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LEGISLATIVE ACTION

Senate	.	House
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Floor: AD/CR	.	Floor: AD
04/30/2021 10:54 AM	.	04/30/2021 01:59 PM
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The Conference Committee on SB 2518 recommended the following:

1 **Senate Conference Committee Amendment (with title**
2 **amendment)**

3
4 Delete everything after the enacting clause
5 and insert:

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

8 296.37 Residents; contribution to support.-

9 (1) Every resident of the home who receives a pension,
10 compensation, or gratuity from the United States Government, or
11 income from any other source of more than \$130 ~~\$105~~ per month,



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12 shall contribute to his or her maintenance and support while a
13 resident of the home in accordance with a schedule of payment
14 determined by the administrator and approved by the director.
15 The total amount of such contributions shall be to the fullest
16 extent possible but may ~~shall~~ not exceed the actual cost of
17 operating and maintaining the home.

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

28 Section 2. Notwithstanding the expiration date in section
29 51 of chapter 2020-114, Laws of Florida, paragraph (d) of
30 subsection (2) of section 400.179, Florida Statutes, is
31 reenacted to read:

32 400.179 Liability for Medicaid underpayments and
33 overpayments.—

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

40 (d) Where the transfer involves a facility that has been



41 leased by the transferor:

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

48 2. A leasehold licensee may meet the requirements of
49 subparagraph 1. by payment of a nonrefundable fee, paid at
50 initial licensure, paid at the time of any subsequent change of
51 ownership, and paid annually thereafter, in the amount of 1
52 percent of the total of 3 months' Medicaid payments to the
53 facility computed on the basis of the preceding 12-month average
54 Medicaid payments to the facility. If a preceding 12-month
55 average is not available, projected Medicaid payments may be
56 used. The fee shall be deposited into the Grants and Donations
57 Trust Fund and shall be accounted for separately as a Medicaid
58 nursing home overpayment account. These fees shall be used at
59 the sole discretion of the agency to repay nursing home Medicaid
60 overpayments or for enhanced payments to nursing facilities as
61 specified in the General Appropriations Act or other law.
62 Payment of this fee shall not release the licensee from any
63 liability for any Medicaid overpayments, nor shall payment bar
64 the agency from seeking to recoup overpayments from the licensee
65 and any other liable party. As a condition of exercising this
66 lease bond alternative, licensees paying this fee must maintain
67 an existing lease bond through the end of the 30-month term
68 period of that bond. The agency is herein granted specific
69 authority to promulgate all rules pertaining to the



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70 administration and management of this account, including
71 withdrawals from the account, subject to federal review and
72 approval. This provision shall take effect upon becoming law and
73 shall apply to any leasehold license application. The financial
74 viability of the Medicaid nursing home overpayment account shall
75 be determined by the agency through annual review of the account
76 balance and the amount of total outstanding, unpaid Medicaid
77 overpayments owing from leasehold licensees to the agency as
78 determined by final agency audits. By March 31 of each year, the
79 agency shall assess the cumulative fees collected under this
80 subparagraph, minus any amounts used to repay nursing home
81 Medicaid overpayments and amounts transferred to contribute to
82 the General Revenue Fund pursuant to s. 215.20. If the net
83 cumulative collections, minus amounts utilized to repay nursing
84 home Medicaid overpayments, exceed \$10 million, the provisions
85 of this subparagraph shall not apply for the subsequent fiscal
86 year.

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

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

96 5. It shall be the responsibility of all nursing facility
97 operators, operating the facility as a leasehold, to renew the
98 30-month bond and to provide proof of such renewal to the agency



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99 annually.

100 6. Any failure of the nursing facility operator to acquire,
101 maintain, renew annually, or provide proof to the agency shall
102 be grounds for the agency to deny, revoke, and suspend the
103 facility license to operate such facility and to take any
104 further action, including, but not limited to, enjoining the
105 facility, asserting a moratorium pursuant to part II of chapter
106 408, or applying for a receiver, deemed necessary to ensure
107 compliance with this section and to safeguard and protect the
108 health, safety, and welfare of the facility's residents. A lease
109 agreement required as a condition of bond financing or
110 refinancing under s. 154.213 by a health facilities authority or
111 required under s. 159.30 by a county or municipality is not a
112 leasehold for purposes of this paragraph and is not subject to
113 the bond requirement of this paragraph.

114 Section 3. Present subsections (5) through (13) of section
115 408.061, Florida Statutes, are redesignated as subsections (7)
116 through (15), respectively, subsection (4) is amended, and new
117 subsections (5) and (6) are added to that section, to read:

118 408.061 Data collection; uniform systems of financial
119 reporting; information relating to physician charges;
120 confidential information; immunity.—

121 (4) Within 120 days after the end of its fiscal year, each
122 health care facility, excluding continuing care facilities, and
123 hospitals operated by state agencies, ~~and nursing homes~~ as those
124 terms are defined in s. 408.07, shall file with the agency, on
125 forms adopted by the agency and based on the uniform system of
126 financial reporting, its actual financial experience for that
127 fiscal year, including expenditures, revenues, and statistical



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128 measures. Such data may be based on internal financial reports
129 which are certified to be complete and accurate by the provider.
130 However, hospitals' actual financial experience shall be their
131 audited actual experience. Every nursing home shall submit to
132 the agency, in a format designated by the agency, a statistical
133 profile of the nursing home residents. The agency, in
134 conjunction with the Department of Elderly Affairs and the
135 Department of Health, shall review these statistical profiles
136 and develop recommendations for the types of residents who might
137 more appropriately be placed in their homes or other
138 noninstitutional settings.

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

154 (6) Within 120 days after the end of its fiscal year, the
155 home office of each nursing home as defined in s. 408.07 shall
156 file with the agency, on forms adopted by the agency and based



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157 on the uniform system of financial reporting, its actual
158 financial experience for that fiscal year, including
159 expenditures, revenues, and statistical measures. Such data may
160 be based on internal financial reports that are certified to be
161 complete and accurate by the chief financial officer of the
162 nursing home. This actual experience must include the fiscal
163 year-end balance sheet, income statement, statement of cash
164 flow, and statement of retained earnings and must be submitted
165 to the agency in addition to the information filed in the
166 uniform system of financial reporting. The financial statements
167 must tie to the information submitted in the uniform system of
168 financial reporting, and a crosswalk must be submitted along
169 with the audited financial statements.

170 Section 4. Present subsections (19) through (27) of section
171 408.07, Florida Statutes, are redesignated as subsections (20)
172 through (28), respectively, and present subsections (28) through
173 (44) are redesignated as subsections (30) through (46),
174 respectively, and new subsections (19) and (29) are added to
175 that section, to read:

176 408.07 Definitions.—As used in this chapter, with the
177 exception of ss. 408.031-408.045, the term:

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

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

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



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186 409.903 Mandatory payments for eligible persons.—The agency
187 shall make payments for medical assistance and related services
188 on behalf of the following persons who the department, or the
189 Social Security Administration by contract with the Department
190 of Children and Families, determines to be eligible, subject to
191 the income, assets, and categorical eligibility tests set forth
192 in federal and state law. Payment on behalf of these Medicaid
193 eligible persons is subject to the availability of moneys and
194 any limitations established by the General Appropriations Act or
195 chapter 216.

196 (5) A pregnant woman for the duration of her pregnancy and
197 for the postpartum period consisting of the 12-month period
198 beginning on the last day of her pregnancy ~~as defined in federal~~
199 ~~law and rule~~, or a child under age 1, if either is living in a
200 family that has an income that ~~which~~ is at or ~~below 150 percent~~
201 ~~of the most current federal poverty level, or, effective January~~
202 ~~1, 1992, that has an income which is at or~~ below 185 percent of
203 the most current federal poverty level. Such a person is not
204 subject to an assets test. Further, a pregnant woman who applies
205 for eligibility for the Medicaid program through a qualified
206 Medicaid provider must be offered the opportunity, subject to
207 federal rules, to be made presumptively eligible for the
208 Medicaid program.

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

211 409.904 Optional payments for eligible persons.—The agency
212 may make payments for medical assistance and related services on
213 behalf of the following persons who are determined to be
214 eligible subject to the income, assets, and categorical



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

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

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

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

227

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

229 Section 7. Notwithstanding the expiration date in section
230 13 of chapter 2020-114, Laws of Florida, subsection (23) of
231 section 409.908, Florida Statutes, is reenacted to read:

232 409.908 Reimbursement of Medicaid providers.—Subject to
233 specific appropriations, the agency shall reimburse Medicaid
234 providers, in accordance with state and federal law, according
235 to methodologies set forth in the rules of the agency and in
236 policy manuals and handbooks incorporated by reference therein.
237 These methodologies may include fee schedules, reimbursement
238 methods based on cost reporting, negotiated fees, competitive
239 bidding pursuant to s. 287.057, and other mechanisms the agency
240 considers efficient and effective for purchasing services or
241 goods on behalf of recipients. If a provider is reimbursed based
242 on cost reporting and submits a cost report late and that cost
243 report would have been used to set a lower reimbursement rate



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244 for a rate semester, then the provider's rate for that semester
245 shall be retroactively calculated using the new cost report, and
246 full payment at the recalculated rate shall be effected
247 retroactively. Medicare-granted extensions for filing cost
248 reports, if applicable, shall also apply to Medicaid cost
249 reports. Payment for Medicaid compensable services made on
250 behalf of Medicaid eligible persons is subject to the
251 availability of moneys and any limitations or directions
252 provided for in the General Appropriations Act or chapter 216.
253 Further, nothing in this section shall be construed to prevent
254 or limit the agency from adjusting fees, reimbursement rates,
255 lengths of stay, number of visits, or number of services, or
256 making any other adjustments necessary to comply with the
257 availability of moneys and any limitations or directions
258 provided for in the General Appropriations Act, provided the
259 adjustment is consistent with legislative intent.

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

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

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

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



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273 General Appropriations Act.

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

278 409.908 Reimbursement of Medicaid providers.—Subject to
279 specific appropriations, the agency shall reimburse Medicaid
280 providers, in accordance with state and federal law, according
281 to methodologies set forth in the rules of the agency and in
282 policy manuals and handbooks incorporated by reference therein.
283 These methodologies may include fee schedules, reimbursement
284 methods based on cost reporting, negotiated fees, competitive
285 bidding pursuant to s. 287.057, and other mechanisms the agency
286 considers efficient and effective for purchasing services or
287 goods on behalf of recipients. If a provider is reimbursed based
288 on cost reporting and submits a cost report late and that cost
289 report would have been used to set a lower reimbursement rate
290 for a rate semester, then the provider's rate for that semester
291 shall be retroactively calculated using the new cost report, and
292 full payment at the recalculated rate shall be effected
293 retroactively. Medicare-granted extensions for filing cost
294 reports, if applicable, shall also apply to Medicaid cost
295 reports. Payment for Medicaid compensable services made on
296 behalf of Medicaid eligible persons is subject to the
297 availability of moneys and any limitations or directions
298 provided for in the General Appropriations Act or chapter 216.
299 Further, nothing in this section shall be construed to prevent
300 or limit the agency from adjusting fees, reimbursement rates,
301 lengths of stay, number of visits, or number of services, or



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302 making any other adjustments necessary to comply with the
303 availability of moneys and any limitations or directions
304 provided for in the General Appropriations Act, provided the
305 adjustment is consistent with legislative intent.

306 (26) The agency may receive funds from state entities,
307 including, but not limited to, the Department of Health, local
308 governments, and other local political subdivisions, for the
309 purpose of making special exception payments and Low Income Pool
310 Program payments, including federal matching funds. Funds
311 received for this purpose shall be separately accounted for and
312 may not be commingled with other state or local funds in any
313 manner. The agency may certify all local governmental funds used
314 as state match under Title XIX of the Social Security Act to the
315 extent and in the manner authorized under the General
316 Appropriations Act and pursuant to an agreement between the
317 agency and the local governmental entity. In order for the
318 agency to certify such local governmental funds, a local
319 governmental entity must submit a final, executed letter of
320 agreement to the agency, which must be received by October 1 of
321 each fiscal year and provide the total amount of local
322 governmental funds authorized by the entity for that fiscal year
323 under the General Appropriations Act. The local governmental
324 entity shall use a certification form prescribed by the agency.
325 At a minimum, the certification form must identify the amount
326 being certified and describe the relationship between the
327 certifying local governmental entity and the local health care
328 provider. Local governmental funds outlined in the letters of
329 agreement must be received by the agency no later than October
330 31 of each fiscal year in which such funds are pledged, unless



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331 an alternative plan is specifically approved by the agency. To
332 be eligible for low-income pool funding or other forms of
333 supplemental payments funded by intergovernmental transfers, and
334 in addition to any other applicable requirements, essential
335 providers identified in s. 409.975(1)(a)2. must offer to
336 contract with each managed care plan in their region and
337 essential providers identified in s. 409.975(1)(b)1. and 3. must
338 offer to contract with each managed care plan in the state.
339 Before releasing such supplemental payments, in the event the
340 parties have not executed network contracts, the agency shall
341 evaluate the parties' efforts to complete negotiations. If such
342 efforts continue to fail, the agency must withhold such
343 supplemental payments beginning in the third quarter of the
344 fiscal year if it determines that, based upon the totality of
345 the circumstances, the essential provider has negotiated with
346 the managed care plan in bad faith. If the agency determines
347 that an essential provider has negotiated in bad faith, it must
348 notify the essential provider at least 90 days in advance of the
349 start of the third quarter of the fiscal year and afford the
350 essential provider hearing rights in accordance with chapter
351 120.

352 Section 9. Subsections (2), (3), and (10) of section
353 409.911, Florida Statutes, are amended to read:

354 409.911 Disproportionate share program.—Subject to specific
355 allocations established within the General Appropriations Act
356 and any limitations established pursuant to chapter 216, the
357 agency shall distribute, pursuant to this section, moneys to
358 hospitals providing a disproportionate share of Medicaid or
359 charity care services by making quarterly Medicaid payments as



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360 required. Notwithstanding the provisions of s. 409.915, counties
361 are exempt from contributing toward the cost of this special
362 reimbursement for hospitals serving a disproportionate share of
363 low-income patients.

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

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

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

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

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

385

386

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

387

388 Where:



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389 DSHP = disproportionate share hospital payment.

390 HMD = hospital Medicaid days.

391 TSD = total state Medicaid days.

392

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

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

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

404 409.9113 Disproportionate share program for teaching
405 hospitals.—In addition to the payments made under s. 409.911,
406 the agency shall make disproportionate share payments to
407 teaching hospitals, as defined in s. 408.07, for their increased
408 costs associated with medical education programs and for
409 tertiary health care services provided to the indigent. This
410 system of payments must conform to federal requirements and
411 distribute funds in each fiscal year for which an appropriation
412 is made by making quarterly Medicaid payments. Notwithstanding
413 s. 409.915, counties are exempt from contributing toward the
414 cost of this special reimbursement for hospitals serving a
415 disproportionate share of low-income patients. The agency shall
416 distribute the moneys provided in the General Appropriations Act
417 to statutorily defined teaching hospitals and family practice



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418 teaching hospitals, as defined in s. 395.805, pursuant to this
419 section. The funds provided for statutorily defined teaching
420 hospitals shall be distributed as provided in the General
421 Appropriations Act. The funds provided for family practice
422 teaching hospitals shall be distributed equally among family
423 practice teaching hospitals.

424 (3) Notwithstanding any provision of this section to the
425 contrary, for each ~~the 2020-2021~~ state fiscal year, the agency
426 shall make disproportionate share payments to teaching
427 hospitals, as defined in s. 408.07, as provided in the ~~2020-2021~~
428 General Appropriations Act. ~~This subsection expires July 1,~~
429 ~~2021.~~

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

432 409.9119 Disproportionate share program for specialty
433 hospitals for children.—In addition to the payments made under
434 s. 409.911, the Agency for Health Care Administration shall
435 develop and implement a system under which disproportionate
436 share payments are made to those hospitals that are separately
437 licensed by the state as specialty hospitals for children, have
438 a federal Centers for Medicare and Medicaid Services
439 certification number in the 3300-3399 range, have Medicaid days
440 that exceed 55 percent of their total days and Medicare days
441 that are less than 5 percent of their total days, and were
442 licensed on January 1, 2013, as specialty hospitals for
443 children. This system of payments must conform to federal
444 requirements and must distribute funds in each fiscal year for
445 which an appropriation is made by making quarterly Medicaid
446 payments. Notwithstanding s. 409.915, counties are exempt from



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447 contributing toward the cost of this special reimbursement for
448 hospitals that serve a disproportionate share of low-income
449 patients. The agency may make disproportionate share payments to
450 specialty hospitals for children as provided for in the General
451 Appropriations Act.

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

458 Section 12. Paragraph (a) of subsection (1) of section
459 409.975, Florida Statutes, is amended to read:

460 409.975 Managed care plan accountability.—In addition to
461 the requirements of s. 409.967, plans and providers
462 participating in the managed medical assistance program shall
463 comply with the requirements of this section.

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

470 (a) Plans must include all providers in the region that are
471 classified by the agency as essential Medicaid providers, unless
472 the agency approves, in writing, an alternative arrangement for
473 securing the types of services offered by the essential
474 providers. Providers are essential for serving Medicaid
475 enrollees if they offer services that are not available from any



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476 other provider within a reasonable access standard, or if they
477 provided a substantial share of the total units of a particular
478 service used by Medicaid patients within the region during the
479 last 3 years and the combined capacity of other service
480 providers in the region is insufficient to meet the total needs
481 of the Medicaid patients. The agency may not classify physicians
482 and other practitioners as essential providers. The agency, at a
483 minimum, shall determine which providers in the following
484 categories are essential Medicaid providers:

- 485 1. Federally qualified health centers.
- 486 2. Statutory teaching hospitals as defined in s. 408.07(46)
487 ~~s. 408.07(44)~~.
- 488 3. Hospitals that are trauma centers as defined in s.
489 395.4001(15).
- 490 4. Hospitals located at least 25 miles from any other
491 hospital with similar services.

492
493 Managed care plans that have not contracted with all essential
494 providers in the region as of the first date of recipient
495 enrollment, or with whom an essential provider has terminated
496 its contract, must negotiate in good faith with such essential
497 providers for 1 year or until an agreement is reached, whichever
498 is first. Payments for services rendered by a nonparticipating
499 essential provider shall be made at the applicable Medicaid rate
500 as of the first day of the contract between the agency and the
501 plan. A rate schedule for all essential providers shall be
502 attached to the contract between the agency and the plan. After
503 1 year, managed care plans that are unable to contract with
504 essential providers shall notify the agency and propose an



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

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

519 430.502 Alzheimer's disease; memory disorder clinics and
520 day care and respite care programs.—

521 (1) There is established:

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

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

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

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

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



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

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

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

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

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

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

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

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

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

554 (o) A memory disorder clinic at Miami Jewish Health System
555 in Miami-Dade County,
556
557 for the purpose of conducting research and training in a
558 diagnostic and therapeutic setting for persons suffering from
559 Alzheimer's disease and related memory disorders. However,
560 memory disorder clinics may ~~shall~~ not receive decreased funding
561 due solely to subsequent additions of memory disorder clinics in
562 this subsection.



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563 Section 14. Notwithstanding the expiration date in section
564 19 of chapter 2020-114, Laws of Florida, paragraph (b) of
565 subsection (5) of section 624.91, Florida Statutes, is reenacted
566 to read:

567 624.91 The Florida Healthy Kids Corporation Act.—

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

569 (b) The Florida Healthy Kids Corporation shall:

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

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

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

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

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



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592 | pediatricians.

593 | 6. Determine eligibility for children seeking to
594 | participate in the Title XXI-funded components of the Florida
595 | Kidcare program consistent with the requirements specified in s.
596 | 409.814, as well as the non-Title-XXI-eligible children as
597 | provided in subsection (3).

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

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

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

609 | 10. Contract with authorized insurers or any provider of
610 | health care services, meeting standards established by the
611 | corporation, for the provision of comprehensive insurance
612 | coverage to participants. Such standards shall include criteria
613 | under which the corporation may contract with more than one
614 | provider of health care services in program sites. Health plans
615 | shall be selected through a competitive bid process. The Florida
616 | Healthy Kids Corporation shall purchase goods and services in
617 | the most cost-effective manner consistent with the delivery of
618 | quality medical care. The maximum administrative cost for a
619 | Florida Healthy Kids Corporation contract shall be 15 percent.
620 | For health care contracts, the minimum medical loss ratio for a



621 Florida Healthy Kids Corporation contract shall be 85 percent.
622 For dental contracts, the remaining compensation to be paid to
623 the authorized insurer or provider under a Florida Healthy Kids
624 Corporation contract shall be no less than an amount which is 85
625 percent of premium; to the extent any contract provision does
626 not provide for this minimum compensation, this section shall
627 prevail. For an insurer or any provider of health care services
628 which achieves an annual medical loss ratio below 85 percent,
629 the Florida Healthy Kids Corporation shall validate the medical
630 loss ratio and calculate an amount to be refunded by the insurer
631 or any provider of health care services to the state which shall
632 be deposited into the General Revenue Fund unallocated. The
633 health plan selection criteria and scoring system, and the
634 scoring results, shall be available upon request for inspection
635 after the bids have been awarded.

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

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

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

647 14. In consultation with the partner agencies, provide a
648 report on the Florida Kidcare program annually to the Governor,
649 the Chief Financial Officer, the Commissioner of Education, the



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650 President of the Senate, the Speaker of the House of
651 Representatives, and the Minority Leaders of the Senate and the
652 House of Representatives.

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

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

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

664 16. Establish benefit packages that conform to the
665 provisions of the Florida Kidcare program, as created in ss.
666 409.810-409.821.

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

669 1011.52 Appropriation to first accredited medical school.-

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

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

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



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679 (c) Must, upon the formation and establishment of an
680 accredited medical school, transmit and file with the Department
681 of Education documentary proof evidencing the facts that such
682 institution has been certified and approved by the council on
683 medical education and hospitals of the American Medical
684 Association and has adequately met the requirements of that
685 council in regard to its administrative facilities,
686 administrative plant, clinical facilities, curriculum, and all
687 other such requirements as may be necessary to qualify with the
688 council as a recognized, approved, and accredited medical
689 school;

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

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

706 Section 16. Subject to federal approval of the application
707 to be a site for the Program of All-inclusive Care for the



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708 Elderly (PACE), the Agency for Health Care Administration shall
709 contract with one private health care organization, the sole
710 member of which is a private, not-for-profit corporation that
711 owns and manages health care organizations that provide
712 comprehensive long-term care services, including nursing home,
713 assisted living, independent housing, home care, adult day care,
714 and care management. This organization shall provide these
715 services to frail and elderly persons who reside in Escambia,
716 Okaloosa, and Santa Rosa Counties. The organization is exempt
717 from the requirements of chapter 641, Florida Statutes. The
718 agency, in consultation with the Department of Elderly Affairs
719 and subject to an appropriation, shall approve up to 200 initial
720 enrollees in the PACE program established by this organization
721 to serve elderly persons who reside in Escambia, Okaloosa, and
722 Santa Rosa Counties.

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

735 Section 18. Subject to federal approval of an application
736 to be a provider of the Program of All-inclusive Care for the



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737 Elderly (PACE), the Agency for Health Care Administration shall
738 contract with a private organization that has demonstrated the
739 ability to operate PACE centers in more than one state and that
740 serves more than 500 eligible PACE participants, to provide PACE
741 services to frail and elderly persons who reside in
742 Hillsborough, Hernando, or Pasco Counties. The organization is
743 exempt from the requirements of chapter 641, Florida Statutes.
744 The agency, in consultation with the Department of Elderly
745 Affairs and subject to the appropriation of funds by the
746 Legislature, shall approve up to 500 initial enrollees in the
747 PACE program established by the organization to serve frail and
748 elderly persons who reside in Hillsborough, Hernando, or Pasco
749 Counties.

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



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

775 Section 21. The Program of All-inclusive Care for the
776 Elderly (PACE) organization that is authorized as of July 1,
777 2021 to provide PACE services for up to 150 enrollee slots to
778 serve frail and elderly persons residing in Hospice Service
779 Areas 7B (Orange and Osceola Counties) and 3E (Lake and Sumter
780 Counties), as previously authorized by section 29 of Chapter
781 2016-65, Laws of Florida, and the PACE organization that is
782 authorized as of July 1, 2021 to provide PACE services for up to
783 150 initial enrollee slots to serve frail and elderly persons
784 who reside in Hospice Services Area 7C (Seminole County), as
785 previously authorized by section 22 of Chapter 2017-129, Laws of
786 Florida, may be consolidated. With the consolidation, the PACE
787 organization that has demonstrated the ability to operate PACE
788 centers in more than one state and that serves more than 500
789 eligible PACE participants is authorized to provide PACE
790 services for up to 300 initial enrollee slots to serve frail and
791 elderly persons who reside in Orange, Osceola, Lake, Sumter, or
792 Seminole Counties.

793 Section 22. Subject to federal approval, a private
794 organization that owns and manages a health care organization



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795 that provides comprehensive long-term care services, including
796 acute care services, independent living through federally
797 approved affordable housing, and care management, and has
798 demonstrated the ability to operate Program of All-inclusive
799 Care for the Elderly (PACE) centers in more than one state is
800 authorized to provide PACE services to frail and elderly persons
801 who reside in Seminole, Volusia, or Flagler Counties. The
802 organization is exempt from the requirements of chapter 641,
803 Florida Statutes. The agency, in consultation with the
804 Department of Elderly Affairs, and subject to an appropriation,
805 shall approve up to 500 initial enrollee slots to serve frail
806 and elderly persons residing in Seminole, Volusia, or Flagler
807 Counties.

808 Section 23. Subject to federal approval of the application
809 to be a site for the Program of All-Inclusive Care for the
810 Elderly (PACE), the Agency for Health Care Administration shall
811 contract with one public hospital system operating in the
812 northern two-thirds of Broward County to provide comprehensive
813 services to frail and elderly persons residing in the northern
814 two-thirds of Broward County. The public hospital system is
815 exempt from the requirements of chapter 641, Florida Statutes.
816 The agency, in consultation with the Department of Elderly
817 Affairs, and subject to an appropriation, shall approve up to
818 200 initial enrollee slots in the PACE program established by
819 the public hospital system to serve frail and elderly persons
820 residing in the northern two-thirds of Broward County.

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

822
823 ===== T I T L E A M E N D M E N T =====



824 And the title is amended as follows:

825 Delete everything before the enacting clause
826 and insert:

827 A bill to be entitled
828 An act relating to health care; amending s. 296.37,
829 F.S.; revising the amount of money residents of a
830 veterans' nursing home must receive monthly before
831 being required to contribute to their maintenance and
832 support; reenacting s. 400.179(2)(d), F.S., relating
833 to liability for Medicaid underpayments and
834 overpayments; amending s. 408.061, F.S.; requiring
835 nursing homes and their home offices to annually
836 submit to the Agency of Health Care Administration
837 certain information within a specified timeframe;
838 amending s. 408.07, F.S.; defining the terms "FNHURS"
839 and "home office"; amending s. 409.903, F.S.; revising
840 the postpartum Medicaid eligibility period for
841 pregnant women; amending s. 409.904, F.S.; deleting
842 the effective date and the expiration date of a
843 provision requiring the agency to make payments to
844 Medicaid-covered services; reenacting s. 409.908(23),
845 F.S., relating to reimbursement of Medicaid providers;
846 amending s. 409.908, F.S.; authorizing the agency to
847 receive funds to be used for Low Income Pool Program
848 payments; requiring certain essential providers to
849 offer to contract with certain managed care plans to
850 be eligible for low-income pool funding; requiring the
851 agency to evaluate contract negotiations and withhold
852 supplemental payments under certain circumstances;



853 requiring the agency to notify and afford hearing
854 rights to providers under certain circumstances;
855 amending s. 409.911, F.S.; revising the years of
856 audited disproportionate share data the agency must
857 use for calculating an average for purposes of
858 calculating disproportionate share payments;
859 authorizing the agency to use data available for a
860 hospital; conforming provisions to changes made by the
861 act; revising the requirement that the agency
862 distribute moneys to hospitals providing a
863 disproportionate share of Medicaid or charity care
864 services, as provided in the General Appropriations
865 Act, to apply to each fiscal year, rather than a
866 specified fiscal year; deleting the expiration date of
867 such requirement; amending s. 409.9113, F.S.; revising
868 the requirement that the agency make disproportionate
869 share payments to teaching hospitals, as provided in
870 the General Appropriations Act, to apply to each
871 fiscal year, rather than a specified fiscal year;
872 deleting the expiration date of such requirement;
873 amending s. 409.9119, F.S.; revising the requirement
874 that the agency make disproportionate share payments
875 to certain specialty hospitals for children to apply
876 to each fiscal year, rather than a specified fiscal
877 year; deleting the expiration date of such
878 requirement; amending s. 409.975, F.S.; conforming a
879 cross-reference; amending s. 430.502, F.S.; revising
880 the name of a memory disorder clinic in Pensacola;
881 reenacting s. 624.91(5)(b), F.S., relating to The



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882 Florida Healthy Kids Corporation Act; amending s.
883 1011.52, F.S.; conforming a cross-reference; requiring
884 the agency to contract with organizations for the
885 provision of elder care services in specified counties
886 if certain conditions are met; requiring the agency to
887 contract with hospitals for the provision of elder
888 care services in specified counties if certain
889 conditions are met; authorizing an organization
890 providing elder care services in specified counties to
891 provide elder care services in additional specified
892 counties if certain conditions are met; authorizing
893 the consolidation of organizations providing elder
894 care services in specified counties; authorizing an
895 organization to provide elder care services with the
896 consolidation if certain criteria are met; authorizing
897 an organization to provide elder care services in
898 specified counties if certain criteria are met;
899 providing an effective date.