The Florida Senate

Local Funding Initiative Request - Fiscal Year 2018-2019

1. **Title of Project:** Lower Keys Medical Center Rural Hospital APR-DRG Policy Adjustor
2. **Senate Sponsor:** Anitere Flores
3. **Date of Submission:** 01/22/2018
4. **Project/Program Description:**

   APR-DRG Inpatient Medicaid Payment

5. **State Agency Contacted?** Yes

   a. If yes, which state agency? Agency for Health Care Administration

   b. If no, which is the most appropriate state agency to place an appropriation for the issue being requested?

6. **Amount of Non-recurring Requested for fiscal year 2018-19:**

Amount Requested for Operations	Amount Requested for Fixed Capital Outlay	Total Amount of Requested State Funds
876,013		876,013

7. **Type, amount and percent of matching funds available for this project for fiscal year 2018-19:**

Type	Amount	Percent
Federal	1,408,840	61.7%
State (excluding the amount of this request)	0	0.0%
Local	0	0.0%
Other	0	0.0%
TOTAL	1,408,840	61.7 %

8. **Total Project Cost for fiscal year 2018-19 (including the Total Amount of Requested State Funds):** 2,284,853

9. **Previous Year Funding Details:**

   a. Has funding been provided in a previous state budget for this activity? Yes
   b. In the previous 5 fiscal years, how many years was funding provided? (Optional) 1
   c. What is the most recent fiscal year the project was funded? 2017-18
   d. Were the funds provided in the most recent fiscal year subsequently vetoed? No
   e. Complete the following Worksheet.

FY:	Input Prior FY Appropriation for this project for FY 2017-18

	(If appropriated in FY 2017-18 enter the appropriated amount, even if vetoed.)		
Column:	**A**	**B**	**C**
Funds Description:	**Prior Year Recurring Funds ***	**Prior Year Nonrecurring Funds ***	**Total Funds Appropriated (Column A + Column B)**
Input Amounts:		**2,778,035**	**2,778,035**

10. Is future-year funding likely to be requested?

Yes

a. If yes, indicate non-recurring amount per year.

Yes. It depends on the Medicaid volume.

11. Program Performance:

a. What is the specific purpose or goal that will be achieved by the funds requested?

Provide Medicaid services to the rural community in the Florida Keys.

b. What are the activities and services that will be provided to meet the intended purpose of these funds?

Treat and serve the Medicaid population in the Florida Keys

c. How will the funds be expended?

Spending Category	Description	Amount
Administrative Costs		
☐Executive Director/Project Head Salary and Benefits		
☐Other Salary and Benefits		
☐Expense/Equipment/Travel/Supplies/Other		
☐Consultants/Contracted Services/Study		
Operational Costs		
☐Salary and Benefits		
☑Expense/Equipment/Travel/Supplies/Other	The rural hospital adjuster	876,013

	payment would go towards Medicaid inpatient services at LKMC.	
☐Consultants/Contracted Services/Study		
Fixed Capital Construction/Major Renovation		
☐Construction/Renovation/Land/Planning Engineering		
TOTAL		876,013

d. What are the direct services to be provided to citizens by the appropriations project?

Healthcare Services.

e. Who is the target population served by this project? How many individuals are expected to be served?

Medicaid Recipients.

f. What is the expected benefit or outcome of this project? What is the methodology by which this outcome will be measured?

Patient well being and increased quality of care.

g. What are the suggested penalties that the contracting agency may consider in addition to its standard penalties for failing to meet deliverables or performance measures provided for in the contract?

None.

12. The owner(s) of the facility to receive, directly or indirectly, any fixed capital outlay funding. Include the relationship between the owner(s) of the facility and the entity.

N/A

13. Requestor Contact Information:

a. Name: Ellen Anderson
b. Organization: Community Health Systems
c. Email: Ellen_anderson@chs.net
d. Phone Number: (850)228-7959

14. Recipient Contact Information:

a. Organization: Lower Keys Medical Center
b. County: Monroe
c. Organization Type:

⦿ For Profit
○ Non Profit 501(c) (3)

- ○ Non Profit 501(c) (4)
- ○ Local Entity
- ○ University or College
- ○ Other (Please specify)

d. Contact Name: David Clay
e. E-mail Address: David.clay@lkmc.com
f. Phone Number: (305)294-9200

15. If there is a registered lobbyist, fill out the lobbyist information below.

a. Name: None
b. Firm: None
c. Email:
d. Phone Number: