CHAPTER 2021-41

Senate Bill No. 2518

An act relating to health care; amending s. 296.37, F.S.; revising the amount of money residents of a veterans' nursing home must receive monthly before being required to contribute to their maintenance and support; reenacting s. 400.179(2)(d), F.S., relating to liability for Medicaid underpayments and overpayments; amending s. 408.061, F.S.; requiring nursing homes and their home offices to annually submit to the Agency for Health Care Administration certain information within a specified timeframe; amending s. 408.07, F.S.; defining the terms "FNHURS" and "home office"; amending s. 409.903, F.S.; revising the postpartum Medicaid eligibility period for pregnant women; amending s. 409.904, F.S.; deleting the effective date and the expiration date of a provision requiring the agency to make payments to Medicaid-covered services; reenacting s. 409.908(23), F.S., relating to reimbursement of Medicaid providers; amending s. 409.908, F.S.; authorizing the agency to receive funds to be used for Low Income Pool Program payments; requiring certain essential providers to offer to contract with certain managed care plans to be eligible for low-income pool funding; requiring the agency to evaluate contract negotiations and withhold supplemental payments under certain circumstances; requiring the agency to notify and afford hearing rights to providers under certain circumstances; amending s. 409.911, F.S.; revising the years of audited disproportionate share data the agency must use for calculating an average for purposes of calculating disproportionate share payments; authorizing the agency to use data available for a hospital; conforming provisions to changes made by the act; revising the requirement that the agency distribute moneys to hospitals providing a disproportionate share of Medicaid or charity care services, as provided in the General Appropriations Act, to apply to each fiscal year, rather than a specified fiscal year; deleting the expiration date of such requirement; amending s. 409.9113, F.S.; revising the requirement that the agency make disproportionate share payments to teaching hospitals, as provided in the General Appropriations Act, to apply to each fiscal year, rather than a specified fiscal year; deleting the expiration date of such requirement; amending s. 409.9119, F.S.; revising the requirement that the agency make disproportionate share payments to certain specialty hospitals for children to apply to each fiscal year, rather than a specified fiscal year; deleting the expiration date of such requirement; amending s. 409.975, F.S.; conforming a cross-reference; amending s. 430.502, F.S.; revising the name of a memory disorder clinic in Pensacola; reenacting s. 624.91(5)(b), F.S., relating to The Florida Healthy Kids Corporation Act; amending s. 1011.52, F.S.; conforming a cross-reference; requiring the agency to contract with organizations for the provision of elder care services in specified counties if certain conditions are met; requiring the agency to contract with hospitals for the provision of elder care services in specified counties if certain conditions are met; authorizing an

organization providing elder care services in specified counties to provide elder care services in additional specified counties if certain conditions are met; authorizing the consolidation of organizations providing elder care services in specified counties; authorizing an organization to provide elder care services with the consolidation if certain criteria are met; authorizing an organization to provide elder care services in specified counties if certain criteria are met; providing an effective date.

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

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

296.37 Residents; contribution to support.—

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

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

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

400.179 Liability for Medicaid underpayments and overpayments.—

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

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

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

2. A leasehold licensee may meet the requirements of subparagraph 1. by payment of a nonrefundable fee, paid at initial licensure, paid at the time of any subsequent change of ownership, and paid annually thereafter, in the amount of 1 percent of the total of 3 months' Medicaid payments to the facility computed on the basis of the preceding 12-month average Medicaid payments to the facility. If a preceding 12-month average is not available, projected Medicaid payments may be used. The fee shall be deposited into the Grants and Donations Trust Fund and shall be accounted for separately as a Medicaid nursing home overpayment account. These fees shall be used at the sole discretion of the agency to repay nursing home Medicaid overpayments or for enhanced payments to nursing facilities as specified in the General Appropriations Act or other law. Payment of this fee shall not release the licensee from any liability for any Medicaid overpayments, nor shall payment bar the agency from seeking to recoup overpayments from the licensee and any other liable party. As a condition of exercising this lease bond alternative, licensees paying this fee must maintain an existing lease bond through the end of the 30-month term period of that bond. The agency is herein granted specific authority to promulgate all rules pertaining to the administration and management of this account, including withdrawals from the account, subject to federal review and approval. This provision shall take effect upon becoming law and shall apply to any leasehold license application. The financial viability of the Medicaid nursing home overpayment account shall be determined by the agency through annual review of the account balance and the amount of total outstanding, unpaid Medicaid overpayments owing from leasehold licensees to the agency as determined by final agency audits. By March 31 of each year, the agency shall assess the cumulative fees collected under this subparagraph, minus any amounts used to repay nursing home Medicaid overpayments and amounts transferred to contribute to the General Revenue Fund pursuant to s. 215.20. If the net cumulative collections, minus amounts utilized to repay nursing home Medicaid overpayments, exceed $10 million, the provisions of this subparagraph shall not apply for the subsequent fiscal year.

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

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

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

6. Any failure of the nursing facility operator to acquire, maintain, renew annually, or provide proof to the agency shall be grounds for the agency to deny, revoke, and suspend the facility license to operate such facility and to take any further action, including, but not limited to, enjoining the facility, asserting a moratorium pursuant to part II of chapter 408, or applying for a receiver, deemed necessary to ensure compliance with this section and to safeguard and protect the health, safety, and welfare of the facility's residents. A lease agreement required as a condition of bond financing or refinancing under s. 154.213 by a health facilities authority or required under s. 159.30 by a county or municipality is not a leasehold for purposes of this paragraph and is not subject to the bond requirement of this paragraph.

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

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

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

(5) Within 120 days after the end of its fiscal year, each nursing home as defined in s. 408.07 shall file with the agency, on forms adopted by the agency and based on the uniform system of financial reporting, its actual financial experience for that fiscal year, including expenditures, revenues, and statistical measures. Such data may be based on internal financial reports that are certified to be complete and accurate by the chief financial officer of the nursing home. This actual experience must include the fiscal year-end balance sheet, income statement, statement of cash flow, and statement of retained earnings and must be submitted to the agency in addition to the information filed in the uniform system of financial reporting.

The financial statements must tie to the information submitted in the uniform system of financial reporting, and a crosswalk must be submitted along with the financial statements.

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

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

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

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

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

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

409.903 Mandatory payments for eligible persons.—The agency shall make payments for medical assistance and related services on behalf of the following persons who the department, or the Social Security Administration by contract with the Department of Children and Families, determines to be eligible, subject to the income, assets, and categorical eligibility tests set forth in federal and state law. Payment on behalf of these Medicaid eligible persons is subject to the availability of moneys and any limitations established by the General Appropriations Act or chapter 216.

(5) A pregnant woman for the duration of her pregnancy and for the postpartum period consisting of the 12-month period beginning on the last day of her pregnancy ~~as defined in federal law and rule~~, or a child under age 1, if either is living in a family that has an income that ~~which~~ is at or ~~below~~

~~150 percent of the most current federal poverty level, or, effective January 1, 1992, that has an income which is at or~~ below 185 percent of the most current federal poverty level. Such a person is not subject to an assets test. Further, a pregnant woman who applies for eligibility for the Medicaid program through a qualified Medicaid provider must be offered the opportunity, subject to federal rules, to be made presumptively eligible for the Medicaid program.

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

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

(12) ~~Effective July 1, 2020,~~ The agency shall make payments to Medicaid-covered services:

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

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

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

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

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

behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

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

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

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

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

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

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

lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(26) The agency may receive funds from state entities, including, but not limited to, the Department of Health, local governments, and other local political subdivisions, for the purpose of making special exception payments and Low Income Pool Program payments, including federal matching funds. Funds received for this purpose shall be separately accounted for and may not be commingled with other state or local funds in any manner. The agency may certify all local governmental funds used as state match under Title XIX of the Social Security Act to the extent and in the manner authorized under the General Appropriations Act and pursuant to an agreement between the agency and the local governmental entity. In order for the agency to certify such local governmental funds, a local governmental entity must submit a final, executed letter of agreement to the agency, which must be received by October 1 of each fiscal year and provide the total amount of local governmental funds authorized by the entity for that fiscal year under the General Appropriations Act. The local governmental entity shall use a certification form prescribed by the agency. At a minimum, the certification form must identify the amount being certified and describe the relationship between the certifying local governmental entity and the local health care provider. Local governmental funds outlined in the letters of agreement must be received by the agency no later than October 31 of each fiscal year in which such funds are pledged, unless an alternative plan is specifically approved by the agency. To be eligible for low-income pool funding or other forms of supplemental payments funded by intergovernmental transfers, and in addition to any other applicable requirements, essential providers identified in s. 409.975(1)(a)2. must offer to contract with each managed care plan in their region and essential providers identified in s. 409.975(1)(b)1. and 3. must offer to contract with each managed care plan in the state. Before releasing such supplemental payments, in the event the parties have not executed network contracts, the agency shall evaluate the parties' efforts to complete negotiations. If such efforts continue to fail, the agency must withhold such supplemental payments beginning in the third quarter of the fiscal year if it determines that, based upon the totality of the circumstances, the essential provider has negotiated with the managed care plan in bad faith. If the agency determines that an essential provider has negotiated in bad faith, it must notify the essential provider at least 90 days in advance of the start of the third quarter of the fiscal year and afford the essential provider hearing rights in accordance with chapter 120.

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

409.911 Disproportionate share program.—Subject to specific allocations established within the General Appropriations Act and any limitations established pursuant to chapter 216, the agency shall distribute, pursuant to this section, moneys to hospitals providing a disproportionate share of

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

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

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

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

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

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

DSHP = (HMD/TMSD) x $1 million

Where:

DSHP = disproportionate share hospital payment.

HMD = hospital Medicaid days.

TSD = total state Medicaid days.

Any funds not allocated to hospitals qualifying under this section shall be redistributed to the non-state government owned or operated hospitals with greater than 3,100 Medicaid days.

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

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

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

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

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

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

(4) Notwithstanding any provision of this section to the contrary, for each ~~the 2020-2021~~ state fiscal year, for hospitals achieving full compliance

under subsection (3), the agency shall make disproportionate share payments to specialty hospitals for children as provided in the ~~2020-2021~~ General Appropriations Act. ~~This subsection expires July 1, 2021.~~

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

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

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

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

1. Federally qualified health centers.

2. Statutory teaching hospitals as defined in s. 408.07(46) ~~s. 408.07(44)~~.

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

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

Managed care plans that have not contracted with all essential providers in the region as of the first date of recipient enrollment, or with whom an essential provider has terminated its contract, must negotiate in good faith with such essential providers for 1 year or until an agreement is reached, whichever is first. Payments for services rendered by a nonparticipating essential provider shall be made at the applicable Medicaid rate as of the first day of the contract between the agency and the plan. A rate schedule for all essential providers shall be attached to the contract between the agency and the plan. After 1 year, managed care plans that are unable to contract with essential providers shall notify the agency and propose an alternative

arrangement for securing the essential services for Medicaid enrollees. The arrangement must rely on contracts with other participating providers, regardless of whether those providers are located within the same region as the nonparticipating essential service provider. If the alternative arrangement is approved by the agency, payments to nonparticipating essential providers after the date of the agency's approval shall equal 90 percent of the applicable Medicaid rate. Except for payment for emergency services, if the alternative arrangement is not approved by the agency, payment to nonparticipating essential providers shall equal 110 percent of the applicable Medicaid rate.

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

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

(1) There is established:

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

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

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

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

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

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

(g) A memory disorder center located in a public hospital that is operated by an independent special hospital taxing district that governs multiple hospitals and is located in a county with a population greater than 800,000 persons;

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

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

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

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

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

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

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

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

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

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

624.91 The Florida Healthy Kids Corporation Act.—

(5) CORPORATION AUTHORIZATION, DUTIES, POWERS.—

(b) The Florida Healthy Kids Corporation shall:

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

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

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

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

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

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

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

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

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

10. Contract with authorized insurers or any provider of health care services, meeting standards established by the corporation, for the provision of comprehensive insurance coverage to participants. Such standards shall include criteria under which the corporation may contract with more than one provider of health care services in program sites. Health plans shall be selected through a competitive bid process. The Florida Healthy Kids Corporation shall purchase goods and services in the most cost-effective manner consistent with the delivery of quality medical care. The maximum administrative cost for a Florida Healthy Kids Corporation contract shall be 15 percent. For health care contracts, the minimum medical loss ratio for a Florida Healthy Kids Corporation contract shall be 85 percent. For dental contracts, the remaining compensation to be paid to the authorized insurer or provider under a Florida Healthy Kids Corporation contract shall be no less than an amount which is 85 percent of premium; to the extent any contract provision does not provide for this minimum compensation, this section shall prevail. For an insurer or any provider of health care services which achieves an annual medical loss ratio below 85 percent, the Florida Healthy Kids Corporation shall validate the medical loss ratio and calculate an amount to be refunded by the insurer or any provider of health care services to the state which shall be deposited into the General Revenue Fund unallocated. The health plan selection criteria and scoring system, and the scoring results, shall be available upon request for inspection after the bids have been awarded.

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

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

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

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

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

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

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

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

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

1011.52 Appropriation to first accredited medical school.—

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

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

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

(c) Must, upon the formation and establishment of an accredited medical school, transmit and file with the Department of Education documentary proof evidencing the facts that such institution has been certified and approved by the council on medical education and hospitals of the American Medical Association and has adequately met the requirements of that council in regard to its administrative facilities, administrative plant, clinical facilities, curriculum, and all other such requirements as may be

necessary to qualify with the council as a recognized, approved, and accredited medical school;

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

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

Section 16. Subject to federal approval of the application to be a site for the Program of All-inclusive Care for the Elderly (PACE), the Agency for Health Care Administration shall contract with one private health care organization, the sole member of which is a private, not-for-profit corporation that owns and manages health care organizations that provide comprehensive long-term care services, including nursing home, assisted living, independent housing, home care, adult day care, and care management. This organization shall provide these services to frail and elderly persons who reside in Escambia, Okaloosa, and Santa Rosa Counties. The organization is exempt from the requirements of chapter 641, Florida Statutes. The agency, in consultation with the Department of Elderly Affairs and subject to an appropriation, shall approve up to 200 initial enrollees in the PACE program established by this organization to serve elderly persons who reside in Escambia, Okaloosa, and Santa Rosa Counties.

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

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

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

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

Section 20. Subject to federal approval, a current Program of All-inclusive Care for the Elderly (PACE) organization that is authorized to provide PACE services in Northeast Florida and that is granted authority under section 28 of Chapter 2016-65, Laws of Florida, for up to 300 enrollee slots to serve frail and elderly persons residing in Baker, Clay, Duval, Nassau, and St. Johns Counties, may also use those PACE slots for enrollees residing in Alachua and Putnam Counties, subject to a contract amendment with the Agency for Health Care Administration.

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

Section 22. Subject to federal approval, a private organization that owns and manages a health care organization that provides comprehensive long-term care services, including acute care services, independent living through

federally approved affordable housing, and care management, and has demonstrated the ability to operate Program of All-inclusive Care for the Elderly (PACE) centers in more than one state is authorized to provide PACE services to frail and elderly persons who reside in Seminole, Volusia, or Flagler Counties. The organization is exempt from the requirements of chapter 641, Florida Statutes. The agency, in consultation with the Department of Elderly Affairs, and subject to an appropriation, shall approve up to 500 initial enrollee slots to serve frail and elderly persons residing in Seminole, Volusia, or Flagler Counties.

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

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

Approved by the Governor June 2, 2021.

Filed in Office Secretary of State June 2, 2021.