in Pensacola;

603 (e) A memory disorder clinic operated by Health First in  
604 Brevard County;

605 (f) A memory disorder clinic at the Orlando Regional  
606 Healthcare System, Inc.;

607 (g) A memory disorder center located in a public hospital  
608 that is operated by an independent special hospital taxing  
609 district that governs multiple hospitals and is located in a

20212518e1

610 county with a population greater than 800,000 persons;

611 (h) A memory disorder clinic at St. Mary's Medical Center  
612 in Palm Beach County;

613 (i) A memory disorder clinic at Tallahassee Memorial  
614 Healthcare;

615 (j) A memory disorder clinic at Lee Memorial Hospital  
616 created by chapter 63-1552, Laws of Florida, as amended;

617 (k) A memory disorder clinic at Sarasota Memorial Hospital  
618 in Sarasota County;

619 (l) A memory disorder clinic at Morton Plant Hospital,  
620 Clearwater, in Pinellas County;

621 (m) A memory disorder clinic at Florida Atlantic  
622 University, Boca Raton, in Palm Beach County;

623 (n) A memory disorder clinic at AdventHealth in Orange  
624 County; and

625 (o) A memory disorder clinic at Miami Jewish Health System  
626 in Miami-Dade County,

627  
628 for the purpose of conducting research and training in a  
629 diagnostic and therapeutic setting for persons suffering from  
630 Alzheimer's disease and related memory disorders. However,  
631 memory disorder clinics may ~~shall~~ not receive decreased funding  
632 due solely to subsequent additions of memory disorder clinics in  
633 this subsection.

634 Section 14. Notwithstanding the expiration date in section  
635 19 of chapter 2020-114, Laws of Florida, paragraph (b) of  
636 subsection (5) of section 624.91, Florida Statutes, is reenacted  
637 to read:

638 624.91 The Florida Healthy Kids Corporation Act.—

20212518e1

639 (5) CORPORATION AUTHORIZATION, DUTIES, POWERS.—

640 (b) The Florida Healthy Kids Corporation shall:

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

646 2. Arrange for the collection of any voluntary  
647 contributions to provide for payment of Florida Kidcare program  
648 premiums for children who are not eligible for medical  
649 assistance under Title XIX or Title XXI of the Social Security  
650 Act.

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

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

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

664 6. Determine eligibility for children seeking to  
665 participate in the Title XXI-funded components of the Florida  
666 Kidcare program consistent with the requirements specified in s.  
667 409.814, as well as the non-Title-XXI-eligible children as

20212518e1

668 provided in subsection (3).

669 7. Establish procedures under which providers of local  
670 match to, applicants to and participants in the program may have  
671 grievances reviewed by an impartial body and reported to the  
672 board of directors of the corporation.

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

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

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



20212518e1

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

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

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

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

718 14. In consultation with the partner agencies, provide a  
719 report on the Florida Kidcare program annually to the Governor,  
720 the Chief Financial Officer, the Commissioner of Education, the  
721 President of the Senate, the Speaker of the House of  
722 Representatives, and the Minority Leaders of the Senate and the  
723 House of Representatives.

724 15. Provide information on a quarterly basis to the  
725 Legislature and the Governor which compares the costs and

20212518e1

726 utilization of the full-pay enrolled population and the Title  
727 XXI-subsidized enrolled population in the Florida Kidcare  
728 program. The information, at a minimum, must include:

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

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

735 16. Establish benefit packages that conform to the  
736 provisions of the Florida Kidcare program, as created in ss.  
737 409.810-409.821.

738 Section 15. Subsection (2) of section 1011.52, Florida  
739 Statutes, is amended to read:

740 1011.52 Appropriation to first accredited medical school.-

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

744 (a) Must be primarily operated and established to offer,  
745 afford, and render a medical education to residents of the state  
746 qualifying for admission to such institution;

747 (b) Must be operated by a municipality or county of this  
748 state, or by a nonprofit organization heretofore or hereafter  
749 established exclusively for educational purposes;

750 (c) Must, upon the formation and establishment of an  
751 accredited medical school, transmit and file with the Department  
752 of Education documentary proof evidencing the facts that such  
753 institution has been certified and approved by the council on  
754 medical education and hospitals of the American Medical

20212518e1

755 Association and has adequately met the requirements of that  
756 council in regard to its administrative facilities,  
757 administrative plant, clinical facilities, curriculum, and all  
758 other such requirements as may be necessary to qualify with the  
759 council as a recognized, approved, and accredited medical  
760 school;

761 (d) Must certify to the Department of Education the name,  
762 address, and educational history of each student approved and  
763 accepted for enrollment in such institution for the ensuing  
764 school year; and

765 (e) Must have in place an operating agreement with a  
766 government-owned hospital that is located in the same county as  
767 the medical school and that is a statutory teaching hospital as  
768 defined in s. 408.07(46) ~~s. 408.07(44)~~. The operating agreement  
769 must provide for the medical school to maintain the same level  
770 of affiliation with the hospital, including the level of  
771 services to indigent and charity care patients served by the  
772 hospital, which was in place in the prior fiscal year. Each  
773 year, documentation demonstrating that an operating agreement is  
774 in effect shall be submitted jointly to the Department of  
775 Education by the hospital and the medical school prior to the  
776 payment of moneys from the annual appropriation.

777 Section 16. Subject to federal approval of the application  
778 to be a site for the Program of All-inclusive Care for the  
779 Elderly (PACE), the Agency for Health Care Administration shall  
780 contract with one private health care organization, the sole  
781 member of which is a private, not-for-profit corporation that  
782 owns and manages health care organizations that provide  
783 comprehensive long-term care services, including nursing home,

20212518e1

784 assisted living, independent housing, home care, adult day care,  
785 and care management. This organization shall provide these  
786 services to frail and elderly persons who reside in Escambia,  
787 Okaloosa, and Santa Rosa Counties. The organization is exempt  
788 from the requirements of chapter 641, Florida Statutes. The  
789 agency, in consultation with the Department of Elderly Affairs  
790 and subject to an appropriation, shall approve up to 200 initial  
791 enrollees in the PACE program established by this organization  
792 to serve elderly persons who reside in Escambia, Okaloosa, and  
793 Santa Rosa Counties.

794 Section 17. Subject to federal approval of the application  
795 to be a site for the Program of All-inclusive Care for the  
796 Elderly (PACE), the Agency for Health Care Administration shall  
797 contract with one private, not-for-profit hospital located in  
798 Miami-Dade County to provide comprehensive services to frail and  
799 elderly persons residing in Northwest Miami-Dade County, as  
800 defined by the agency. The hospital is exempt from the  
801 requirements of chapter 641, Florida Statutes. The agency, in  
802 consultation with the Department of Elderly Affairs and subject  
803 to appropriation, shall approve up to 100 initial enrollees in  
804 the PACE program established by this hospital to serve persons  
805 in Northwest Miami-Dade County.

806 Section 18. Subject to federal approval of an application  
807 to be a provider of the Program of All-inclusive Care for the  
808 Elderly (PACE), the Agency for Health Care Administration shall  
809 contract with a private organization that has demonstrated the  
810 ability to operate PACE centers in more than one state and that  
811 serves more than 500 eligible PACE participants, to provide PACE  
812 services to frail and elderly persons who reside in

20212518e1

813 Hillsborough, Hernando, or Pasco Counties. The organization is  
814 exempt from the requirements of chapter 641, Florida Statutes.  
815 The agency, in consultation with the Department of Elderly  
816 Affairs and subject to the appropriation of funds by the  
817 Legislature, shall approve up to 500 initial enrollees in the  
818 PACE program established by the organization to serve frail and  
819 elderly persons who reside in Hillsborough, Hernando, or Pasco  
820 Counties.

821 Section 19. Subject to federal approval of an application  
822 to be a provider of the Program of All-inclusive Care for the  
823 Elderly (PACE), the Agency for Health Care Administration shall  
824 contract with a private organization that has demonstrated the  
825 ability to service high-risk, frail elderly residents in either  
826 nursing homes or in the community in Florida through its  
827 operation of long-term care facilities, as well as approved  
828 special needs plans for institutionalized Medicare residents.  
829 This organization shall provide these services to frail and  
830 elderly persons who reside in Broward County. The organization  
831 is exempt from the requirements of chapter 641, Florida  
832 Statutes. The agency, in consultation with the Department of  
833 Elderly Affairs and subject to the appropriation of funds by the  
834 Legislature, shall approve up to 300 initial enrollees in the  
835 PACE program established by the organization to serve frail and  
836 elderly persons who reside in Broward County.

837 Section 20. Subject to federal approval, a current Program  
838 of All-inclusive Care for the Elderly (PACE) organization that  
839 is authorized to provide PACE services in Northeast Florida and  
840 that is granted authority under section 28 of Chapter 2016-65,  
841 Laws of Florida, for up to 300 enrollee slots to serve frail and

20212518e1

842 elderly persons residing in Baker, Clay, Duval, Nassau, and St.  
843 Johns Counties, may also use those PACE slots for enrollees  
844 residing in Alachua and Putnam Counties, subject to a contract  
845 amendment with the Agency for Health Care Administration.

846 Section 21. The Program of All-inclusive Care for the  
847 Elderly (PACE) organization that is authorized as of July 1,  
848 2021 to provide PACE services for up to 150 enrollee slots to  
849 serve frail and elderly persons residing in Hospice Service  
850 Areas 7B (Orange and Osceola Counties) and 3E (Lake and Sumter  
851 Counties), as previously authorized by section 29 of Chapter  
852 2016-65, Laws of Florida, and the PACE organization that is  
853 authorized as of July 1, 2021 to provide PACE services for up to  
854 150 initial enrollee slots to serve frail and elderly persons  
855 who reside in Hospice Services Area 7C (Seminole County), as  
856 previously authorized by section 22 of Chapter 2017-129, Laws of  
857 Florida, may be consolidated. With the consolidation, the PACE  
858 organization that has demonstrated the ability to operate PACE  
859 centers in more than one state and that serves more than 500  
860 eligible PACE participants is authorized to provide PACE  
861 services for up to 300 initial enrollee slots to serve frail and  
862 elderly persons who reside in Orange, Osceola, Lake, Sumter, or  
863 Seminole Counties.

864 Section 22. Subject to federal approval, a private  
865 organization that owns and manages a health care organization  
866 that provides comprehensive long-term care services, including  
867 acute care services, independent living through federally  
868 approved affordable housing, and care management, and has  
869 demonstrated the ability to operate Program of All-inclusive  
870 Care for the Elderly (PACE) centers in more than one state is

20212518e1

871 authorized to provide PACE services to frail and elderly persons  
872 who reside in Seminole, Volusia, or Flagler Counties. The  
873 organization is exempt from the requirements of chapter 641,  
874 Florida Statutes. The agency, in consultation with the  
875 Department of Elderly Affairs, and subject to an appropriation,  
876 shall approve up to 500 initial enrollee slots to serve frail  
877 and elderly persons residing in Seminole, Volusia, or Flagler  
878 Counties.

879 Section 23. Subject to federal approval of the application  
880 to be a site for the Program of All-inclusive Care for the  
881 Elderly (PACE), the Agency for Health Care Administration shall  
882 contract with one public hospital system operating in the  
883 northern two-thirds of Broward County to provide comprehensive  
884 services to frail and elderly persons residing in the northern  
885 two-thirds of Broward County. The public hospital system is  
886 exempt from the requirements of chapter 641, Florida Statutes.  
887 The agency, in consultation with the Department of Elderly  
888 Affairs, and subject to an appropriation, shall approve up to  
889 200 initial enrollee slots in the PACE program established by  
890 the public hospital system to serve frail and elderly persons  
891 residing in the northern two-thirds of Broward County.

892 Section 24. This act shall take effect July 1, 2021.