FOR CONSIDERATION By the Committee on Appropriations

576-03118B-21 20212518pb

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; amending s. 393.0661, F.S.; correcting a
7 cross-reference; reenacting s. 400.179(2)(d), F.S.,
8 relating to liability for Medicaid underpayments and
9 overpayments; amending s. 409.903, F.S.; revising
10 eligibility for Medicaid coverage for children
11 according to the resource limits under the Temporary
12 Cash Assistance Program; amending s. 409.904, F.S.;
13 deleting the effective date and expiration date of a
14 provision requiring the Agency for Health Care
15 Administration to make payments to Medicaid-covered
16 services; amending s. 409.906, F.S.; deleting
17 authorization for payment for chiropractic, hearing,
18 optometric, podiatric, and visual services provided to
19 Medicaid recipients; reenacting s. 409.908, F.S.,
20 relating to reimbursement of Medicaid providers;
21 amending s. 409.908, F.S.; authorizing the agency to
22 receive funds to be used for Low Income Pool Program
23 payments; amending s. 409.911, F.S.; revising the
24 years of audited disproportionate share data the
25 agency must use for calculating an average for
26 purposes of calculating disproportionate share
27 payments; authorizing the agency to use data available
28 for a hospital; conforming provisions to changes made
29 by the act; correcting a cross-reference; revising the

30 requirement that the agency distribute moneys to
31 hospitals providing a disproportionate share of
32 Medicaid or charity care services, as provided in the
33 General Appropriations Act, to apply to each fiscal
34 year, rather than a specified fiscal year; deleting
35 the expiration date of such requirement; amending s.
36 409.9113, F.S.; revising the requirement that the
37 agency make disproportionate share payments to
38 teaching hospitals, as provided in the General
39 Appropriations Act, to apply to each fiscal year,
40 rather than a specified fiscal year; deleting the
41 expiration date of such requirement; amending s.
42 409.9119, F.S.; revising the requirement that the
43 agency make disproportionate share payments to certain
44 specialty hospitals for children to apply to each
45 fiscal year, rather than a specified fiscal year;
46 deleting the expiration date of such requirement;
47 amending s. 409.968, F.S.; correcting a cross-
48 reference; amending s. 409.975, F.S.; deleting a
49 requirement that the agency contract with a
50 representative of all Healthy Start Coalitions to
51 provide certain services to recipients; revising
52 requirements for specified programs and procedures
53 established by managed care plans; amending s.
54 430.502, F.S.; revising the name of a memory disorder
55 clinic in Pensacola; reenacting s. 624.91(5)(b), F.S.;
56 relating to The Florida Healthy Kids Corporation Act;
57 amending s. 893.055, F.S.; deleting the effective date
58 and expiration date; requiring the agency to contract

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59 with organizations for the provision of elder care
60 services in specified counties if certain conditions
61 are met; requiring the agency to contract with a
62 hospital for the provision of elder care services in a
63 specified county if certain conditions are met;
64 authorizing an organization providing elder care
65 services in specified counties to provide elder care
66 services in additional specified counties if certain
67 conditions are met; providing effective dates.
68
69 Be It Enacted by the Legislature of the State of Florida:
70
71 Section 1. Subsections (1) and (3) of section 296.37,
72 Florida Statutes, are amended to read:
73 296.37 Residents; contribution to support.—
74 (1) Every resident of the home who receives a pension,
75 compensation, or gratuity from the United States Government, or
76 income from any other source of more than <u>$130</u> ~~$105~~ per month,
77 shall contribute to his or her maintenance and support while a
78 resident of the home in accordance with a schedule of payment
79 determined by the administrator and approved by the director.
80 The total amount of such contributions shall be to the fullest
81 extent possible but <u>may</u> ~~shall~~ not exceed the actual cost of
82 operating and maintaining the home.
83 ~~(3) Notwithstanding subsection (1), each resident of the~~
84 ~~home who receives a pension, compensation, or gratuity from the~~
85 ~~United States Government, or income from any other source, of~~
86 ~~more than $130 per month shall contribute to his or her~~
87 ~~maintenance and support while a resident of the home in~~

88 ~~accordance with a payment schedule determined by the~~
89 ~~administrator and approved by the director. The total amount of~~
90 ~~such contributions shall be to the fullest extent possible, but,~~
91 ~~in no case, shall exceed the actual cost of operating and~~
92 ~~maintaining the home. This subsection expires July 1, 2021.~~
93 Section 2. Subsection (7) of section 393.0661, Florida
94 Statutes, is amended to read:
95 393.0661 Home and community-based services delivery system;
96 comprehensive redesign.—The Legislature finds that the home and
97 community-based services delivery system for persons with
98 developmental disabilities and the availability of appropriated
99 funds are two of the critical elements in making services
100 available. Therefore, it is the intent of the Legislature that
101 the Agency for Persons with Disabilities shall develop and
102 implement a comprehensive redesign of the system.
103 (7) The agency shall collect premiums or cost sharing
104 pursuant to s. 409.906(11)(c) ~~409.906(13)(c)~~.
105 Section 3. Notwithstanding the expiration date in section
106 51 of chapter 2020-114, Laws of Florida, paragraph (d) of
107 subsection (2) of section 400.179, Florida Statutes, is
108 reenacted to read:
109 400.179 Liability for Medicaid underpayments and
110 overpayments.—
111 (2) Because any transfer of a nursing facility may expose
112 the fact that Medicaid may have underpaid or overpaid the
113 transferor, and because in most instances, any such underpayment
114 or overpayment can only be determined following a formal field
115 audit, the liabilities for any such underpayments or
116 overpayments shall be as follows:

117 (d) Where the transfer involves a facility that has been
118 leased by the transferor:
119 1. The transferee shall, as a condition to being issued a
120 license by the agency, acquire, maintain, and provide proof to
121 the agency of a bond with a term of 30 months, renewable
122 annually, in an amount not less than the total of 3 months'
123 Medicaid payments to the facility computed on the basis of the
124 preceding 12-month average Medicaid payments to the facility.
125 2. A leasehold licensee may meet the requirements of
126 subparagraph 1. by payment of a nonrefundable fee, paid at
127 initial licensure, paid at the time of any subsequent change of
128 ownership, and paid annually thereafter, in the amount of 1
129 percent of the total of 3 months' Medicaid payments to the
130 facility computed on the basis of the preceding 12-month average
131 Medicaid payments to the facility. If a preceding 12-month
132 average is not available, projected Medicaid payments may be
133 used. The fee shall be deposited into the Grants and Donations
134 Trust Fund and shall be accounted for separately as a Medicaid
135 nursing home overpayment account. These fees shall be used at
136 the sole discretion of the agency to repay nursing home Medicaid
137 overpayments or for enhanced payments to nursing facilities as
138 specified in the General Appropriations Act or other law.
139 Payment of this fee shall not release the licensee from any
140 liability for any Medicaid overpayments, nor shall payment bar
141 the agency from seeking to recoup overpayments from the licensee
142 and any other liable party. As a condition of exercising this
143 lease bond alternative, licensees paying this fee must maintain
144 an existing lease bond through the end of the 30-month term
145 period of that bond. The agency is herein granted specific

146 authority to promulgate all rules pertaining to the
147 administration and management of this account, including
148 withdrawals from the account, subject to federal review and
149 approval. This provision shall take effect upon becoming law and
150 shall apply to any leasehold license application. The financial
151 viability of the Medicaid nursing home overpayment account shall
152 be determined by the agency through annual review of the account
153 balance and the amount of total outstanding, unpaid Medicaid
154 overpayments owing from leasehold licensees to the agency as
155 determined by final agency audits. By March 31 of each year, the
156 agency shall assess the cumulative fees collected under this
157 subparagraph, minus any amounts used to repay nursing home
158 Medicaid overpayments and amounts transferred to contribute to
159 the General Revenue Fund pursuant to s. 215.20. If the net
160 cumulative collections, minus amounts utilized to repay nursing
161 home Medicaid overpayments, exceed $10 million, the provisions
162 of this subparagraph shall not apply for the subsequent fiscal
163 year.
164 3. The leasehold licensee may meet the bond requirement
165 through other arrangements acceptable to the agency. The agency
166 is herein granted specific authority to promulgate rules
167 pertaining to lease bond arrangements.
168 4. All existing nursing facility licensees, operating the
169 facility as a leasehold, shall acquire, maintain, and provide
170 proof to the agency of the 30-month bond required in
171 subparagraph 1., above, on and after July 1, 1993, for each
172 license renewal.
173 5. It shall be the responsibility of all nursing facility
174 operators, operating the facility as a leasehold, to renew the

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175 30-month bond and to provide proof of such renewal to the agency
176 annually.
177 6. Any failure of the nursing facility operator to acquire,
178 maintain, renew annually, or provide proof to the agency shall
179 be grounds for the agency to deny, revoke, and suspend the
180 facility license to operate such facility and to take any
181 further action, including, but not limited to, enjoining the
182 facility, asserting a moratorium pursuant to part II of chapter
183 408, or applying for a receiver, deemed necessary to ensure
184 compliance with this section and to safeguard and protect the
185 health, safety, and welfare of the facility’s residents. A lease
186 agreement required as a condition of bond financing or
187 refinancing under s. 154.213 by a health facilities authority or
188 required under s. 159.30 by a county or municipality is not a
189 leasehold for purposes of this paragraph and is not subject to
190 the bond requirement of this paragraph.
191 Section 4. Effective January 1, 2022, subsection (3) of
192 section 409.903, Florida Statutes, is amended to read:
193 409.903 Mandatory payments for eligible persons.—The agency
194 shall make payments for medical assistance and related services
195 on behalf of the following persons who the department, or the
196 Social Security Administration by contract with the Department
197 of Children and Families, determines to be eligible, subject to
198 the income, assets, and categorical eligibility tests set forth
199 in federal and state law. Payment on behalf of these Medicaid
200 eligible persons is subject to the availability of moneys and
201 any limitations established by the General Appropriations Act or
202 chapter 216.
203 (3) A ~~child under age 21 living in a low-income, two-parent~~

204 ~~family, and a~~ child under age 7 living with a nonrelative, if
205 the income and assets of the family or child, as applicable, do
206 not exceed the resource limits under the Temporary Cash
207 Assistance Program.
208 Section 5. Subsection (12) of section 409.904, Florida
209 Statutes, is amended to read:
210 409.904 Optional payments for eligible persons.—The agency
211 may make payments for medical assistance and related services on
212 behalf of the following persons who are determined to be
213 eligible subject to the income, assets, and categorical
214 eligibility tests set forth in federal and state law. Payment on
215 behalf of these Medicaid eligible persons is subject to the
216 availability of moneys and any limitations established by the
217 General Appropriations Act or chapter 216.
218 (12) ~~Effective July 1, 2020,~~ The agency shall make payments
219 to Medicaid-covered services:
220 (a) For eligible children and pregnant women, retroactive
221 for a period of no more than 90 days before the month in which
222 an application for Medicaid is submitted.
223 (b) For eligible nonpregnant adults, retroactive to the
224 first day of the month in which an application for Medicaid is
225 submitted.
226
227 ~~This subsection expires July 1, 2021.~~
228 Section 6. Subsections (7), (12), (17), (19), and (23) of
229 section 409.906, Florida Statutes, are amended to read:
230 409.906 Optional Medicaid services.—Subject to specific
231 appropriations, the agency may make payments for services which
232 are optional to the state under Title XIX of the Social Security

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233 Act and are furnished by Medicaid providers to recipients who
234 are determined to be eligible on the dates on which the services
235 were provided. Any optional service that is provided shall be
236 provided only when medically necessary and in accordance with
237 state and federal law. Optional services rendered by providers
238 in mobile units to Medicaid recipients may be restricted or
239 prohibited by the agency. Nothing in this section shall be
240 construed to prevent or limit the agency from adjusting fees,
241 reimbursement rates, lengths of stay, number of visits, or
242 number of services, or making any other adjustments necessary to
243 comply with the availability of moneys and any limitations or
244 directions provided for in the General Appropriations Act or
245 chapter 216. If necessary to safeguard the state's systems of
246 providing services to elderly and disabled persons and subject
247 to the notice and review provisions of s. 216.177, the Governor
248 may direct the Agency for Health Care Administration to amend
249 the Medicaid state plan to delete the optional Medicaid service
250 known as "Intermediate Care Facilities for the Developmentally
251 Disabled." Optional services may include:
252 ~~(7) CHIROPRACTIC SERVICES.—The agency may pay for manual~~
253 ~~manipulation of the spine and initial services, screening, and X~~
254 ~~rays provided to a recipient by a licensed chiropractic~~
255 ~~physician.~~
256 ~~(12) HEARING SERVICES.—The agency may pay for hearing and~~
257 ~~related services, including hearing evaluations, hearing aid~~
258 ~~devices, dispensing of the hearing aid, and related repairs, if~~
259 ~~provided to a recipient by a licensed hearing aid specialist,~~
260 ~~otolaryngologist, otologist, audiologist, or physician.~~
261 ~~(17) OPTOMETRIC SERVICES.—The agency may pay for services~~

262 ~~provided to a recipient, including examination, diagnosis,~~
263 ~~treatment, and management, related to ocular pathology, if the~~
264 ~~services are provided by a licensed optometrist or physician.~~
265 ~~(19) PODIATRIC SERVICES.—The agency may pay for services,~~
266 ~~including diagnosis and medical, surgical, palliative, and~~
267 ~~mechanical treatment, related to ailments of the human foot and~~
268 ~~lower leg, if provided to a recipient by a podiatric physician~~
269 ~~licensed under state law.~~
270 ~~(23) VISUAL SERVICES.—The agency may pay for visual~~
271 ~~examinations, eyeglasses, and eyeglass repairs for a recipient~~
272 ~~if they are prescribed by a licensed physician specializing in~~
273 ~~diseases of the eye or by a licensed optometrist. Eyeglass~~
274 ~~frames for adult recipients shall be limited to one pair per~~
275 ~~recipient every 2 years, except a second pair may be provided~~
276 ~~during that period after prior authorization. Eyeglass lenses~~
277 ~~for adult recipients shall be limited to one pair per year~~
278 ~~except a second pair may be provided during that period after~~
279 ~~prior authorization.~~
280 Section 7. Notwithstanding the expiration date in section
281 13 of chapter 2020-114, Laws of Florida, subsection (23) of
282 section 409.908, Florida Statutes, is reenacted to read:
283 409.908 Reimbursement of Medicaid providers.—Subject to
284 specific appropriations, the agency shall reimburse Medicaid
285 providers, in accordance with state and federal law, according
286 to methodologies set forth in the rules of the agency and in
287 policy manuals and handbooks incorporated by reference therein.
288 These methodologies may include fee schedules, reimbursement
289 methods based on cost reporting, negotiated fees, competitive
290 bidding pursuant to s. 287.057, and other mechanisms the agency

291 considers efficient and effective for purchasing services or
292 goods on behalf of recipients. If a provider is reimbursed based
293 on cost reporting and submits a cost report late and that cost
294 report would have been used to set a lower reimbursement rate
295 for a rate semester, then the provider’s rate for that semester
296 shall be retroactively calculated using the new cost report, and
297 full payment at the recalculated rate shall be effected
298 retroactively. Medicare-granted extensions for filing cost
299 reports, if applicable, shall also apply to Medicaid cost
300 reports. Payment for Medicaid compensable services made on
301 behalf of Medicaid eligible persons is subject to the
302 availability of moneys and any limitations or directions
303 provided for in the General Appropriations Act or chapter 216.
304 Further, nothing in this section shall be construed to prevent
305 or limit the agency from adjusting fees, reimbursement rates,
306 lengths of stay, number of visits, or number of services, or
307 making any other adjustments necessary to comply with the
308 availability of moneys and any limitations or directions
309 provided for in the General Appropriations Act, provided the
310 adjustment is consistent with legislative intent.
311 (23)(a) The agency shall establish rates at a level that
312 ensures no increase in statewide expenditures resulting from a
313 change in unit costs for county health departments effective
314 July 1, 2011. Reimbursement rates shall be as provided in the
315 General Appropriations Act.
316 (b)1. Base rate reimbursement for inpatient services under
317 a diagnosis-related group payment methodology shall be provided
318 in the General Appropriations Act.
319 2. Base rate reimbursement for outpatient services under an

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320 enhanced ambulatory payment group methodology shall be provided
321 in the General Appropriations Act.
322 3. Prospective payment system reimbursement for nursing
323 home services shall be as provided in subsection (2) and in the
324 General Appropriations Act.
325 Section 8. Upon the expiration and reversion of the
326 amendments made to section 409.908, Florida Statutes, pursuant
327 to section 15 of chapter 2020-114, Laws of Florida, subsection
328 (26) of section 409.908, Florida Statutes, is amended to read:
329 409.908 Reimbursement of Medicaid providers.—Subject to
330 specific appropriations, the agency shall reimburse Medicaid
331 providers, in accordance with state and federal law, according
332 to methodologies set forth in the rules of the agency and in
333 policy manuals and handbooks incorporated by reference therein.
334 These methodologies may include fee schedules, reimbursement
335 methods based on cost reporting, negotiated fees, competitive
336 bidding pursuant to s. 287.057, and other mechanisms the agency
337 considers efficient and effective for purchasing services or
338 goods on behalf of recipients. If a provider is reimbursed based
339 on cost reporting and submits a cost report late and that cost
340 report would have been used to set a lower reimbursement rate
341 for a rate semester, then the provider's rate for that semester
342 shall be retroactively calculated using the new cost report, and
343 full payment at the recalculated rate shall be effected
344 retroactively. Medicare-granted extensions for filing cost
345 reports, if applicable, shall also apply to Medicaid cost
346 reports. Payment for Medicaid compensable services made on
347 behalf of Medicaid eligible persons is subject to the
348 availability of moneys and any limitations or directions

349 provided for in the General Appropriations Act or chapter 216.
350 Further, nothing in this section shall be construed to prevent
351 or limit the agency from adjusting fees, reimbursement rates,
352 lengths of stay, number of visits, or number of services, or
353 making any other adjustments necessary to comply with the
354 availability of moneys and any limitations or directions
355 provided for in the General Appropriations Act, provided the
356 adjustment is consistent with legislative intent.
357 (26) The agency may receive funds from state entities,
358 including, but not limited to, the Department of Health, local
359 governments, and other local political subdivisions, for the
360 purpose of making special exception payments and Low Income Pool
361 Program payments, including federal matching funds. Funds
362 received for this purpose shall be separately accounted for and
363 may not be commingled with other state or local funds in any
364 manner. The agency may certify all local governmental funds used
365 as state match under Title XIX of the Social Security Act to the
366 extent and in the manner authorized under the General
367 Appropriations Act and pursuant to an agreement between the
368 agency and the local governmental entity. In order for the
369 agency to certify such local governmental funds, a local
370 governmental entity must submit a final, executed letter of
371 agreement to the agency, which must be received by October 1 of
372 each fiscal year and provide the total amount of local
373 governmental funds authorized by the entity for that fiscal year
374 under the General Appropriations Act. The local governmental
375 entity shall use a certification form prescribed by the agency.
376 At a minimum, the certification form must identify the amount
377 being certified and describe the relationship between the

378 certifying local governmental entity and the local health care
379 provider. Local governmental funds outlined in the letters of
380 agreement must be received by the agency no later than October
381 31 of each fiscal year in which such funds are pledged, unless
382 an alternative plan is specifically approved by the agency.
383 Section 9. Subsections (2), (3), and (10) of section
384 409.911, Florida Statutes, are amended to read:
385 409.911 Disproportionate share program.—Subject to specific
386 allocations established within the General Appropriations Act
387 and any limitations established pursuant to chapter 216, the
388 agency shall distribute, pursuant to this section, moneys to
389 hospitals providing a disproportionate share of Medicaid or
390 charity care services by making quarterly Medicaid payments as
391 required. Notwithstanding the provisions of s. 409.915, counties
392 are exempt from contributing toward the cost of this special
393 reimbursement for hospitals serving a disproportionate share of
394 low-income patients.
395 (2) The Agency for Health Care Administration shall use the
396 following actual audited data to determine the Medicaid days and
397 charity care to be used in calculating the disproportionate
398 share payment:
399 (a) The average of the 3 most recent years of ~~2012, 2013,~~
400 ~~and 2014~~ audited disproportionate share data available for a
401 hospital to determine each hospital's Medicaid days and charity
402 care for each ~~the 2020-2021~~ state fiscal year.
403 (b) ~~If the Agency for Health Care Administration does not~~
404 ~~have the prescribed 3 years of audited disproportionate share~~
405 ~~data as noted in paragraph (a) for a hospital, the agency shall~~
406 ~~use the average of the years of the audited disproportionate~~

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407 ~~share data as noted in paragraph (a) which is available.~~
408 ~~(c)~~ In accordance with s. 1923(b) of the Social Security
409 Act, a hospital with a Medicaid inpatient utilization rate
410 greater than one standard deviation above the statewide mean or
411 a hospital with a low-income utilization rate of 25 percent or
412 greater shall qualify for reimbursement.
413 (3) Hospitals that qualify for a disproportionate share
414 payment solely under paragraph <u>(2)(b)</u> ~~(2)(c)~~ shall have their
415 payment calculated in accordance with the following formulas:
416
417 DSHP = (HMD/TMSD) x $1 million
418
419 Where:
420 DSHP = disproportionate share hospital payment.
421 HMD = hospital Medicaid days.
422 TSD = total state Medicaid days.
423
424 Any funds not allocated to hospitals qualifying under this
425 section shall be redistributed to the non-state government owned
426 or operated hospitals with greater than 3,100 Medicaid days.
427 (10) Notwithstanding any provision of this section to the
428 contrary, for <u>each</u> ~~the 2020-2021~~ state fiscal year, the agency
429 shall distribute moneys to hospitals providing a
430 disproportionate share of Medicaid or charity care services as
431 provided in the ~~2020-2021~~ General Appropriations Act. ~~This~~
432 ~~subsection expires July 1, 2021.~~
433 Section 10. Subsection (3) of section 409.9113, Florida
434 Statutes, is amended to read:
435 409.9113 Disproportionate share program for teaching

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436 hospitals.—In addition to the payments made under s. 409.911,
437 the agency shall make disproportionate share payments to
438 teaching hospitals, as defined in s. 408.07, for their increased
439 costs associated with medical education programs and for
440 tertiary health care services provided to the indigent. This
441 system of payments must conform to federal requirements and
442 distribute funds in each fiscal year for which an appropriation
443 is made by making quarterly Medicaid payments. Notwithstanding
444 s. 409.915, counties are exempt from contributing toward the
445 cost of this special reimbursement for hospitals serving a
446 disproportionate share of low-income patients. The agency shall
447 distribute the moneys provided in the General Appropriations Act
448 to statutorily defined teaching hospitals and family practice
449 teaching hospitals, as defined in s. 395.805, pursuant to this
450 section. The funds provided for statutorily defined teaching
451 hospitals shall be distributed as provided in the General
452 Appropriations Act. The funds provided for family practice
453 teaching hospitals shall be distributed equally among family
454 practice teaching hospitals.
455 (3) Notwithstanding any provision of this section to the
456 contrary, for <u>each</u> ~~the 2020-2021~~ state fiscal year, the agency
457 shall make disproportionate share payments to teaching
458 hospitals, as defined in s. 408.07, as provided in the ~~2020-2021~~
459 General Appropriations Act. ~~This subsection expires July 1,~~
460 ~~2021.~~
461 Section 11. Subsection (4) of section 409.9119, Florida
462 Statutes, is amended to read:
463 409.9119 Disproportionate share program for specialty
464 hospitals for children.—In addition to the payments made under

465 s. 409.911, the Agency for Health Care Administration shall
466 develop and implement a system under which disproportionate
467 share payments are made to those hospitals that are separately
468 licensed by the state as specialty hospitals for children, have
469 a federal Centers for Medicare and Medicaid Services
470 certification number in the 3300-3399 range, have Medicaid days
471 that exceed 55 percent of their total days and Medicare days
472 that are less than 5 percent of their total days, and were
473 licensed on January 1, 2013, as specialty hospitals for
474 children. This system of payments must conform to federal
475 requirements and must distribute funds in each fiscal year for
476 which an appropriation is made by making quarterly Medicaid
477 payments. Notwithstanding s. 409.915, counties are exempt from
478 contributing toward the cost of this special reimbursement for
479 hospitals that serve a disproportionate share of low-income
480 patients. The agency may make disproportionate share payments to
481 specialty hospitals for children as provided for in the General
482 Appropriations Act.
483 (4) Notwithstanding any provision of this section to the
484 contrary, for each ~~the 2020-2021~~ state fiscal year, for
485 hospitals achieving full compliance under subsection (3), the
486 agency shall make disproportionate share payments to specialty
487 hospitals for children as provided in the ~~2020-2021~~ General
488 Appropriations Act. ~~This subsection expires July 1, 2021.~~
489 Section 12. Paragraph (a) of subsection (4) of section
490 409.968, Florida Statutes, is amended to read:
491 409.968 Managed care plan payments.—
492 (4)(a) Subject to a specific appropriation and federal
493 approval under s. 409.906(11)(d) ~~409.906(13)(d)~~, the agency

494 shall establish a payment methodology to fund managed care plans
495 for flexible services for persons with severe mental illness and
496 substance use disorders, including, but not limited to,
497 temporary housing assistance. A managed care plan eligible for
498 these payments must do all of the following:
499 1. Participate as a specialty plan for severe mental
500 illness or substance use disorders or participate in counties
501 designated by the General Appropriations Act;
502 2. Include providers of behavioral health services pursuant
503 to chapters 394 and 397 in the managed care plan’s provider
504 network; and
505 3. Document a capability to provide housing assistance
506 through agreements with housing providers, relationships with
507 local housing coalitions, and other appropriate arrangements.
508 Section 13. Subsection (4) of section 409.975, Florida
509 Statutes, is amended to read:
510 409.975 Managed care plan accountability.—In addition to
511 the requirements of s. 409.967, plans and providers
512 participating in the managed medical assistance program shall
513 comply with the requirements of this section.
514 (4) MOMCARE NETWORK.—
515 ~~(a) The agency shall contract with an administrative~~
516 ~~services organization representing all Healthy Start Coalitions~~
517 ~~providing risk appropriate care coordination and other services~~
518 ~~in accordance with a federal waiver and pursuant to s. 409.906.~~
519 ~~The contract shall require the network of coalitions to provide~~
520 ~~counseling, education, risk-reduction and case management~~
521 ~~services, and quality assurance for all enrollees of the waiver.~~
522 ~~The agency shall evaluate the impact of the MomCare network by~~

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523 ~~monitoring each plan's performance on specific measures to~~
524 ~~determine the adequacy, timeliness, and quality of services for~~
525 ~~pregnant women and infants.~~
526 ~~(b)~~ Each managed care plan shall establish specific
527 programs and procedures to improve pregnancy outcomes and infant
528 health, including, but not limited to, coordination with an
529 administrative services organization representing all ~~the~~
530 Healthy Start Coalitions ~~program~~, immunization programs, and
531 referral to the Special Supplemental Nutrition Program for
532 Women, Infants, and Children, and the Children's Medical
533 Services program for children with special health care needs.
534 Each plan's programs and procedures shall include agreements
535 with an administrative services organization representing all
536 ~~each local~~ Healthy Start Coalitions ~~Coalition in the region~~ to
537 provide risk-appropriate care coordination for pregnant women
538 and infants, consistent with agency policies and the MomCare
539 network. Each managed care plan must notify the agency of the
540 impending birth of a child to an enrollee, or notify the agency
541 as soon as practicable after the child's birth.
542 Section 14. Subsection (1) of section 430.502, Florida
543 Statutes, is amended to read:
544 430.502 Alzheimer's disease; memory disorder clinics and
545 day care and respite care programs.—
546 (1) There is established:
547 (a) A memory disorder clinic at each of the three medical
548 schools in this state;
549 (b) A memory disorder clinic at a major private nonprofit
550 research-oriented teaching hospital, and may fund a memory
551 disorder clinic at any of the other affiliated teaching

552 hospitals;
553 (c) A memory disorder clinic at the Mayo Clinic in
554 Jacksonville;
555 (d) A memory disorder clinic at the ~~West Florida Regional~~
556 Medical Center <u>Clinic in Pensacola</u>;
557 (e) A memory disorder clinic operated by Health First in
558 Brevard County;
559 (f) A memory disorder clinic at the Orlando Regional
560 Healthcare System, Inc.;
561 (g) A memory disorder center located in a public hospital
562 that is operated by an independent special hospital taxing
563 district that governs multiple hospitals and is located in a
564 county with a population greater than 800,000 persons;
565 (h) A memory disorder clinic at St. Mary’s Medical Center
566 in Palm Beach County;
567 (i) A memory disorder clinic at Tallahassee Memorial
568 Healthcare;
569 (j) A memory disorder clinic at Lee Memorial Hospital
570 created by chapter 63-1552, Laws of Florida, as amended;
571 (k) A memory disorder clinic at Sarasota Memorial Hospital
572 in Sarasota County;
573 (l) A memory disorder clinic at Morton Plant Hospital,
574 Clearwater, in Pinellas County;
575 (m) A memory disorder clinic at Florida Atlantic
576 University, Boca Raton, in Palm Beach County;
577 (n) A memory disorder clinic at AdventHealth in Orange
578 County; and
579 (o) A memory disorder clinic at Miami Jewish Health System
580 in Miami-Dade County,

581

582 for the purpose of conducting research and training in a
583 diagnostic and therapeutic setting for persons suffering from
584 Alzheimer's disease and related memory disorders. However,
585 memory disorder clinics may ~~shall~~ not receive decreased funding
586 due solely to subsequent additions of memory disorder clinics in
587 this subsection.

588 Section 15. Notwithstanding the expiration date in section
589 19 of chapter 2020-114, Laws of Florida, paragraph (b) of
590 subsection (5) of section 624.91, Florida Statutes, is reenacted
591 to read:

592 624.91 The Florida Healthy Kids Corporation Act.—

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

594 (b) The Florida Healthy Kids Corporation shall:

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

600 2. Arrange for the collection of any voluntary
601 contributions to provide for payment of Florida Kidcare program
602 premiums for children who are not eligible for medical
603 assistance under Title XIX or Title XXI of the Social Security
604 Act.

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

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

610 4. Establish the administrative and accounting procedures
611 for the operation of the corporation.
612 5. Establish, with consultation from appropriate
613 professional organizations, standards for preventive health
614 services and providers and comprehensive insurance benefits
615 appropriate to children, provided that such standards for rural
616 areas shall not limit primary care providers to board-certified
617 pediatricians.
618 6. Determine eligibility for children seeking to
619 participate in the Title XXI-funded components of the Florida
620 Kidcare program consistent with the requirements specified in s.
621 409.814, as well as the non-Title-XXI-eligible children as
622 provided in subsection (3).
623 7. Establish procedures under which providers of local
624 match to, applicants to and participants in the program may have
625 grievances reviewed by an impartial body and reported to the
626 board of directors of the corporation.
627 8. Establish participation criteria and, if appropriate,
628 contract with an authorized insurer, health maintenance
629 organization, or third-party administrator to provide
630 administrative services to the corporation.
631 9. Establish enrollment criteria that include penalties or
632 waiting periods of 30 days for reinstatement of coverage upon
633 voluntary cancellation for nonpayment of family premiums.
634 10. Contract with authorized insurers or any provider of
635 health care services, meeting standards established by the
636 corporation, for the provision of comprehensive insurance
637 coverage to participants. Such standards shall include criteria
638 under which the corporation may contract with more than one

639 provider of health care services in program sites. Health plans
640 shall be selected through a competitive bid process. The Florida
641 Healthy Kids Corporation shall purchase goods and services in
642 the most cost-effective manner consistent with the delivery of
643 quality medical care. The maximum administrative cost for a
644 Florida Healthy Kids Corporation contract shall be 15 percent.
645 For health care contracts, the minimum medical loss ratio for a
646 Florida Healthy Kids Corporation contract shall be 85 percent.
647 For dental contracts, the remaining compensation to be paid to
648 the authorized insurer or provider under a Florida Healthy Kids
649 Corporation contract shall be no less than an amount which is 85
650 percent of premium; to the extent any contract provision does
651 not provide for this minimum compensation, this section shall
652 prevail. For an insurer or any provider of health care services
653 which achieves an annual medical loss ratio below 85 percent,
654 the Florida Healthy Kids Corporation shall validate the medical
655 loss ratio and calculate an amount to be refunded by the insurer
656 or any provider of health care services to the state which shall
657 be deposited into the General Revenue Fund unallocated. The
658 health plan selection criteria and scoring system, and the
659 scoring results, shall be available upon request for inspection
660 after the bids have been awarded.

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

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

667 13. Secure staff necessary to properly administer the

668 corporation. Staff costs shall be funded from state and local
669 matching funds and such other private or public funds as become
670 available. The board of directors shall determine the number of
671 staff members necessary to administer the corporation.
672 14. In consultation with the partner agencies, provide a
673 report on the Florida Kidcare program annually to the Governor,
674 the Chief Financial Officer, the Commissioner of Education, the
675 President of the Senate, the Speaker of the House of
676 Representatives, and the Minority Leaders of the Senate and the
677 House of Representatives.
678 15. Provide information on a quarterly basis to the
679 Legislature and the Governor which compares the costs and
680 utilization of the full-pay enrolled population and the Title
681 XXI-subsidized enrolled population in the Florida Kidcare
682 program. The information, at a minimum, must include:
683 a. The monthly enrollment and expenditure for full-pay
684 enrollees in the Medikids and Florida Healthy Kids programs
685 compared to the Title XXI-subsidized enrolled population; and
686 b. The costs and utilization by service of the full-pay
687 enrollees in the Medikids and Florida Healthy Kids programs and
688 the Title XXI-subsidized enrolled population.
689 16. Establish benefit packages that conform to the
690 provisions of the Florida Kidcare program, as created in ss.
691 409.810-409.821.
692 Section 16. Subsection (17) of section 893.055, Florida
693 Statutes, is amended to read:
694 893.055 Prescription drug monitoring program.—
695 (17) ~~For the 2020-2021 fiscal year only,~~ Neither the
696 Attorney General nor the department may use funds received as

697 part of a settlement agreement to administer the prescription
698 drug monitoring program. ~~This subsection expires July 1, 2021.~~
699 Section 17. Subject to federal approval of the application
700 to be a site for the Program of All-inclusive Care for the
701 Elderly (PACE), the Agency for Health Care Administration shall
702 contract with one private health care organization, the sole
703 member of which is a private, not-for-profit corporation that
704 owns and manages health care organizations that provide
705 comprehensive long-term care services, including nursing home,
706 assisted living, independent housing, home care, adult day care,
707 and care management. This organization shall provide these
708 services to frail and elderly persons who reside in Escambia,
709 Okaloosa, and Santa Rosa Counties. The organization is exempt
710 from the requirements of chapter 641, Florida Statutes. The
711 agency, in consultation with the Department of Elderly Affairs
712 and subject to an appropriation, shall approve up to 200 initial
713 enrollees in the PACE program established by this organization
714 to serve elderly persons who reside in Escambia, Okaloosa, and
715 Santa Rosa Counties.
716 Section 18. Subject to federal approval of the application
717 to be a site for the Program of All-inclusive Care for the
718 Elderly (PACE), the Agency for Health Care Administration shall
719 contract with one private, not-for-profit hospital located in
720 Miami-Dade County to provide comprehensive services to frail and
721 elderly persons residing in Northwest Miami-Dade County, as
722 defined by the agency. The hospital is exempt from the
723 requirements of chapter 641, Florida Statutes. The agency, in
724 consultation with the Department of Elderly Affairs and subject
725 to appropriation, shall approve up to 100 initial enrollees in

726 the PACE program established by this hospital to serve persons
727 in Northwest Miami-Dade County.
728 Section 19. Subject to federal approval of an application
729 to be a provider of the Program of All-inclusive Care for the
730 Elderly (PACE), the Agency for Health Care Administration shall
731 contract with a private organization that has demonstrated the
732 ability to operate PACE centers in more than one state and that
733 serves more than 500 eligible PACE participants, to provide PACE
734 services to frail and elderly persons who reside in
735 Hillsborough, Hernando, or Pasco Counties. The organization is
736 exempt from the requirements of chapter 641, Florida Statutes.
737 The agency, in consultation with the Department of Elderly
738 Affairs and subject to the appropriation of funds by the
739 Legislature, shall approve up to 500 initial enrollees in the
740 PACE program established by the organization to serve frail and
741 elderly persons who reside in Hillsborough, Hernando, or Pasco
742 Counties.
743 Section 20. Subject to federal approval of an application
744 to be a provider of the Program of All-inclusive Care for the
745 Elderly (PACE), the Agency for Health Care Administration shall
746 contract with a private organization that has demonstrated the
747 ability to service high-risk, frail elderly residents in either
748 nursing homes or in the community in Florida through its
749 operation of long-term care facilities, as well as approved
750 special needs plans for institutionalized Medicare residents.
751 This organization shall provide these services to frail and
752 elderly persons who reside in Broward County. The organization
753 is exempt from the requirements of chapter 641, Florida
754 Statutes. The agency, in consultation with the Department of

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755 Elderly Affairs and subject to the appropriation of funds by the
756 Legislature, shall approve up to 300 initial enrollees in the
757 PACE program established by the organization to serve frail and
758 elderly persons who reside in Broward County.
759 Section 21. Subject to federal approval, a current Program
760 of All-inclusive Care for the Elderly (PACE) organization that
761 is authorized to provide PACE services in Northeast Florida and
762 that is granted authority under section 28 of Chapter 2016-65,
763 Laws of Florida, for up to 300 enrollee slots to serve frail and
764 elderly persons residing in Baker, Clay, Duval, Nassau, and St.
765 Johns Counties, may also use those PACE slots for enrollees
766 residing in Alachua and Putnam Counties, subject to a contract
767 amendment with the Agency for Health Care Administration.
768 Section 22. Except as otherwise expressly provided in this
769 act and except for this section, which shall take effect upon
770 this act becoming a law, this act shall take effect July 1,
771 2021.