Amendment No.

CHAMBER ACTION

Senate House

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Representative Avila offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

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

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

(4) Within 120 days after the end of its fiscal year, each health care facility, excluding continuing care facilities, and hospitals operated by state agencies~~, and nursing homes~~ as those terms are defined in s. 408.07, shall file with the agency, on

forms adopted by the agency and based on the uniform system of financial reporting, its actual financial experience for that fiscal year, including expenditures, revenues, and statistical measures. Such data may be based on internal financial reports which are certified to be complete and accurate by the provider. However, hospitals' actual financial experience shall be their audited actual experience. Every nursing home shall submit to the agency, in a format designated by the agency, a statistical profile of the nursing home residents. The agency, in conjunction with the Department of Elderly Affairs and the Department of Health, shall review these statistical profiles and develop recommendations for the types of residents who might more appropriately be placed in their homes or other noninstitutional settings.

(5) Within 120 days after the end of its fiscal year, each nursing home as defined in s. 408.07 shall file with the agency, on forms adopted by the agency and based on the uniform system of financial reporting, its actual financial experience for that fiscal year, including expenditures, revenues, and statistical measures. Such data may be based on internal financial reports which are certified to be complete and accurate by the chief financial officer of the nursing home. However, the nursing home's actual financial experience shall be its audited actual financial experience, as audited by an independent certified public accountant. This audited actual experience shall include

the fiscal year-end balance sheet, income statement, statement of cash flow, and statement of retained earnings and shall be submitted to the agency in addition to the information filed in the uniform system of financial reporting. The nursing home shall provide all necessary records for the independent certified public accountant to form an opinion and complete an accurate audit report. The independent certified public accountant's opinion and audit report shall accompany the financial statements submitted to the agency. The audited financial statements shall tie to the information submitted in the uniform system of financial reporting and a crosswalk shall be submitted along with the audited financial statements.

(6) Within 120 days after the end of its fiscal year, the home office of each nursing home as defined in s. 408.07 shall file with the agency, on forms adopted by the agency and based on the uniform system of financial reporting, its actual financial experience for that fiscal year, including expenditures, revenues, and statistical measures. Such data may be based on internal financial reports which are certified to be complete and accurate by the chief financial officer of the nursing home. However, the home office's actual financial experience shall be its audited actual financial experience, as audited by an independent certified public accountant. This audited actual experience shall include the fiscal year-end balance sheet, income statement, statement of cash flow, and

statement of retained earnings and shall be submitted to the agency in addition to the information filed in the uniform system of financial reporting. The home office shall provide all necessary records for the independent certified public accountant to form an opinion and complete an accurate audit report. The independent certified public accountant's opinion and audit report shall accompany the financial statements submitted to the agency. The audited financial statements shall tie to the information submitted in the uniform system of financial reporting and a crosswalk shall be submitted along with the audited financial statements.

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

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

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

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

Section 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 ~~as defined in federal law and rule~~ consisting of the 12-month period beginning on the last day of her pregnancy, 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, 2021 ~~July 1, 2020~~, the agency shall make payments for ~~to~~ Medicaid-covered services:

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

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

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

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

(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

(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.

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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.

(VI) Fair Rental Rate of Return.....8 percent.

(VII) Minimum Occupancy.....90 percent.

(VIII) Maximum Facility Age.....40 years.

(IX) Minimum Square Footage per Bed.....350.

(X) Maximum Square Footage for Bed.....500.

(XI) Minimum Cost of a renovation/replacements.....$500 per bed.

h. Ventilator Supplemental payment of $200 per Medicaid 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.

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

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

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

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

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

8. For the period beginning on October 1, 2018, and ending on September 30, 2021, the agency shall reimburse providers the greater of their September 2016 cost-based rate plus the July 1, 2020, unit cost increase or their prospective payment rate plus the July 1, 2020, unit cost increase. Effective October 1, 2021, the agency shall reimburse providers the greater of 95 percent of their cost-based rate plus the July 1, 2020, unit cost increase or their rebased prospective payment rate plus the July 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 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 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 10. Paragraph (e) of subsection (2) of section 1011.52, Florida Statutes, is amended to read:

1011.52 Appropriation to first accredited medical school.—

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

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

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

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

T I T L E A M E N D M E N T

Remove everything before the enacting clause and insert:

A bill to be entitled

An act relating to health care; amending s. 296.37, F.S.; revising the threshold dollar amount relating to a requirement that a resident of a certain health care facility contribute to his or her maintenance and support; reenacting s. 400.179, F.S., relating to specified fees collected by the Agency for Health Care Administration from certain nursing homes to maintain the lease bond alternative; amending s. 408.061, F.S.; requiring nursing homes and their home offices to annually submit to the agency audited financial data and certain other information within a specified timeframe using a certain uniform system of financial reporting; amending s. 408.07, F.S.; providing definitions; amending s. 409.903, F.S.; extending the postpartum Medicaid eligibility period for pregnant women; amending s. 409.904, F.S.; revising a date relating to a requirement that the agency make

payments for Medicaid-covered services retroactive for a specified period for certain eligible persons; abrogating the future expiration of certain provisions; reenacting s. 409.908, F.S., relating to the agency's implementation of a state Title XIX Long-Term Care Reimbursement Plan for nursing home care, 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.