



Health Care Appropriations Subcommittee

**Thursday, March 25, 2021
9:15 AM - 10:45 AM
Webster Hall (212 Knott)**

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Health Care Appropriations Subcommittee

Start Date and Time: Thursday, March 25, 2021 09:15 am

End Date and Time: Thursday, March 25, 2021 10:45 am

Location: Webster Hall (212 Knott)

Duration: 1.50 hrs

Consideration of the following proposed committee bill(s):

PCB HCAS 21-01 -- Health Care

Chair's Budget Proposal for FY 2021-2022

This meeting will be live-streamed on <https://thefloridachannel.org/>. Persons who wish to attend must register at www.myfloridahouse.gov, and pick up a pass at the Legislative Welcome Center on the 4th Floor of the Capitol beginning one hour before the start of the meeting. Audience seating will be socially distanced and will be available on a first-come, first-served basis. Registration closes three hours before the meeting starts.

NOTICE FINALIZED on 03/23/2021 4:10PM by SXA

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCB HCAS 21-01 Health Care
SPONSOR(S): Health Care Appropriations Subcommittee
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Health Care Appropriations Subcommittee		Nobles	Clark

SUMMARY ANALYSIS

The bill conforms statutes to the funding decisions related to Health Care included in the House proposed General Appropriations Act (GAA) for Fiscal Year 2021-2022. The bill:

- Continues the personal needs allowance of residents of Veterans Nursing Homes at \$130 per month;
- Reduces the Medicaid nursing home lease bond alternative collection threshold from \$25 million to \$10 million;
- Requires nursing homes and home offices to report audited financial information to the Agency for Health Care Administration's (AHCA) uniform reporting system;
- Defines Florida Nursing Home Uniform Reporting System (FNHURS) and home office;
- Extends postpartum Medicaid eligibility for pregnant women to 12 months;
- Continues the policy of retroactive Medicaid eligibility for non-pregnant adults to the first day of the month in which an application for Medicaid is submitted;
- Provides a methodology to spread the nursing home rate increase across all providers, even if the provider is held to the September 2016 rate;
- Holds the County Health Departments' reimbursement to the level established on July 1, 2011;
- Conforms the Low Income Pool (LIP) program to the other program's due dates that rely on Intergovernmental Transfers (IGTs) for funding. Requires that Letters of Agreement for LIP be received by the AHCA by October 1 and the funds outlined in the Letters of Agreement be received by October 31;
- Requires essential providers to contract with managed care plans to be eligible to receive supplemental payments, thereby making certain that those who receive supplemental payments treat Medicaid patients;
- Requires the Florida Healthy Kids Corporation to validate and calculate a refund amount for Title XXI providers who achieve a Medical Loss Ratio below 85%. These refunds shall be deposited into the General Revenue Fund, unallocated;
- Provides for technical corrections to statutory cross references in Managed Care Plan Accountability and Appropriations to First Accredited Medical Schools due to the change in the number of definitions listed in s. 408.07, F.S.

The bill provides for an effective date of July 1, 2021.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Veterans Nursing Homes

Once an individual requiring an institutional level of care has established Medicaid eligibility, some of his or her income is used to pay for Medicaid services. For individuals residing in an institution, most of their incomes are applied to the cost of that care, with the exception of a small personal needs allowance used to pay for personal needs that are not covered by Medicaid. A personal needs allowance is the amount of income a resident may retain for personal expenditures not covered by the nursing home such as toiletries and haircuts.

Section 296.37, F.S., requires every resident of a state veteran domiciliary or nursing 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 to contribute to his or her maintenance and support while residing in a home, pursuant to a schedule of payment determined by the home administrator and department director that shall not exceed the actual cost of operating and maintaining the home. Chapter 2017-157, Laws of Florida, amended s. 296.37, F.S., to increase the personal needs allowance to \$105 per month from \$35 per month. For the past three fiscal years, the General Appropriations Act implementing legislation increased the personal needs allowance to \$130 per month.¹ This provision expires July 1, 2021.

Florida Medicaid Program

The Agency for Health Care Administration (AHCA) is the single state agency responsible for the administration of the Florida Medicaid program, authorized under Title XIX of the Social Security Act. This authority includes establishing and maintaining a Medicaid state plan, approved by the Centers for Medicare and Medicaid Services.

Medicaid is the health care safety net for low-income Floridians. Medicaid is a federal and state partnership established to provide coverage for health services for eligible persons and financed by federal and state funds. AHCA delegates certain functions to other state agencies, including the Department of Children and Families, the Department of Health (DOH), the Agency for Persons with Disabilities (APD), and the Department of Elderly Affairs (DOEA).

The Florida Medicaid program covers approximately 4.6 million low-income individuals, including approximately 2.2 million children in Florida. These children make up 55.2% of the Florida Medicaid population.² Medicaid is the second largest single program in the state, behind public education, representing 32.2% of the total FY 2020-21 budget.

A Medicaid state plan is an agreement between a state and the federal government describing how a state administers its Medicaid program. It establishes groups of individuals covered, services that are provided, payment methodologies, and other administrative and organizational requirements. In order to participate in Medicaid, federal law requires states to cover certain population groups (mandatory eligibility groups) and gives them the flexibility to cover other population groups (optional eligibility groups). States set individual eligibility criteria within federal minimum standards.

¹ Chapters 2016-116, 2018-10, 2019-116, and 2020-114, Laws of Florida.

² Agency for Health Care Administration, *Florida Statewide Medicaid Monthly Enrollment Report*, January 2021, available at https://ahca.myflorida.com/medicaid/Finance/data_analytics/enrollment_report/index.shtml (last accessed March 11, 2021).

In Florida, the majority of Medicaid recipients receive their services through a managed care plan contracted with AHCA under the Statewide Medicaid Managed Care (SMMC) program. The SMMC program has three components: the Managed Medical Assistance (MMA) program, the Long-Term Care (LTC) program and the Dental program. Florida's SMMC program benefits are authorized by federal authority and are specifically required by the Florida Legislature in sections 409.973 and 409.98, F.S.

AHCA contracts with managed care plans on a regional basis to provide services to eligible recipients. The MMA program, which covers most medical and acute care services for managed care plan enrollees, was fully implemented in August 2014 and then was re-procured. Current contracts end in 2024.

Nursing Home Lease Bond Alternative

All nursing home facilities currently leasing the property where nursing facility services are provided are required to submit a Surety Bond annually. As an alternative, a nonrefundable fee may be presented to the AHCA in the amount equal to 1% of 3 months of Medicaid payments to the facility based on the preceding 12-month average Medicaid payments to the facility as calculated by the AHCA. These funds are held in a trust fund as a Medicaid nursing home overpayment account. These fees are used at the sole discretion of the AHCA to repay nursing home Medicaid overpayments should a facility be unable to pay the liability but does not release the licensee from any liability for any Medicaid overpayments. Each year, the AHCA will assess the fund after all overpayments have been repaid and, if the balance after all other amounts have been subtracted is greater than \$25 million, collections of the fee will be suspended for the subsequent fiscal year.

Nursing Home Uniform Reporting System

Currently, nursing homes, continuing care facilities, and state run hospitals are exempt from the requirement to submit their actual financial experience for the fiscal year to the AHCA. All other health care facilities are mandated to do so. In addition, hospitals must submit their actual audited financial experience and submit the information in the Florida Hospital Uniform Reporting System (FHURS). The FHURS is a database designed by the AHCA expressly for the reporting of the hospitals' audited actual financial experience. The hospitals have had this requirement since 1992 and it has been an aid to the AHCA to make management decisions and the Legislature to make policy and budgetary decisions. The hospital financial information has been used to determine revenues for the Public Medical Assistance Trust Fund, hospital assessments, review certificates of need, licensure condition compliance, for research, to prepare hospital financial data reports, and to respond to media and legislative requests.

Medicaid Postpartum Eligibility

Medicaid covers pregnant women for their entire pregnancy and a short while after, but, unless a woman qualifies for Medicaid under other criteria, the coverage ends 60 days after birth. This program is particularly important for pregnant women and children. It pays for 56% of Florida's births and provides health care coverage for just under half the state's children. About 700 women die each year in the United States as a result of pregnancy or delivery complications. In Florida, several initiatives at the state and provider level have been put into place in recent years to address the issue of maternal mortality. These efforts have helped reduce the state's overall maternal mortality rate by 25%, cut the rate for non-Hispanic Black women nearly in half, and reduced the rate for Hispanic women and the Black-White disparity gap both by 75% – making Florida a model for the country. Although Florida is trending in the right direction, more can be done to combat maternal mortality in order to keep mothers and their babies safe and healthy.

Medicaid Retroactive Eligibility

The Social Security Act provides the requirements under which state Medicaid programs must operate. Federal law directs state Medicaid programs to cover, and provides federal matching funds for, medical bills up to three months prior to a recipient's application date.³ The federal Medicaid statute requires that Medicaid coverage for most eligibility groups include retroactive coverage for a period of 90 days prior to the date of the application for medical assistance, however, this requirement can be waived pursuant to federal regulations.

An initial analysis by the AHCA indicated that approximately 39,000 non-pregnant adults were made retroactively eligible under the 90-day requirement of federal regulations in State Fiscal Year 2015-2016.⁴ A more recent AHCA analysis indicates that 11,466 distinct individuals were granted such retroactive eligibility and utilized services during their retroactive period during State Fiscal Year 2017-2018.⁵ In compliance with the federal requirement for 90 days of retroactive eligibility, the Florida Medicaid State Plan previously provided that "[c]overage is available beginning the first day of the third month before the date of application if individuals who are aged, blind or disabled, or who are AFDC-related,⁶ would have been eligible at any time during that month, had they applied." These provisions had been applicable to the Florida Medicaid State Plan since at least October 1, 1991.⁷

In 2018, the Florida Legislature, via the General Appropriations Act (GAA)⁸ and the Implementing Bill accompanying the GAA⁹, approved a measure to direct the AHCA to seek a waiver from the federal Centers for Medicare and Medicaid Services (CMS) to eliminate the 90-day retroactive eligibility period for non-pregnant adults aged 21 and older. For these adults, eligibility would become retroactively effective on the first day of the month in which their Medicaid application was filed, instead of the first day of the third month prior to the date of application.

The waiver request that included the retroactive eligibility item was submitted to federal CMS by AHCA on April 27, 2018, and was approved by federal CMS on November 30, 2018 to be effective February 1, 2019. The waiver included the stipulation that waiver authority ends on June 30, 2019 and that AHCA must timely submit a letter to CMS by May 17, 2019 if legislative approval is granted to continue the waiver past June 30, 2019.¹⁰ Legislative approval was granted in section 30 of the 2019 General Appropriations Act Implementing Bill¹¹ and the letter was sent timely to CMS on May 17, 2019. In 2020, the Legislature again granted approval in section 16 of the 2020 General Appropriations Act Implementing Bill.¹²

³ 42 U.S.C. s. 1396a.

⁴ See Agency for Health Care Administration, Florida's 1115 Managed Medical Assistance (MMA) Prepaid Dental Health Program (PDHP), Low Income Pool (LIP), and Retroactive Eligibility Amendment Request (March 28, 2018), Power Point presentation, available at: http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/MMA_PDHP_LIP-Retro_Elig_amendment_presentation_032818.pdf (last visited March 11, 2021).

⁵ Agency for Health Care Administration, Senate Bill 192 Analysis (February 27, 2019).

⁶ Aid to Families with Dependent Children (AFDC) was a federal assistance program in effect from 1935 to 1996 created by the Social Security Act and administered by the United States Department of Health and Human Services that provided financial assistance to children whose families had low or no income.

⁷ See Florida Medicaid State Plan, page 373 of 431, available at https://ahca.myflorida.com/medicaid/stateplanpdf/Florida_Medicaid_State_Plan_Part_I.pdf (last visited March 11, 2021).

⁸ See Specific Appropriation 199 of the General Appropriations Act for Fiscal Year 2018-2019, Chapter 2018-9, Laws of Florida, available at <http://laws.flrules.org/2018/9> (last visited March 11, 2021).

⁹ See section 20 of the Implementing bill for Fiscal Year 2018-2019, Chapter 2018-10, Laws of Florida, available at <http://laws.flrules.org/2018/10> (last visited March 22, 2021).

¹⁰ See the November 30, 2018, CMS letter and waiver approval document, including waiver Special Terms and Conditions, available at <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/fl/fl-mma-ca.pdf> (last visited January 9, 2020).

¹¹ See section 30 of the Implementing bill for Fiscal Year 2019-2020, Chapter 2019-116, Laws of Florida, available at <http://laws.flrules.org/2019/116> (last visited March 22, 2021).

¹² See section 16 of the Implementing bill for Fiscal Year 2020-2021, Chapter 2020-114, Laws of Florida, available at <http://laws.flrules.org/2020/114> (last visited March 11, 2021).

Nursing Homes Reimbursement

On October 1, 2018, Medicaid nursing homes migrated to the prospective rate reimbursement methodology. Under the new methodology, nursing home providers were limited to the greater of their September cost-based rate or their prospective rate. This limitation will end on September 30, 2021. On October 1, 2021, each facility will be limited to the greater of 95% of their September cost-based rate or their rebased prospective rate that was calculated using the most recently audited cost report. This limitation will end on September 30, 2023.¹³

County Health Departments

Section 19 of the 2019 General Appropriations Act Implementing Bill, Ch. 2019-116, Laws of Florida, amended s. 409.908(23), F.S., to provide that Nursing Home Medicaid reimbursement would no longer be held to a rate freeze, but rather be based upon a prospective payment system. This change left only the county health departments subject to the rate freeze.

Low Income Pool

The terms and conditions of CMS Florida Managed Medical Assistance Waiver Approval Document created a Low Income Pool (LIP) to be used to provide supplemental payments to providers who provide services to Medicaid and uninsured patients. This pool constituted a new method for such supplemental payments, different from the prior program called Upper Payment Limit. The LIP program also authorized supplemental Medicaid payments to provider access systems, such as federally qualified health centers, county health departments, and hospital primary care programs, to cover the cost of providing services to Medicaid recipients, the uninsured and the underinsured. The current LIP pool is authorized for \$1.5 billion and has federal approval to operate through the 2029-2030 fiscal year.¹⁴

The LIP is funded through county and other local tax dollars that are transferred to the state and used to draw federal match. Local dollars transferred to the state and used in this way are known as “intergovernmental transfers” or IGTs. The local taxing authorities commit to sending these funds to the state in the form of an executed Letter of Agreement with the AHCA. In order for AHCA to make timely payments to hospitals, AHCA must know which local governments will be submitting IGTs and the amount of the funds prior to using the funds to draw the federal match. Current law requires local governments who participate in IGT-funded programs, to submit to AHCA the final executed letter of agreement containing the total amount of the IGTs authorized by the entity, no later than October 1 of each year. Additionally, the local governments are required to transfer the actual IGT funds to AHCA by October 31. There is currently no requirement for local governments to comply with these date requirements for the participation in the LIP program.

Section 409.975, F.S., defines certain Medicaid providers as “essential” providers. These providers are essential for serving Medicaid enrollees if they offer services that are not available from any other provider within a reasonable area, or they serve a particular Medicaid population within a region that has limited access to services. Some essential providers are essential only to their own region, whereas others are essential statewide. Medicaid managed care plans are required to contract with these essential providers; however, the law does not require the essential providers to contract with the managed care plans. Essential providers that fail to contract with managed care plans, cannot serve Medicaid patients, thereby leaving these patients with no provider.

Many essential providers receive supplemental payments through the General Appropriations Act. During Fiscal Year 2020-2021, the Legislature appropriated over \$2.9 billion in supplemental payments across health care services. While not all essential providers receive supplemental funding, many of

¹³ See Chapter 2017-129, Laws of Florida.

¹⁴ Agency for Health Care Administration, CMS Florida Managed Medical Assistance Waiver Approval Document, available at https://ahca.myflorida.com/Medicaid/Finance/finance/LIP-DSH/lip/docs/FL_MMA_Extension_STCs_1.15.2021.pdf, (last visited March 15, 2021).

them do. Currently, there is no requirement that essential providers receiving supplemental funding contract with managed care plans to serve Medicaid patients.

Florida Healthy Kids Corporation

The Florida Healthy Kids Corporation was created in 1990 by the Florida Legislature as a public-private effort to improve access to health insurance for the state's uninsured children. The program came about as a result of an article published in the March 31, 1988, New England Journal of Medicine by Steve A. Freedman, Ph.D., F.A.A.P., then-Director of the Institute for Child Health Policy at the University of Florida.

Since its beginning, Healthy Kids has covered millions of children in Florida. Identified as one of three state programs that was grandfathered into the original Children's Health Insurance Program (CHIP) legislation in 1997. Healthy Kids was joined with two other existing state health care programs for children (Medicaid and Children's Medical Services) and a new program (Medikids) to create Florida's KidCare program in 1998.¹⁵

In s. 624.91, F.S., Florida Healthy Kids Corporation is mandated to purchase goods and services in the most cost-effective manner consistent with the delivery of quality medical care to uninsured and underinsured children through contracts with health care providers. These contracted health care providers must maintain a minimum medical loss ratio (MLR) of 85% and maximum administrative costs of 15%.

Effect of Proposed Changes

Veterans Nursing Homes

The bill amends s. 296.37(1), F.S., to permanently set the personal needs allowance at \$130 per month to reflect Medicaid funding in the General Appropriations Act for the 2021-2022 Fiscal Year.

Nursing Home Lease Bond Alternative

The bill amends s. 400.179(d), F.S., to decrease the collection threshold for the nursing home lease bond alternative from \$25 million to \$10 million.

Nursing Home Uniform Reporting System

The bill requires nursing homes and their respective home offices to submit annually audited financial information to the agency in a uniform reporting system. Nursing homes will now have the same requirements as all other health care facilities, with the exception of continuing care facilities and state run hospitals.

Medicaid Postpartum Eligibility

The bill amends s. 409.903(5), F.S., to extend postpartum Medicaid-eligibility of pregnant women from 60 days following birth to 12 months following birth. The extension of full Medicaid benefits to these women for 12 months, will improve access to care, lead to better health outcomes, and combat maternal mortality.

¹⁵ Florida Healthy Kids Corporation History, 2019, retrieved from <https://www.healthykids.org/healthykids/history/> (last visited March 11, 2021).

Medicaid Retroactive Eligibility

The bill amends s. 409.904, F.S., to continue the policy that began in the 2018-2019 fiscal year by providing payments for Medicaid eligible services for eligible non-pregnant adults retroactive to the first day of the month in which an application for Medicaid is submitted. Eligible children and pregnant women will continue to have retroactive Medicaid eligibility for a period of no more than 90 days before the month in which an application for Medicaid is submitted.

Nursing Homes Reimbursement

This bill amends s. 409.908(2)(b), F.S., to reenact language in Section 47 of the 2020 General Appropriations Act Implementing Bill, Ch. 2020-114, Laws of Florida, that is applicable to nursing homes reimbursed under the prospective payment system and gave those nursing homes a unit cost increase add-on to the greater of the cost-based rate or their prospective payment rate. This unit cost increase was included in the 2020 General Appropriations Act, Ch. 2020-111, Laws of Florida.

County Health Departments

The bill amends s. 409.908(23), F.S., to reenact the language in Section 19 of the 2019 General Appropriations Act Implementing Bill, Ch. 2019-116, Laws of Florida, that is applicable to the reimbursement of county health departments, thereby keeping the county health departments subject to the rate freeze.

Low Income Pool

The bill amends s. 409.908(26), F.S., to include the Low Income Pool program among the other programs that rely on IGTs to be provided to AHCA. Local governments, on behalf of providers participating in the LIP program, will be required to submit a final, executed Letter of Agreement to AHCA no later than October 1, which will delineate the amount of funds the local government will submit. Additionally, the funds pledged in the Letter of Agreement on behalf of a provider participating in the LIP program, must be transferred to AHCA no later than October 31, unless an alternative plan is approved by AHCA.

The bill amends s. 409.908(26), F.S., to require that essential providers contract with the relevant managed care plans as a condition of receiving supplemental payments.

Florida Healthy Kids Corporation

The bill amends s. 624.91, F.S., to require the Florida Healthy Kids Corporation to validate and calculate a refund amount for Title XXI authorized insurers and providers of health care services who achieve a MLR below 85%. These refunds shall be deposited into the General Revenue Fund, unallocated.

B. SECTION DIRECTORY:

- Section 1: Amends s. 296.37(1), F.S., relating to personal needs allowances for residents of Veterans Nursing Homes.
- Section 2: Reenacts s. 400.179, F.S., relating to nursing home lease bonds.
- Section 3: Amends s. 408.061, F.S., relating to reporting audited financial information.
- Section 4: Amends s. 408.07, F.S., relating to definitions for Health Care Administration.
- Section 5: Amends s. 409.903, F.S., relating to postpartum Medicaid eligibility.
- Section 6: Amends s. 409.904, F.S., relating to Medicaid eligibility.
- Section 7: Reenacts s. 409.908, F.S., relating to reimbursement of Medicaid providers, prospective payments, the Low Income Pool, supplemental payments, and essential providers.
- Section 8: Amends s. 409.975(a), F.S., relating to a technical correction of a statutory cross reference.
- Section 9: Reenacts s. 624.91, F.S., relating to Florida Healthy Kids Corporation.
- Section 10: Amends s. 1011.52(2), F.S., relating to a technical correction of a statutory cross reference.
- Section 11: Provides an effective date of July 1, 2021.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

With the collection threshold for the Lease Bond Alternative decreasing from \$25 million to \$10 million, revenues would decrease due to the new, lower threshold for halting collections. The fund would also keep a lower balance, leading to a decrease in interest earned. The current balance of the fund is \$14.67 million.

In order for providers to earn matching federal dollars for LIP, local governments and other local political subdivisions will be required to provide to AHCA an executed letter of agreement by October 1 of each fiscal year and the transfer of all funds as pledged in the LIP IGT agreement letter, no later than October 31 of each fiscal year, unless an alternative plan is approved by AHCA.

In Fiscal Year 2018-2019, \$3.99 million in refunds were collected due to the Title XXI provider plans not achieving the 85% MLR. In future periods, the refunds will be transferred to the General Revenue Fund, unallocated. It is unknown if the refunds will continue at the same level as the prior year, or whether adjusted premiums, increased services, or other approaches will mitigate the refund amounts.

2. Expenditures:

Medicaid Retroactive Eligibility began in FY 2018-2019 under the 2018 GAA Implementing Bill. The 2018 GAA included a recurring savings due to the implementation of Medicaid Retroactive Eligibility. AHCA estimates that the Legislature will need to appropriate an additional \$103.6 million if this policy is not continued.

The Nursing Home Unit Cost Increase began in the FY 2020-2021 General Appropriations Act, 2020-111, Laws of Florida. It was effective on July 1, 2020 and totaled \$74.8 million recurring (\$28.6 million GR recurring). It provided nursing homes a unit cost increase add-on to the greater of the cost-based rate or their prospective payment rate.

The extension of Medicaid Postpartum eligibility for mothers to 12 months is estimated to cost \$239.8 million (\$93.0 million GR). Approximately 97,600 Medicaid beneficiaries will receive full Medicaid coverage for the extended 12 month period.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

In order to earn matching federal dollars for LIP, local governments and other local political subdivisions would be required to provide all funds pledged in LIP IGT agreements, no later than October 31, 2020.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

With the decrease in the threshold from \$25 million to \$10 million to halt collection of the lease bond alternative, the private sector nursing homes may pay less in lease bond alternative fees.

Residents in a veteran's nursing home will retain \$130 per month as a personal needs allowance.

The Nursing Home unit cost increase was a \$74.8 million increase to nursing homes providing services to the State's most needy.

Requires essential providers to contract with the relevant managed care plans as a condition of receiving supplemental payments.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

None.

1 A bill to be entitled

2 An act relating to health care; amending s. 296.37,
3 F.S.; revising the threshold dollar amount relating to
4 a requirement that a resident of a certain health care
5 facility contribute to his or her maintenance and
6 support; reenacting s. 400.179, F.S., relating to
7 specified fees collected by the Agency for Health Care
8 Administration from certain nursing homes to maintain
9 the lease bond alternative; amending s. 408.061, F.S.;
10 requiring nursing homes and their home offices to
11 annually submit to the agency audited financial data
12 and certain other information within a specified
13 timeframe using a certain uniform system of financial
14 reporting; amending s. 408.07, F.S.; providing
15 definitions; amending s. 409.903, F.S.; extending the
16 postpartum Medicaid eligibility period for pregnant
17 women; amending s. 409.904, F.S.; revising a date
18 relating to a requirement that the agency make
19 payments for Medicaid-covered services retroactive for
20 a specified period for certain eligible persons;
21 abrogating the future expiration of certain
22 provisions; reenacting s. 409.908, F.S., relating to
23 the agency's implementation of a state Title XIX Long-
24 Term Care Reimbursement Plan for nursing home care,
25 the reimbursement of Medicaid providers, and Low

Income Pool Program payments; amending s. 409.975, F.S.; conforming a cross-reference; reenacting s. 624.91, F.S., relating to a requirement that the Florida Healthy Kids Corporation validate the medical loss ratio and calculate a refund amount for insurers and providers of health care services who meet certain criteria; amending s. 1011.52, F.S.; conforming a cross-reference; providing an effective date.

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

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

296.37 Residents; contribution to support.—

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

Section 2. Notwithstanding the expiration date in section 51 of chapter 2020-114, Laws of Florida, paragraph (d) of

51 subsection (2) of section 400.179, Florida Statutes, is
52 reenacted to read:

53 400.179 Liability for Medicaid underpayments and
54 overpayments.—

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

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

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

69 2. A leasehold licensee may meet the requirements of
70 subparagraph 1. by payment of a nonrefundable fee, paid at
71 initial licensure, paid at the time of any subsequent change of
72 ownership, and paid annually thereafter, in the amount of 1
73 percent of the total of 3 months' Medicaid payments to the
74 facility computed on the basis of the preceding 12-month average
75 Medicaid payments to the facility. If a preceding 12-month

PCB HCA 21-01

Redraft - A

2021

76 | average is not available, projected Medicaid payments may be
77 | used. The fee shall be deposited into the Grants and Donations
78 | Trust Fund and shall be accounted for separately as a Medicaid
79 | nursing home overpayment account. These fees shall be used at
80 | the sole discretion of the agency to repay nursing home Medicaid
81 | overpayments or for enhanced payments to nursing facilities as
82 | specified in the General Appropriations Act or other law.
83 | Payment of this fee shall not release the licensee from any
84 | liability for any Medicaid overpayments, nor shall payment bar
85 | the agency from seeking to recoup overpayments from the licensee
86 | and any other liable party. As a condition of exercising this
87 | lease bond alternative, licensees paying this fee must maintain
88 | an existing lease bond through the end of the 30-month term
89 | period of that bond. The agency is herein granted specific
90 | authority to promulgate all rules pertaining to the
91 | administration and management of this account, including
92 | withdrawals from the account, subject to federal review and
93 | approval. This provision shall take effect upon becoming law and
94 | shall apply to any leasehold license application. The financial
95 | viability of the Medicaid nursing home overpayment account shall
96 | be determined by the agency through annual review of the account
97 | balance and the amount of total outstanding, unpaid Medicaid
98 | overpayments owing from leasehold licensees to the agency as
99 | determined by final agency audits. By March 31 of each year, the
100 | 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. Subsections (5) through (13) of section 408.061, Florida Statutes, are renumbered as subsections (7) through (15), respectively, subsection (4) is amended, and new subsections (5) and (6) are added to that section, to read:

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

(4) Within 120 days after the end of its fiscal year, each health care facility, excluding continuing care facilities, and hospitals operated by state agencies, ~~and nursing homes~~ as those terms are defined in s. 408.07, shall file with the agency, on forms adopted by the agency and based on the uniform system of financial reporting, its actual financial experience for that fiscal year, including expenditures, revenues, and statistical measures. Such data may be based on internal financial reports which are certified to be complete and accurate by the provider.

151 However, hospitals' actual financial experience shall be their
152 audited actual experience. Every nursing home shall submit to
153 the agency, in a format designated by the agency, a statistical
154 profile of the nursing home residents. The agency, in
155 conjunction with the Department of Elderly Affairs and the
156 Department of Health, shall review these statistical profiles
157 and develop recommendations for the types of residents who might
158 more appropriately be placed in their homes or other
159 noninstitutional settings.

160 (5) Within 120 days after the end of its fiscal year, each
161 nursing home as defined in s. 408.07 shall file with the agency,
162 on forms adopted by the agency and based on the uniform system
163 of financial reporting, its actual financial experience for that
164 fiscal year, including expenditures, revenues, and statistical
165 measures. Such data may be based on internal financial reports
166 which are certified to be complete and accurate by the chief
167 financial officer of the nursing home. However, the nursing
168 home's actual financial experience shall be its audited actual
169 financial experience, as audited by an independent certified
170 public accountant. This audited actual experience shall include
171 the fiscal year-end balance sheet, income statement, statement
172 of cash flow, and statement of retained earnings and shall be
173 submitted to the agency in addition to the information filed in
174 the uniform system of financial reporting. The nursing home
175 shall provide all necessary records for the independent

176 certified public accountant to form an opinion and complete an
177 accurate audit report. The independent certified public
178 accountant's opinion and audit report shall accompany the
179 financial statements submitted to the agency. The audited
180 financial statements shall tie to the information submitted in
181 the uniform system of financial reporting and a crosswalk shall
182 be submitted along with the audited financial statements.

183 (6) Within 120 days after the end of its fiscal year, the
184 home office of each nursing home as defined in s. 408.07 shall
185 file with the agency, on forms adopted by the agency and based
186 on the uniform system of financial reporting, its actual
187 financial experience for that fiscal year, including
188 expenditures, revenues, and statistical measures. Such data may
189 be based on internal financial reports which are certified to be
190 complete and accurate by the chief financial officer of the
191 nursing home. However, the home office's actual financial
192 experience shall be its audited actual financial experience, as
193 audited by an independent certified public accountant. This
194 audited actual experience shall include the fiscal year-end
195 balance sheet, income statement, statement of cash flow, and
196 statement of retained earnings and shall be submitted to the
197 agency in addition to the information filed in the uniform
198 system of financial reporting. The home office shall provide all
199 necessary records for the independent certified public
200 accountant to form an opinion and complete an accurate audit

201 report. The independent certified public accountant's opinion
202 and audit report shall accompany the financial statements
203 submitted to the agency. The audited financial statements shall
204 tie to the information submitted in the uniform system of
205 financial reporting and a crosswalk shall be submitted along
206 with the audited financial statements.

207 Section 4. Subsections (19) through (27) of section
208 408.07, Florida Statutes, are renumbered as subsections (20)
209 through (28), respectively, and subsections (28) through (44)
210 are renumbered as subsections (30) through (46), and new
211 subsections (19) and (29) are added to that section, to read:

212 408.07 Definitions.—As used in this chapter, with the
213 exception of ss. 408.031-408.045, the term:

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

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

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

222 409.903 Mandatory payments for eligible persons.—The
223 agency shall make payments for medical assistance and related
224 services on behalf of the following persons who the department,
225 or the Social Security Administration by contract with the

PCB HCA 21-01

Redraft - A

2021

226 Department of Children and Families, determines to be eligible,
227 subject to the income, assets, and categorical eligibility tests
228 set forth in federal and state law. Payment on behalf of these
229 Medicaid eligible persons is subject to the availability of
230 moneys and any limitations established by the General
231 Appropriations Act or chapter 216.

232 (5) A pregnant woman for the duration of her pregnancy and
233 for the postpartum period ~~as defined in federal law and rule~~
234 consisting of the 12-month period beginning on the last day of
235 her pregnancy, or a child under age 1, if either is living in a
236 family that has an income that ~~which~~ is at or ~~below 150 percent~~
237 ~~of the most current federal poverty level, or, effective January~~
238 ~~1, 1992, that has an income which is at or below 185 percent of~~
239 the most current federal poverty level. Such a person is not
240 subject to an assets test. Further, a pregnant woman who applies
241 for eligibility for the Medicaid program through a qualified
242 Medicaid provider must be offered the opportunity, subject to
243 federal rules, to be made presumptively eligible for the
244 Medicaid program.

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

247 409.904 Optional payments for eligible persons.—The agency
248 may make payments for medical assistance and related services on
249 behalf of the following persons who are determined to be
250 eligible subject to the income, assets, and categorical

251 eligibility tests set forth in federal and state law. Payment on
252 behalf of these Medicaid eligible persons is subject to the
253 availability of moneys and any limitations established by the
254 General Appropriations Act or chapter 216.

255 (12) Effective July 1, 2021 ~~July 1, 2020~~, the agency shall
256 make payments for ~~to~~ Medicaid-covered services:

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

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

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

264 Section 7. Notwithstanding the expiration dates in
265 sections 13, 15, and 48 of chapter 2020-114, Laws of Florida,
266 paragraph (b) of subsection (2) and subsections (23) and (26) of
267 section 409.908, Florida Statutes, are reenacted to read:

268 409.908 Reimbursement of Medicaid providers.—Subject to
269 specific appropriations, the agency shall reimburse Medicaid
270 providers, in accordance with state and federal law, according
271 to methodologies set forth in the rules of the agency and in
272 policy manuals and handbooks incorporated by reference therein.
273 These methodologies may include fee schedules, reimbursement
274 methods based on cost reporting, negotiated fees, competitive
275 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.

(2)

(b) Subject to any limitations or directions in the General Appropriations Act, the agency shall establish and implement a state Title XIX Long-Term Care Reimbursement Plan for nursing home care in order to provide care and services in

conformance with the applicable state and federal laws, rules, regulations, and quality and safety standards and to ensure that individuals eligible for medical assistance have reasonable geographic access to such care.

1. The agency shall amend the long-term care reimbursement plan and cost reporting system to create direct care and indirect care subcomponents of the patient care component of the per diem rate. These two subcomponents together shall equal the patient care component of the per diem rate. Separate prices shall be calculated for each patient care subcomponent, initially based on the September 2016 rate setting cost reports and subsequently based on the most recently audited cost report used during a rebasing year. The direct care subcomponent of the per diem rate for any providers still being reimbursed on a cost basis shall be limited by the cost-based class ceiling, and the indirect care subcomponent may be limited by the lower of the cost-based class ceiling, the target rate class ceiling, or the individual provider target. The ceilings and targets apply only to providers being reimbursed on a cost-based system. Effective October 1, 2018, a prospective payment methodology shall be implemented for rate setting purposes with the following parameters:

a. Peer Groups, including:

(I) North-SMMC Regions 1-9, less Palm Beach and Okeechobee Counties; and

PCB HCA 21-01

Redraft - A

2021

(II) South-SMMC Regions 10-11, plus Palm Beach and Okeechobee Counties.

b. Percentage of Median Costs based on the cost reports used for September 2016 rate setting:

(I) Direct Care Costs.....100 percent.

(II) Indirect Care Costs.....92 percent.

(III) Operating Costs.....86 percent.

c. Floors:

(I) Direct Care Component.....95 percent.

(II) Indirect Care Component.....92.5 percent.

(III) Operating Component.....None.

d. Pass-through Payments.....Real Estate and
Personal Property
Taxes and Property Insurance.

e. Quality Incentive Program Payment Pool....6.5 percent of
September 2016 non-property related
payments of included facilities.

f. Quality Score Threshold to Quality for Quality Incentive Payment....20th percentile of included facilities.

g. Fair Rental Value System Payment Parameters:

(I) Building Value per Square Foot based on 2018 RS Means.

(II) Land Valuation.....10 percent of Gross Building value.

(III) Facility Square Footage.....Actual Square Footage.

(IV) Moveable Equipment Allowance.....\$8,000 per bed.

(V) Obsolescence Factor.....1.5 percent.

PCB HCA 21-01

Redraft - A

2021

351	(VI)	Fair Rental Rate of Return.....	8 percent.
352	(VII)	Minimum Occupancy.....	90 percent.
353	(VIII)	Maximum Facility Age.....	40 years.
354	(IX)	Minimum Square Footage per Bed.....	350.
355	(X)	Maximum Square Footage for Bed.....	500.
356	(XI)	Minimum Cost of a renovation/replacements.....	\$500 per
357			bed.

358 h. Ventilator Supplemental payment of \$200 per Medicaid
359 day of 40,000 ventilator Medicaid days per fiscal year.

2. The direct care subcomponent shall include salaries and benefits of direct care staff providing nursing services including registered nurses, licensed practical nurses, and certified nursing assistants who deliver care directly to residents in the nursing home facility, allowable therapy costs, and dietary costs. This excludes nursing administration, staff development, the staffing coordinator, and the administrative portion of the minimum data set and care plan coordinators. The direct care subcomponent also includes medically necessary dental care, vision care, hearing care, and podiatric care.

370 3. All other patient care costs shall be included in the
371 indirect care cost subcomponent of the patient care per diem
372 rate, including complex medical equipment, medical supplies, and
373 other allowable ancillary costs. Costs may not be allocated
374 directly or indirectly to the direct care subcomponent from a
375 home office or management company.

376 4. On July 1 of each year, the agency shall report to the
377 Legislature direct and indirect care costs, including average
378 direct and indirect care costs per resident per facility and
379 direct care and indirect care salaries and benefits per category
380 of staff member per facility.

381 5. Every fourth year, the agency shall rebase nursing home
382 prospective payment rates to reflect changes in cost based on
383 the most recently audited cost report for each participating
384 provider.

385 6. A direct care supplemental payment may be made to
386 providers whose direct care hours per patient day are above the
387 80th percentile and who provide Medicaid services to a larger
388 percentage of Medicaid patients than the state average.

389 7. For the period beginning July 1, 2020, the agency shall
390 establish a unit cost increase as an equal percentage for each
391 nursing home.

392 8. For the period beginning on October 1, 2018, and ending
393 on September 30, 2021, the agency shall reimburse providers the
394 greater of their September 2016 cost-based rate plus the July 1,
395 2020, unit cost increase or their prospective payment rate plus
396 the July 1, 2020, unit cost increase. Effective October 1, 2021,
397 the agency shall reimburse providers the greater of 95 percent
398 of their cost-based rate plus the July 1, 2020, unit cost
399 increase or their rebased prospective payment rate plus the July
400 1, 2020, unit cost increase, using the most recently audited

cost report for each facility. This subparagraph shall expire September 30, 2023.

9. Pediatric, Florida Department of Veterans Affairs, and government-owned facilities are exempt from the pricing model established in this subsection and shall remain on a cost-based prospective payment system. Effective October 1, 2018, the agency shall set rates for all facilities remaining on a cost-based prospective payment system using each facility's most recently audited cost report, eliminating retroactive settlements.

It is the intent of the Legislature that the reimbursement plan achieve the goal of providing access to health care for nursing home residents who require large amounts of care while encouraging diversion services as an alternative to nursing home care for residents who can be served within the community. The agency shall base the establishment of any maximum rate of payment, whether overall or component, on the available moneys as provided for in the General Appropriations Act. The agency may base the maximum rate of payment on the results of scientifically valid analysis and conclusions derived from objective statistical data pertinent to the particular maximum rate of payment.

(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.

(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

PCB HCA 21-01

Redraft - A

2021

governmental entity must submit a final, executed letter of agreement to the agency, which must be received by October 1 of each fiscal year and provide the total amount of local governmental funds authorized by the entity for that fiscal year under the General Appropriations Act. The local governmental entity shall use a certification form prescribed by the agency. At a minimum, the certification form must identify the amount being certified and describe the relationship between the certifying local governmental entity and the local health care provider. Local governmental funds outlined in the letters of agreement must be received by the agency no later than October 31 of each fiscal year in which such funds are pledged, unless an alternative plan is specifically approved by the agency. To be eligible for low-income pool funding or other forms of supplemental payments funded by intergovernmental transfers, and in addition to any other applicable requirements, essential providers under s. 409.975(1)(a)2. must offer to contract with each managed care plan in their region and essential providers under 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 shall 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 8. 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 9. 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

551 contributions, or employer payment or premium, in an amount to
552 be determined by the board of directors, to provide for payment
553 of premiums for comprehensive insurance coverage and for the
554 actual or estimated administrative expenses.

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

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

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

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

573 6. Determine eligibility for children seeking to
574 participate in the Title XXI-funded components of the Florida
575 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

601 Florida Healthy Kids Corporation contract shall be 85 percent.
602 For dental contracts, the remaining compensation to be paid to
603 the authorized insurer or provider under a Florida Healthy Kids
604 Corporation contract shall be no less than an amount which is 85
605 percent of premium; to the extent any contract provision does
606 not provide for this minimum compensation, this section shall
607 prevail. For an insurer or any provider of health care services
608 which achieves an annual medical loss ratio below 85 percent,
609 the Florida Healthy Kids Corporation shall validate the medical
610 loss ratio and calculate an amount to be refunded by the insurer
611 or any provider of health care services to the state which shall
612 be deposited into the General Revenue Fund unallocated. The
613 health plan selection criteria and scoring system, and the
614 scoring results, shall be available upon request for inspection
615 after the bids have been awarded.

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

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

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

626 staff members necessary to administer the corporation.

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

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

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

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

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

646 Section 10. Paragraph (e) of subsection (2) of section
647 1011.52, Florida Statutes, is amended to read:

648 1011.52 Appropriation to first accredited medical school.—

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

PCB HCA 21-01

Redraft - A

2021

651 school:

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

664 Section 11. This act shall take effect July 1, 2021.