

1 A bill to be entitled
2 An act relating to Medicaid services; amending s. 400.141,
3 F.S.; conforming a cross-reference to changes made by the
4 act; amending s. 400.179, F.S.; revising requirements for
5 nursing home lease bond alternative fees; amending s.
6 400.23, F.S.; providing for flexibility in how to meet the
7 minimum staffing requirements for nursing home facilities;
8 amending s. 409.904, F.S.; revising the expiration date of
9 provisions authorizing the federal waiver for certain
10 persons age 65 and over or who have a disability; revising
11 the expiration date of provisions authorizing a specified
12 medically needy program; amending s. 409.905, F.S.;
13 authorizing the Agency for Health Care Administration to
14 develop and implement a program to reduce hospital
15 readmissions for a certain population in certain areas of
16 the state; amending s. 409.907, F.S.; authorizing the
17 agency to enroll entities as Medicare crossover-only
18 providers for payment and claims processing purposes only;
19 specifying requirements for Medicare crossover-only
20 agreements; amending s. 409.908, F.S.; providing penalties
21 for providers that fail to report suspension or
22 disenrollment from Medicare within a specified time;
23 amending s. 409.9082, F.S.; revising the purpose of the
24 use of the nursing home facility quality assessment and
25 federal matching funds; amending s. 409.9083, F.S.;
26 revising the purpose of the use of the privately operated
27 intermediate care facilities for the developmentally
28 disabled quality assessment and federal matching funds;

29 | amending s. 409.911, F.S.; continuing the audited data
30 | specified for use in calculating disproportionate share;
31 | revising the formula used to pay disproportionate share
32 | dollars to provider service network hospitals; amending s.
33 | 409.9112, F.S.; continuing the prohibition against
34 | distributing moneys under the perinatal intensive care
35 | centers disproportionate share program; amending s.
36 | 409.9113, F.S.; continuing authorization for the
37 | distribution of moneys to teaching hospitals under the
38 | disproportionate share program; amending s. 409.9117,
39 | F.S.; continuing the prohibition against distributing
40 | moneys under the primary care disproportionate share
41 | program; authorizing the agency to contract with an
42 | organization to provide certain benefits under a federal
43 | program in Polk, Highlands, Hardee, and Hillsborough
44 | Counties; providing an exemption from ch. 641, F.S., for
45 | the organization; authorizing, subject to appropriation,
46 | enrollment slots for the Program of All-inclusive Care for
47 | the Elderly in Polk, Highlands, and Hardee Counties;
48 | authorizing the agency, subject to appropriation and
49 | federal approval of an expansion application, to contract
50 | with an Organized Health Care Delivery System in Miami-
51 | Dade County to provide certain benefits under a federal
52 | program; providing an exemption from ch. 641, F.S., for
53 | the Organized Health Care Delivery System; authorizing,
54 | subject to appropriation, enrollment slots for the Program
55 | of All-inclusive Care for the Elderly in Southwest Miami-
56 | Dade County; providing an effective date.

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

Section 1. Paragraph (o) of subsection (1) of section 400.141, Florida Statutes, is amended to read:

400.141 Administration and management of nursing home facilities.—

(1) Every licensed facility shall comply with all applicable standards and rules of the agency and shall:

(o)1. Submit semiannually to the agency, or more frequently if requested by the agency, information regarding facility staff-to-resident ratios, staff turnover, and staff stability, including information regarding certified nursing assistants, licensed nurses, the director of nursing, and the facility administrator. For purposes of this reporting:

a. Staff-to-resident ratios must be reported in the categories specified in s. 400.23(3)(a) and applicable rules. The ratio must be reported as an average for the most recent calendar quarter.

b. Staff turnover must be reported for the most recent 12-month period ending on the last workday of the most recent calendar quarter prior to the date the information is submitted. The turnover rate must be computed quarterly, with the annual rate being the cumulative sum of the quarterly rates. The turnover rate is the total number of terminations or separations experienced during the quarter, excluding any employee terminated during a probationary period of 3 months or less, divided by the total number of staff employed at the end of the

85 | period for which the rate is computed, and expressed as a
86 | percentage.

87 | c. The formula for determining staff stability is the
88 | total number of employees that have been employed for more than
89 | 12 months, divided by the total number of employees employed at
90 | the end of the most recent calendar quarter, and expressed as a
91 | percentage.

92 | d. A nursing facility that has failed to comply with state
93 | minimum-staffing requirements for 2 consecutive days is
94 | prohibited from accepting new admissions until the facility has
95 | achieved the minimum-staffing requirements for a period of 6
96 | consecutive days. For the purposes of this sub-subparagraph, any
97 | person who was a resident of the facility and was absent from
98 | the facility for the purpose of receiving medical care at a
99 | separate location or was on a leave of absence is not considered
100 | a new admission. Failure to impose such an admissions moratorium
101 | constitutes a class II deficiency.

102 | e. A nursing facility which does not have a conditional
103 | license may be cited for failure to comply with the standards in
104 | s. 400.23(3)(a)1.b. and c. ~~s. 400.23(3)(a)1.a.~~ only if it has
105 | failed to meet those standards on 2 consecutive days or if it
106 | has failed to meet at least 97 percent of those standards on any
107 | one day.

108 | f. A facility which has a conditional license must be in
109 | compliance with the standards in s. 400.23(3)(a) at all times.

110 | 2. This paragraph does not limit the agency's ability to
111 | impose a deficiency or take other actions if a facility does not
112 | have enough staff to meet the residents' needs.

113 Section 2. Paragraph (d) of subsection (2) of section
 114 400.179, Florida Statutes, is amended to read:

115 400.179 Liability for Medicaid underpayments and
 116 overpayments.—

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

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

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

131 2. A leasehold licensee may meet the requirements of
 132 subparagraph 1. by payment of a nonrefundable fee, paid at
 133 initial licensure, paid at the time of any subsequent change of
 134 ownership, and paid annually thereafter, in the amount of 1
 135 percent of the total of 3 months' Medicaid payments to the
 136 facility computed on the basis of the preceding 12-month average
 137 Medicaid payments to the facility. If a preceding 12-month
 138 average is not available, projected Medicaid payments may be
 139 used. The fee shall be deposited into the Grants and Donations
 140 Trust Fund and shall be accounted for separately as a Medicaid

141 nursing home overpayment account. These fees shall be used at
142 the sole discretion of the agency to repay nursing home Medicaid
143 overpayments. Payment of this fee shall not release the licensee
144 from any liability for any Medicaid overpayments, nor shall
145 payment bar the agency from seeking to recoup overpayments from
146 the licensee and any other liable party. As a condition of
147 exercising this lease bond alternative, licensees paying this
148 fee must maintain an existing lease bond through the end of the
149 30-month term period of that bond. The agency is herein granted
150 specific authority to promulgate all rules pertaining to the
151 administration and management of this account, including
152 withdrawals from the account, subject to federal review and
153 approval. This provision shall take effect upon becoming law and
154 shall apply to any leasehold license application. The financial
155 viability of the Medicaid nursing home overpayment account shall
156 be determined by the agency through annual review of the account
157 balance and the amount of total outstanding, unpaid Medicaid
158 overpayments owing from leasehold licensees to the agency as
159 determined by final agency audits. By March 31 of each year, the
160 agency shall assess the cumulative fees collected under this
161 subparagraph, minus any amounts used to repay nursing home
162 Medicaid overpayments and amounts transferred to contribute to
163 the General Revenue Fund pursuant to s. 215.20. If the net
164 cumulative collections, minus amounts utilized to repay nursing
165 home Medicaid overpayments, exceed \$25 million, the provisions
166 of this subparagraph shall not apply for the subsequent fiscal
167 year.

168 3. The leasehold licensee may meet the bond requirement

169 through other arrangements acceptable to the agency. The agency
170 is herein granted specific authority to promulgate rules
171 pertaining to lease bond arrangements.

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

177 5. It shall be the responsibility of all nursing facility
178 operators, operating the facility as a leasehold, to renew the
179 30-month bond and to provide proof of such renewal to the agency
180 annually.

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

195 Section 3. Paragraph (a) of subsection (3) of section
196 400.23, Florida Statutes, is amended to read:

197 400.23 Rules; evaluation and deficiencies; licensure
198 status.—

199 (3)(a)1. The agency shall adopt rules providing minimum
200 staffing requirements for nursing homes. These requirements
201 shall include, for each nursing home facility:

202 a. A minimum weekly average of certified nursing assistant
203 and licensed nursing staffing combined of 3.9 hours of direct
204 care per resident per day. As used in this sub-subparagraph, a
205 week is defined as Sunday through Saturday.

206 b. A minimum certified nursing assistant staffing of 2.7
207 hours of direct care per resident per day. A facility may not
208 staff below one certified nursing assistant per 20 residents.

209 c. A minimum licensed nursing staffing of 1.0 hour of
210 direct care per resident per day. A facility may not staff below
211 one licensed nurse per 40 residents.

212 ~~a. A minimum certified nursing assistant staffing of 2.6~~
213 ~~hours of direct care per resident per day beginning January 1,~~
214 ~~2003, and increasing to 2.7 hours of direct care per resident~~
215 ~~per day beginning January 1, 2007. Beginning January 1, 2002, no~~
216 ~~facility shall staff below one certified nursing assistant per~~
217 ~~20 residents, and a minimum licensed nursing staffing of 1.0~~
218 ~~hour of direct care per resident per day but never below one~~
219 ~~licensed nurse per 40 residents.~~

220 ~~b. Beginning January 1, 2007, a minimum weekly average~~
221 ~~certified nursing assistant staffing of 2.9 hours of direct care~~
222 ~~per resident per day. For the purpose of this sub-subparagraph,~~
223 ~~a week is defined as Sunday through Saturday.~~

224 2. Nursing assistants employed under s. 400.211(2) may be

225 included in computing the staffing ratio for certified nursing
226 assistants only if their job responsibilities include only
227 nursing-assistant-related duties.

228 3. Each nursing home must document compliance with
229 staffing standards as required under this paragraph and post
230 daily the names of staff on duty for the benefit of facility
231 residents and the public.

232 4. The agency shall recognize the use of licensed nurses
233 for compliance with minimum staffing requirements for certified
234 nursing assistants, provided that the facility otherwise meets
235 the minimum staffing requirements for licensed nurses and that
236 the licensed nurses are performing the duties of a certified
237 nursing assistant. Unless otherwise approved by the agency,
238 licensed nurses counted toward the minimum staffing requirements
239 for certified nursing assistants must exclusively perform the
240 duties of a certified nursing assistant for the entire shift and
241 not also be counted toward the minimum staffing requirements for
242 licensed nurses. If the agency approved a facility's request to
243 use a licensed nurse to perform both licensed nursing and
244 certified nursing assistant duties, the facility must allocate
245 the amount of staff time specifically spent on certified nursing
246 assistant duties for the purpose of documenting compliance with
247 minimum staffing requirements for certified and licensed nursing
248 staff. In no event may the hours of a licensed nurse with dual
249 job responsibilities be counted twice.

250 Section 4. Subsections (1) and (2) of section 409.904,
251 Florida Statutes, are amended to read:

252 409.904 Optional payments for eligible persons.—The agency

253 | may make payments for medical assistance and related services on
254 | behalf of the following persons who are determined to be
255 | eligible subject to the income, assets, and categorical
256 | eligibility tests set forth in federal and state law. Payment on
257 | behalf of these Medicaid eligible persons is subject to the
258 | availability of moneys and any limitations established by the
259 | General Appropriations Act or chapter 216.

260 | (1) Effective January 1, 2006, and subject to federal
261 | waiver approval, a person who is age 65 or older or is
262 | determined to be disabled, whose income is at or below 88
263 | percent of the federal poverty level, whose assets do not exceed
264 | established limitations, and who is not eligible for Medicare
265 | or, if eligible for Medicare, is also eligible for and receiving
266 | Medicaid-covered institutional care services, hospice services,
267 | or home and community-based services. The agency shall seek
268 | federal authorization through a waiver to provide this coverage.
269 | This subsection expires June 30, 2011 ~~December 31, 2010~~.

270 | (2) (a) A family, a pregnant woman, a child under age 21, a
271 | person age 65 or over, or a blind or disabled person, who would
272 | be eligible under any group listed in s. 409.903(1), (2), or
273 | (3), except that the income or assets of such family or person
274 | exceed established limitations. For a family or person in one of
275 | these coverage groups, medical expenses are deductible from
276 | income in accordance with federal requirements in order to make
277 | a determination of eligibility. A family or person eligible
278 | under the coverage known as the "medically needy," is eligible
279 | to receive the same services as other Medicaid recipients, with
280 | the exception of services in skilled nursing facilities and

281 intermediate care facilities for the developmentally disabled.
 282 This paragraph expires June 30, 2011 ~~December 31, 2010~~.

283 (b) Effective July 1, 2011 ~~January 1, 2011~~, a pregnant
 284 woman or a child younger than 21 years of age who would be
 285 eligible under any group listed in s. 409.903, except that the
 286 income or assets of such group exceed established limitations.
 287 For a person in one of these coverage groups, medical expenses
 288 are deductible from income in accordance with federal
 289 requirements in order to make a determination of eligibility. A
 290 person eligible under the coverage known as the "medically
 291 needy" is eligible to receive the same services as other
 292 Medicaid recipients, with the exception of services in skilled
 293 nursing facilities and intermediate care facilities for the
 294 developmentally disabled.

295 Section 5. Paragraph (f) is added to subsection (5) of
 296 section 409.905, Florida Statutes, to read:

297 409.905 Mandatory Medicaid services.—The agency may make
 298 payments for the following services, which are required of the
 299 state by Title XIX of the Social Security Act, furnished by
 300 Medicaid providers to recipients who are determined to be
 301 eligible on the dates on which the services were provided. Any
 302 service under this section shall be provided only when medically
 303 necessary and in accordance with state and federal law.
 304 Mandatory services rendered by providers in mobile units to
 305 Medicaid recipients may be restricted by the agency. Nothing in
 306 this section shall be construed to prevent or limit the agency
 307 from adjusting fees, reimbursement rates, lengths of stay,
 308 number of visits, number of services, or any other adjustments

309 necessary to comply with the availability of moneys and any
 310 limitations or directions provided for in the General
 311 Appropriations Act or chapter 216.

312 (5) HOSPITAL INPATIENT SERVICES.—The agency shall pay for
 313 all covered services provided for the medical care and treatment
 314 of a recipient who is admitted as an inpatient by a licensed
 315 physician or dentist to a hospital licensed under part I of
 316 chapter 395. However, the agency shall limit the payment for
 317 inpatient hospital services for a Medicaid recipient 21 years of
 318 age or older to 45 days or the number of days necessary to
 319 comply with the General Appropriations Act.

320 (f) The agency may develop and implement a program to
 321 reduce the number of hospital readmissions among the non-
 322 Medicare population eligible in areas 9, 10, and 11.

323 Section 6. Paragraphs (d) and (e) are added to subsection
 324 (5) of section 409.907, Florida Statutes, to read:

325 409.907 Medicaid provider agreements.—The agency may make
 326 payments for medical assistance and related services rendered to
 327 Medicaid recipients only to an individual or entity who has a
 328 provider agreement in effect with the agency, who is performing
 329 services or supplying goods in accordance with federal, state,
 330 and local law, and who agrees that no person shall, on the
 331 grounds of handicap, race, color, or national origin, or for any
 332 other reason, be subjected to discrimination under any program
 333 or activity for which the provider receives payment from the
 334 agency.

335 (5) The agency:

336 (d) May enroll entities as Medicare crossover-only

337 providers for payment and claims processing purposes only. The
338 provider agreement shall:

339 1. Require that the provider be able to demonstrate to the
340 satisfaction of the agency that the provider is an eligible
341 Medicare provider and has a current provider agreement in place
342 with the Centers for Medicare and Medicaid Services.

343 2. Require the provider to notify the agency immediately
344 in writing upon being suspended or disenrolled as a Medicare
345 provider. If the provider does not provide such notification
346 within 5 business days after suspension or disenrollment,
347 sanctions may be imposed pursuant to this chapter and the
348 provider may be required to return funds paid to the provider
349 during the period of time that the provider was suspended or
350 disenrolled as a Medicare provider.

351 3. Require that all records pertaining to health care
352 services provided to each of the provider's recipients be kept
353 for a minimum of 6 years. The agreement shall also require that
354 records and any information relating to payments claimed by the
355 provider for services under the agreement be delivered to the
356 agency or the Office of the Attorney General Medicaid Fraud
357 Control Unit when requested. If a provider does not provide such
358 records and information when requested, sanctions may be imposed
359 pursuant to this chapter.

360 4. Disclose that the agreement is for the purposes of
361 paying and processing Medicare crossover claims only.

362

363 This paragraph pertains solely to Medicare crossover-only
364 providers. In order to become a standard Medicaid provider, the

365 requirements of this section and applicable rules must be met.

366 (e) Providers that are required to post a surety bond as
 367 part of the Medicaid enrollment process are excluded for
 368 enrollment under paragraph (d).

369 Section 7. Subsection (24) is added to section 409.908,
 370 Florida Statutes, to read:

371 409.908 Reimbursement of Medicaid providers.—Subject to
 372 specific appropriations, the agency shall reimburse Medicaid
 373 providers, in accordance with state and federal law, according
 374 to methodologies set forth in the rules of the agency and in
 375 policy manuals and handbooks incorporated by reference therein.
 376 These methodologies may include fee schedules, reimbursement
 377 methods based on cost reporting, negotiated fees, competitive
 378 bidding pursuant to s. 287.057, and other mechanisms the agency
 379 considers efficient and effective for purchasing services or
 380 goods on behalf of recipients. If a provider is reimbursed based
 381 on cost reporting and submits a cost report late and that cost
 382 report would have been used to set a lower reimbursement rate
 383 for a rate semester, then the provider's rate for that semester
 384 shall be retroactively calculated using the new cost report, and
 385 full payment at the recalculated rate shall be effected
 386 retroactively. Medicare-granted extensions for filing cost
 387 reports, if applicable, shall also apply to Medicaid cost
 388 reports. Payment for Medicaid compensable services made on
 389 behalf of Medicaid eligible persons is subject to the
 390 availability of moneys and any limitations or directions
 391 provided for in the General Appropriations Act or chapter 216.
 392 Further, nothing in this section shall be construed to prevent

393 or limit the agency from adjusting fees, reimbursement rates,
 394 lengths of stay, number of visits, or number of services, or
 395 making any other adjustments necessary to comply with the
 396 availability of moneys and any limitations or directions
 397 provided for in the General Appropriations Act, provided the
 398 adjustment is consistent with legislative intent.

399 (24) If a provider fails to notify the agency within 5
 400 business days after suspension or disenrollment from Medicare,
 401 sanctions may be imposed pursuant to this chapter and the
 402 provider may be required to return funds paid to the provider
 403 during the period of time that the provider was suspended or
 404 disenrolled as a Medicare provider.

405 Section 8. Subsection (4) of section 409.9082, Florida
 406 Statutes, is amended to read:

407 409.9082 Quality assessment on nursing home facility
 408 providers; exemptions; purpose; federal approval required;
 409 remedies.—

410 (4) The purpose of the nursing home facility quality
 411 assessment is to ensure continued quality of care. Collected
 412 assessment funds shall be used to obtain federal financial
 413 participation through the Medicaid program to make Medicaid
 414 payments for nursing home facility services up to the amount of
 415 nursing home facility Medicaid rates as calculated in accordance
 416 with the approved state Medicaid plan in effect on December 31,
 417 2007. The quality assessment and federal matching funds shall be
 418 used exclusively for the following purposes and in the following
 419 order of priority:

420 (a) To reimburse the Medicaid share of the quality

421 assessment as a pass-through, Medicaid-allowable cost;

422 (b) To increase to each nursing home facility's Medicaid
 423 rate, as needed, an amount that restores ~~the~~ rate reductions
 424 effective on or after ~~implemented~~ January 1, 2008, as provided
 425 in the General Appropriations Act; ~~January 1, 2009; and March 1,~~
 426 ~~2009; and~~

427 ~~(c) To increase to each nursing home facility's Medicaid~~
 428 ~~rate, as needed, an amount that restores any rate reductions for~~
 429 ~~the 2009-2010 fiscal year; and~~

430 (c)(d) To increase each nursing home facility's Medicaid
 431 rate that accounts for the portion of the total assessment not
 432 included in paragraphs (a) and (b) ~~(a)-(e)~~ which begins a phase-
 433 in to a pricing model for the operating cost component.

434 Section 9. Subsection (3) of section 409.9083, Florida
 435 Statutes, is amended to read:

436 409.9083 Quality assessment on privately operated
 437 intermediate care facilities for the developmentally disabled;
 438 exemptions; purpose; federal approval required; remedies.-

439 (3) The purpose of the facility quality assessment is to
 440 ensure continued quality of care. Collected assessment funds
 441 shall be used to obtain federal financial participation through
 442 the Medicaid program to make Medicaid payments for ICF/DD
 443 services up to the amount of the Medicaid rates for such
 444 facilities as calculated in accordance with the approved state
 445 Medicaid plan in effect on April 1, 2008. The quality assessment
 446 and federal matching funds shall be used exclusively for the
 447 following purposes and in the following order of priority to:

448 (a) Reimburse the Medicaid share of the quality assessment

449 as a pass-through, Medicaid-allowable cost.

450 (b) Increase each privately operated ICF/DD Medicaid rate,
 451 as needed, by an amount that restores ~~the~~ rate reductions
 452 effective on or after ~~implemented on~~ October 1, 2008, as
 453 provided in the General Appropriations Act.

454 ~~(c) Increase each ICF/DD Medicaid rate, as needed, by an~~
 455 ~~amount that restores any rate reductions for the 2008-2009~~
 456 ~~fiscal year and the 2009-2010 fiscal year.~~

457 (c) ~~(d)~~ Increase payments to such facilities to fund
 458 covered services to Medicaid beneficiaries.

459 Section 10. Paragraph (a) of subsection (2) and subsection
 460 (5) of section 409.911, Florida Statutes, are amended to read:

461 409.911 Disproportionate share program.—Subject to
 462 specific allocations established within the General
 463 Appropriations Act and any limitations established pursuant to
 464 chapter 216, the agency shall distribute, pursuant to this
 465 section, moneys to hospitals providing a disproportionate share
 466 of Medicaid or charity care services by making quarterly
 467 Medicaid payments as required. Notwithstanding the provisions of
 468 s. 409.915, counties are exempt from contributing toward the
 469 cost of this special reimbursement for hospitals serving a
 470 disproportionate share of low-income patients.

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

475 (a) The average of the 2003, 2004, and 2005 audited
 476 disproportionate share data to determine each hospital's

477 Medicaid days and charity care for the 2010-2011 ~~2009-2010~~ state
 478 fiscal year.

479 (5) The following formula shall be used to pay
 480 disproportionate share dollars to provider service network (PSN)
 481 hospitals:

482
$$DSHP = TAAPSNH \times \left(\frac{IHPSND}{THPSND} \right) \text{ ~~IHPSND } \times \text{ THPSND}~~$$

483 Where:

484 DSHP = Disproportionate share hospital payments.

485 TAAPSNH = Total amount available for PSN hospitals.

486 IHPSND = Individual hospital PSN days.

487 THPSND = Total of all hospital PSN days.

488 For purposes of this subsection, the PSN inpatient days shall be
 489 provided in the General Appropriations Act.

490 Section 11. Section 409.9112, Florida Statutes, is amended
 491 to read:

492 409.9112 Disproportionate share program for regional
 493 perinatal intensive care centers.—In addition to the payments
 494 made under s. 409.911, the agency shall design and implement a
 495 system for making disproportionate share payments to those
 496 hospitals that participate in the regional perinatal intensive
 497 care center program established pursuant to chapter 383. The
 498 system of payments must conform to federal requirements and
 499 distribute funds in each fiscal year for which an appropriation
 500 is made by making quarterly Medicaid payments. Notwithstanding
 501 s. 409.915, counties are exempt from contributing toward the
 502 cost of this special reimbursement for hospitals serving a
 503 disproportionate share of low-income patients. For the 2010-2011
 504 ~~2009-2010~~ state fiscal year, the agency may not distribute

505 moneys under the regional perinatal intensive care centers
 506 disproportionate share program.

507 (1) The following formula shall be used by the agency to
 508 calculate the total amount earned for hospitals that participate
 509 in the regional perinatal intensive care center program:

$$TAE = HDSP/THDSP$$

511 Where:

512 TAE = total amount earned by a regional perinatal intensive
 513 care center.

514 HDSP = the prior state fiscal year regional perinatal
 515 intensive care center disproportionate share payment to the
 516 individual hospital.

517 THDSP = the prior state fiscal year total regional
 518 perinatal intensive care center disproportionate share payments
 519 to all hospitals.

520 (2) The total additional payment for hospitals that
 521 participate in the regional perinatal intensive care center
 522 program shall be calculated by the agency as follows:

$$TAP = TAE \times TA$$

524 Where:

525 TAP = total additional payment for a regional perinatal
 526 intensive care center.

527 TAE = total amount earned by a regional perinatal intensive
 528 care center.

529 TA = total appropriation for the regional perinatal
 530 intensive care center disproportionate share program.

531 (3) In order to receive payments under this section, a
 532 hospital must be participating in the regional perinatal

533 intensive care center program pursuant to chapter 383 and must
534 meet the following additional requirements:

535 (a) Agree to conform to all departmental and agency
536 requirements to ensure high quality in the provision of
537 services, including criteria adopted by departmental and agency
538 rule concerning staffing ratios, medical records, standards of
539 care, equipment, space, and such other standards and criteria as
540 the department and agency deem appropriate as specified by rule.

541 (b) Agree to provide information to the department and
542 agency, in a form and manner to be prescribed by rule of the
543 department and agency, concerning the care provided to all
544 patients in neonatal intensive care centers and high-risk
545 maternity care.

546 (c) Agree to accept all patients for neonatal intensive
547 care and high-risk maternity care, regardless of ability to pay,
548 on a functional space-available basis.

549 (d) Agree to develop arrangements with other maternity and
550 neonatal care providers in the hospital's region for the
551 appropriate receipt and transfer of patients in need of
552 specialized maternity and neonatal intensive care services.

553 (e) Agree to establish and provide a developmental
554 evaluation and services program for certain high-risk neonates,
555 as prescribed and defined by rule of the department.

556 (f) Agree to sponsor a program of continuing education in
557 perinatal care for health care professionals within the region
558 of the hospital, as specified by rule.

559 (g) Agree to provide backup and referral services to the
560 county health departments and other low-income perinatal

561 providers within the hospital's region, including the
 562 development of written agreements between these organizations
 563 and the hospital.

564 (h) Agree to arrange for transportation for high-risk
 565 obstetrical patients and neonates in need of transfer from the
 566 community to the hospital or from the hospital to another more
 567 appropriate facility.

568 (4) Hospitals which fail to comply with any of the
 569 conditions in subsection (3) or the applicable rules of the
 570 department and agency may not receive any payments under this
 571 section until full compliance is achieved. A hospital which is
 572 not in compliance in two or more consecutive quarters may not
 573 receive its share of the funds. Any forfeited funds shall be
 574 distributed by the remaining participating regional perinatal
 575 intensive care center program hospitals.

576 Section 12. Section 409.9113, Florida Statutes, is amended
 577 to read:

578 409.9113 Disproportionate share program for teaching
 579 hospitals.—In addition to the payments made under ss. 409.911
 580 and 409.9112, the agency shall make disproportionate share
 581 payments to statutorily defined teaching hospitals for their
 582 increased costs associated with medical education programs and
 583 for tertiary health care services provided to the indigent. This
 584 system of payments must conform to federal requirements and
 585 distribute funds in each fiscal year for which an appropriation
 586 is made by making quarterly Medicaid payments. Notwithstanding
 587 s. 409.915, counties are exempt from contributing toward the
 588 cost of this special reimbursement for hospitals serving a

589 disproportionate share of low-income patients. For the 2010-2011
 590 ~~2009-2010~~ state fiscal year, the agency shall distribute the
 591 moneys provided in the General Appropriations Act to statutorily
 592 defined teaching hospitals and family practice teaching
 593 hospitals under the teaching hospital disproportionate share
 594 program. The funds provided for statutorily defined teaching
 595 hospitals shall be distributed in the same proportion as the
 596 state fiscal year 2003-2004 teaching hospital disproportionate
 597 share funds were distributed or as otherwise provided in the
 598 General Appropriations Act. The funds provided for family
 599 practice teaching hospitals shall be distributed equally among
 600 family practice teaching hospitals.

601 (1) On or before September 15 of each year, the agency
 602 shall calculate an allocation fraction to be used for
 603 distributing funds to state statutory teaching hospitals.
 604 Subsequent to the end of each quarter of the state fiscal year,
 605 the agency shall distribute to each statutory teaching hospital,
 606 as defined in s. 408.07, an amount determined by multiplying
 607 one-fourth of the funds appropriated for this purpose by the
 608 Legislature times such hospital's allocation fraction. The
 609 allocation fraction for each such hospital shall be determined
 610 by the sum of the following three primary factors, divided by
 611 three:

612 (a) The number of nationally accredited graduate medical
 613 education programs offered by the hospital, including programs
 614 accredited by the Accreditation Council for Graduate Medical
 615 Education and the combined Internal Medicine and Pediatrics
 616 programs acceptable to both the American Board of Internal

617 Medicine and the American Board of Pediatrics at the beginning
618 of the state fiscal year preceding the date on which the
619 allocation fraction is calculated. The numerical value of this
620 factor is the fraction that the hospital represents of the total
621 number of programs, where the total is computed for all state
622 statutory teaching hospitals.

623 (b) The number of full-time equivalent trainees in the
624 hospital, which comprises two components:

625 1. The number of trainees enrolled in nationally
626 accredited graduate medical education programs, as defined in
627 paragraph (a). Full-time equivalents are computed using the
628 fraction of the year during which each trainee is primarily
629 assigned to the given institution, over the state fiscal year
630 preceding the date on which the allocation fraction is
631 calculated. The numerical value of this factor is the fraction
632 that the hospital represents of the total number of full-time
633 equivalent trainees enrolled in accredited graduate programs,
634 where the total is computed for all state statutory teaching
635 hospitals.

636 2. The number of medical students enrolled in accredited
637 colleges of medicine and engaged in clinical activities,
638 including required clinical clerkships and clinical electives.
639 Full-time equivalents are computed using the fraction of the
640 year during which each trainee is primarily assigned to the
641 given institution, over the course of the state fiscal year
642 preceding the date on which the allocation fraction is
643 calculated. The numerical value of this factor is the fraction
644 that the given hospital represents of the total number of full-

645 time equivalent students enrolled in accredited colleges of
 646 medicine, where the total is computed for all state statutory
 647 teaching hospitals.

648
 649 The primary factor for full-time equivalent trainees is computed
 650 as the sum of these two components, divided by two.

651 (c) A service index that comprises three components:

652 1. The Agency for Health Care Administration Service
 653 Index, computed by applying the standard Service Inventory
 654 Scores established by the agency to services offered by the
 655 given hospital, as reported on Worksheet A-2 for the last fiscal
 656 year reported to the agency before the date on which the
 657 allocation fraction is calculated. The numerical value of this
 658 factor is the fraction that the given hospital represents of the
 659 total Agency for Health Care Administration Service Index
 660 values, where the total is computed for all state statutory
 661 teaching hospitals.

662 2. A volume-weighted service index, computed by applying
 663 the standard Service Inventory Scores established by the Agency
 664 for Health Care Administration to the volume of each service,
 665 expressed in terms of the standard units of measure reported on
 666 Worksheet A-2 for the last fiscal year reported to the agency
 667 before the date on which the allocation factor is calculated.
 668 The numerical value of this factor is the fraction that the
 669 given hospital represents of the total volume-weighted service
 670 index values, where the total is computed for all state
 671 statutory teaching hospitals.

672 3. Total Medicaid payments to each hospital for direct

673 inpatient and outpatient services during the fiscal year
 674 preceding the date on which the allocation factor is calculated.
 675 This includes payments made to each hospital for such services
 676 by Medicaid prepaid health plans, whether the plan was
 677 administered by the hospital or not. The numerical value of this
 678 factor is the fraction that each hospital represents of the
 679 total of such Medicaid payments, where the total is computed for
 680 all state statutory teaching hospitals.

681
 682 The primary factor for the service index is computed as the sum
 683 of these three components, divided by three.

684 (2) By October 1 of each year, the agency shall use the
 685 following formula to calculate the maximum additional
 686 disproportionate share payment for statutorily defined teaching
 687 hospitals:

$$TAP = THAF \times A$$

688
 689 Where:

690 TAP = total additional payment.

691 THAF = teaching hospital allocation factor.

692 A = amount appropriated for a teaching hospital
 693 disproportionate share program.

694 Section 13. Section 409.9117, Florida Statutes, is amended
 695 to read:

696 409.9117 Primary care disproportionate share program.—For
 697 the 2010-2011 ~~2009-2010~~ state fiscal year, the agency shall not
 698 distribute moneys under the primary care disproportionate share
 699 program.

700 (1) If federal funds are available for disproportionate

701 share programs in addition to those otherwise provided by law,
 702 there shall be created a primary care disproportionate share
 703 program.

704 (2) The following formula shall be used by the agency to
 705 calculate the total amount earned for hospitals that participate
 706 in the primary care disproportionate share program:

$$707 \quad \text{TAE} = \text{HDSP} / \text{THDSP}$$

708 Where:

709 TAE = total amount earned by a hospital participating in
 710 the primary care disproportionate share program.

711 HDSP = the prior state fiscal year primary care
 712 disproportionate share payment to the individual hospital.

713 THDSP = the prior state fiscal year total primary care
 714 disproportionate share payments to all hospitals.

715 (3) The total additional payment for hospitals that
 716 participate in the primary care disproportionate share program
 717 shall be calculated by the agency as follows:

$$718 \quad \text{TAP} = \text{TAE} \times \text{TA}$$

719 Where:

720 TAP = total additional payment for a primary care hospital.

721 TAE = total amount earned by a primary care hospital.

722 TA = total appropriation for the primary care
 723 disproportionate share program.

724 (4) In the establishment and funding of this program, the
 725 agency shall use the following criteria in addition to those
 726 specified in s. 409.911, and payments may not be made to a
 727 hospital unless the hospital agrees to:

728 (a) Cooperate with a Medicaid prepaid health plan, if one

729 exists in the community.

730 (b) Ensure the availability of primary and specialty care
731 physicians to Medicaid recipients who are not enrolled in a
732 prepaid capitated arrangement and who are in need of access to
733 such physicians.

734 (c) Coordinate and provide primary care services free of
735 charge, except copayments, to all persons with incomes up to 100
736 percent of the federal poverty level who are not otherwise
737 covered by Medicaid or another program administered by a
738 governmental entity, and to provide such services based on a
739 sliding fee scale to all persons with incomes up to 200 percent
740 of the federal poverty level who are not otherwise covered by
741 Medicaid or another program administered by a governmental
742 entity, except that eligibility may be limited to persons who
743 reside within a more limited area, as agreed to by the agency
744 and the hospital.

745 (d) Contract with any federally qualified health center,
746 if one exists within the agreed geopolitical boundaries,
747 concerning the provision of primary care services, in order to
748 guarantee delivery of services in a nonduplicative fashion, and
749 to provide for referral arrangements, privileges, and
750 admissions, as appropriate. The hospital shall agree to provide
751 at an onsite or offsite facility primary care services within 24
752 hours to which all Medicaid recipients and persons eligible
753 under this paragraph who do not require emergency room services
754 are referred during normal daylight hours.

755 (e) Cooperate with the agency, the county, and other
756 entities to ensure the provision of certain public health

757 services, case management, referral and acceptance of patients,
758 and sharing of epidemiological data, as the agency and the
759 hospital find mutually necessary and desirable to promote and
760 protect the public health within the agreed geopolitical
761 boundaries.

762 (f) In cooperation with the county in which the hospital
763 resides, develop a low-cost, outpatient, prepaid health care
764 program to persons who are not eligible for the Medicaid
765 program, and who reside within the area.

766 (g) Provide inpatient services to residents within the
767 area who are not eligible for Medicaid or Medicare, and who do
768 not have private health insurance, regardless of ability to pay,
769 on the basis of available space, except that hospitals may not
770 be prevented from establishing bill collection programs based on
771 ability to pay.

772 (h) Work with the Florida Healthy Kids Corporation, the
773 Florida Health Care Purchasing Cooperative, and business health
774 coalitions, as appropriate, to develop a feasibility study and
775 plan to provide a low-cost comprehensive health insurance plan
776 to persons who reside within the area and who do not have access
777 to such a plan.

778 (i) Work with public health officials and other experts to
779 provide community health education and prevention activities
780 designed to promote healthy lifestyles and appropriate use of
781 health services.

782 (j) Work with the local health council to develop a plan
783 for promoting access to affordable health care services for all
784 persons who reside within the area, including, but not limited

785 to, public health services, primary care services, inpatient
 786 services, and affordable health insurance generally.

787
 788 Any hospital that fails to comply with any of the provisions of
 789 this subsection, or any other contractual condition, may not
 790 receive payments under this section until full compliance is
 791 achieved.

792 Section 14. Notwithstanding s. 430.707, Florida Statutes,
 793 and subject to federal approval of the application to be a site
 794 for the Program of All-inclusive Care for the Elderly, the
 795 Agency for Health Care Administration shall contract with one
 796 private health care organization, the sole member of which is a
 797 private, not-for-profit corporation that owns and manages health
 798 care organizations which provide comprehensive services,
 799 including hospice and palliative care services, to frail and
 800 elderly persons who reside in Polk, Highlands, Hardee, and
 801 Hillsborough Counties. Such an entity shall be exempt from the
 802 requirements of chapter 641, Florida Statutes. The agency, in
 803 consultation with the Department of Elderly Affairs and subject
 804 to appropriation, shall approve up to 150 initial enrollees in
 805 the Program of All-inclusive Care for the Elderly established by
 806 this organization to serve persons in Polk, Highlands, and
 807 Hardee Counties.

808 Section 15. Notwithstanding s. 430.707, Florida Statutes,
 809 and subject to federal approval of an application for expansion
 810 to a new site, the Agency for Health Care Administration shall
 811 contract with an Organized Health Care Delivery System (OHCD)
 812 in Miami-Dade County that currently offers benefits pursuant to

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2010

813 the Program of All-inclusive Care for the Elderly to provide
814 comprehensive services to frail and elderly persons residing in
815 Southwest Miami-Dade County. Such an entity shall be exempt from
816 the requirements of chapter 641, Florida Statutes. The agency,
817 in consultation with the Department of Elderly Affairs and
818 subject to appropriation, shall approve up to 50 initial
819 enrollees in the Program of All-inclusive Care for the Elderly
820 established by this organization to serve persons in Southwest
821 Miami-Dade County.

822 Section 16. This act shall take effect July 1, 2010.