20152508Ae1

1 A bill to be entitled
2 An act relating to Medicaid; amending s. 395.602,
3 F.S.; revising the term “rural hospital”; amending s.
4 409.908, F.S.; authorizing the Agency for Health Care
5 Administration to receive intergovernmental transfers
6 of funds from governmental entities for specified
7 purposes; requiring the agency to seek and maintain a
8 low-income pool under certain parameters; requiring
9 the agency to seek Medicaid waiver authority for the
10 use of local intergovernmental transfers under certain
11 parameters; requiring the Agency for Health Care
12 Administration to provide written notice, pursuant to
13 ch. 120, F.S., of reimbursement rates to providers;
14 specifying procedures and requirements to challenge
15 the calculation of or the methodology used to
16 calculate such rates; providing that the failure to
17 timely file a certain challenge constitutes acceptance
18 of the rates; specifying limits on and procedures for
19 the correction or adjustment of the rates; providing
20 applicability; prohibiting the agency from being
21 compelled by an administrative body or a court to pay
22 additional compensation that exceeds a certain amount
23 to a hospital for specified matters unless an
24 appropriation is made by law; prohibiting certain
25 periods of time from being tolled under specified
26 circumstances; specifying that an administrative
27 proceeding is the exclusive means for challenging
28 certain issues; reenacting ss. 383.18, 409.8132(4),
29 and 409.905(5)(c) and (6)(b), F.S., relating to

30 contracts for the regional perinatal intensive care
31 centers program, the Medikids program component, and
32 mandatory Medicaid services, respectively, to
33 incorporate the amendment made to s. 409.908, F.S., in
34 references thereto; amending s. 409.908, F.S.;
35 revising the list of provider types that are subject
36 to certain statutory provisions relating to the
37 establishment of rates; amending s. 409.9082, F.S.;
38 revising the date in each calendar month on which the
39 agency shall collect an assessment from nursing home
40 facility providers; amending s. 409.909, F.S.;
41 revising a term; revising the annual allocation cap
42 for hospitals participating in the Statewide Medicaid
43 Residency Program; establishing the Graduate Medical
44 Education Startup Bonus Program; providing allocations
45 for the program; amending s. 409.911, F.S.; updating
46 references to data used for calculating
47 disproportionate share program payments to certain
48 hospitals for the 2015-2016 fiscal year; amending s.
49 409.967, F.S.; requiring that certain achieved savings
50 rebates be placed in the General Revenue Fund,
51 unallocated; requiring that certain funds to support
52 Medicaid and indigent care be deposited into the
53 Grants and Donations Trust Fund; repealing s. 409.97,
54 F.S., relating to state and local Medicaid
55 partnerships; amending s. 409.975, F.S.; deleting a
56 requirement that the agency support Healthy Start
57 services with public expenditures and federal matching
58 funds; amending s. 409.983, F.S.; providing parameters

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59 for the reconciliation of managed care plan payments
60 in the long-term care managed care program;
61 authorizing the agency to partner with other states or
62 territories to provide Medicaid fiscal agent
63 operations under certain conditions and limitations;
64 amending s. 408.07, F.S.; conforming a cross-
65 reference; providing an incorporation by reference,
66 the purposes and legislative intent of the
67 incorporation, and for the expiration of the section;
68 providing a legislative determination of the
69 interdependence and interrelatedness of the act, the
70 incorporation by reference and certain specific
71 appropriations; providing that, if the act or any
72 portion of the act is determined to be
73 unconstitutional or held invalid, then all other
74 provisions or applications of the act are invalid and
75 not severable; providing for the expiration of the
76 section; providing that the act is remedial, intended
77 to confirm and clarify law, and applies to proceedings
78 pending on or commenced after the effective date;
79 providing for construction of the act in pari materia
80 with laws enacted during the 2015 Regular Session of
81 the Legislature; providing for contingent retroactive
82 operation; providing effective dates.
83
84 Be It Enacted by the Legislature of the State of Florida:
85
86 Section 1. Paragraph (e) of subsection (2) of section
87 395.602, Florida Statutes, is amended to read:

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88 395.602 Rural hospitals.—
89 (2) DEFINITIONS.—As used in this part<u>, the term</u>:
90 (e) “Rural hospital” means an acute care hospital licensed
91 under this chapter, having 100 or fewer licensed beds and an
92 emergency room, which is:
93 1. The sole provider within a county with a population
94 density of up to 100 persons per square mile;
95 2. An acute care hospital, in a county with a population
96 density of up to 100 persons per square mile, which is at least
97 30 minutes of travel time, on normally traveled roads under
98 normal traffic conditions, from any other acute care hospital
99 within the same county;
100 3. A hospital supported by a tax district or subdistrict
101 whose boundaries encompass a population of up to 100 persons per
102 square mile;
103 ~~4. A hospital classified as a sole community hospital under~~
104 ~~42 C.F.R. s. 412.92 which has up to 340 licensed beds;~~
105 <u>4.</u>~~5.~~ A hospital with a service area that has a population
106 of up to 100 persons per square mile. As used in this
107 subparagraph, the term “service area” means the fewest number of
108 zip codes that account for 75 percent of the hospital’s
109 discharges for the most recent 5-year period, based on
110 information available from the hospital inpatient discharge
111 database in the Florida Center for Health Information and Policy
112 Analysis at the agency; or
113 <u>5.</u>~~6.~~ A hospital designated as a critical access hospital,
114 as defined in s. 408.07.
115
116 Population densities used in this paragraph must be based upon

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117 the most recently completed United States census. A hospital
118 that received funds under s. 409.9116 for a quarter beginning no
119 later than July 1, 2002, is deemed to have been and shall
120 continue to be a rural hospital from that date through June 30,
121 2021 ~~2015~~, if the hospital continues to have up to 100 licensed
122 beds and an emergency room. An acute care hospital that has not
123 previously been designated as a rural hospital and that meets
124 the criteria of this paragraph shall be granted such designation
125 upon application, including supporting documentation, to the
126 agency. A hospital that was licensed as a rural hospital during
127 the 2010-2011 or 2011-2012 fiscal year shall continue to be a
128 rural hospital from the date of designation through June 30,
129 2021 ~~2015~~, if the hospital continues to have up to 100 licensed
130 beds and an emergency room.
131 Section 2. Effective upon this act becoming a law,
132 paragraphs (c) and (d) of subsection (1) of section 409.908,
133 Florida Statutes, are redesignated as paragraphs (d) and (e),
134 respectively, and new paragraphs (c) and (f) are added to that
135 subsection, to read:
136 409.908 Reimbursement of Medicaid providers.—Subject to
137 specific appropriations, the agency shall reimburse Medicaid
138 providers, in accordance with state and federal law, according
139 to methodologies set forth in the rules of the agency and in
140 policy manuals and handbooks incorporated by reference therein.
141 These methodologies may include fee schedules, reimbursement
142 methods based on cost reporting, negotiated fees, competitive
143 bidding pursuant to s. 287.057, and other mechanisms the agency
144 considers efficient and effective for purchasing services or
145 goods on behalf of recipients. If a provider is reimbursed based

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146 on cost reporting and submits a cost report late and that cost
147 report would have been used to set a lower reimbursement rate
148 for a rate semester, then the provider's rate for that semester
149 shall be retroactively calculated using the new cost report, and
150 full payment at the recalculated rate shall be effected
151 retroactively. Medicare-granted extensions for filing cost
152 reports, if applicable, shall also apply to Medicaid cost
153 reports. Payment for Medicaid compensable services made on
154 behalf of Medicaid eligible persons is subject to the
155 availability of moneys and any limitations or directions
156 provided for in the General Appropriations Act or chapter 216.
157 Further, nothing in this section shall be construed to prevent
158 or limit the agency from adjusting fees, reimbursement rates,
159 lengths of stay, number of visits, or number of services, or
160 making any other adjustments necessary to comply with the
161 availability of moneys and any limitations or directions
162 provided for in the General Appropriations Act, provided the
163 adjustment is consistent with legislative intent.
164 (1) Reimbursement to hospitals licensed under part I of
165 chapter 395 must be made prospectively or on the basis of
166 negotiation.
167 (c) The agency may receive intergovernmental transfers of
168 funds from governmental entities, including, but not limited to,
169 the Department of Health, local governments, and other local
170 political subdivisions, for the advancement of the Medicaid
171 program and for enhancing or supplementing provider
172 reimbursement under this part and part IV. The agency shall seek
173 and maintain a low-income pool in a manner authorized by federal
174 waiver and implemented under spending authority granted in the

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175 General Appropriations Act. The low-income pool must be used to
176 support enhanced access to services by offsetting shortfalls in
177 Medicaid reimbursement or paying for otherwise uncompensated
178 care, and the agency shall seek waiver authority to encourage
179 the donation of intergovernmental transfers and to utilize
180 intergovernmental transfers as the state’s share of Medicaid
181 funding within the low-income pool.
182 (f)1. Pursuant to chapter 120, the agency shall furnish to
183 providers written notice of the audited hospital cost-based per
184 diem reimbursement rate for inpatient and outpatient care
185 established by the agency. The written notice constitutes final
186 agency action. A substantially affected provider seeking to
187 correct or adjust the calculation of the audited hospital cost-
188 based per diem reimbursement rate for inpatient and outpatient
189 care, other than a challenge to the methodologies set forth in
190 the rules of the agency and in reimbursement plans incorporated
191 by reference therein used to calculate the reimbursement rate
192 for inpatient and outpatient care, may request an administrative
193 hearing to challenge the final agency action by filing a
194 petition with the agency within 180 days after receipt of the
195 written notice by the provider. The petition must include all
196 documentation supporting the challenge upon which the provider
197 intends to rely at the administrative hearing and may not be
198 amended or supplemented except as authorized under uniform rules
199 adopted pursuant to s. 120.54(5). The failure to timely file a
200 petition in compliance with this subparagraph is deemed
201 conclusive acceptance of the audited hospital cost-based per
202 diem reimbursement rate for inpatient and outpatient care
203 established by the agency.

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204 2. Any challenge to the methodologies set forth in the
205 rules of the agency and in reimbursement plans incorporated by
206 reference therein used to calculate the reimbursement rate for
207 inpatient and outpatient care may not result in a correction or
208 an adjustment of a reimbursement rate for a rate period that
209 occurred more than 5 years before the date the petition
210 initiating the proceeding was filed.
211 3. This paragraph applies to any challenge to final agency
212 action which seeks the correction or adjustment of a provider's
213 audited hospital cost-based per diem reimbursement rate for
214 inpatient and outpatient care and to any challenge to the
215 methodologies set forth in the rules of the agency and in
216 reimbursement plans incorporated by reference therein used to
217 calculate the reimbursement rate for inpatient and outpatient
218 care, including any right to challenge which arose before July
219 1, 2015. A correction or adjustment of an audited hospital cost-
220 based per diem reimbursement rate for inpatient and outpatient
221 care which is required by an administrative order or appellate
222 decision:
223 a. Must be reconciled in the first rate period after the
224 order or decision becomes final;
225 b. May not be the basis for any challenge to correct or
226 adjust hospital rates required to be paid by any Medicaid
227 managed care provider pursuant to part IV of chapter 409.
228 4. The agency may not be compelled by an administrative
229 body or a court to pay additional compensation to a hospital
230 relating to the establishment of audited hospital cost-based per
231 diem reimbursement rates by the agency or for remedies relating
232 to such rates, unless an appropriation has been made by law for

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233 the exclusive, specific purpose of paying such additional
234 compensation. As used in this subparagraph, the term
235 "appropriation made by law" has the same meaning as provided in
236 s. 11.066.
237 5. Any period of time specified in this paragraph is not
238 tolled by the pendency of any administrative or appellate
239 proceeding.
240 6. The exclusive means to challenge a written notice of an
241 audited hospital cost-based per diem reimbursement rate for
242 inpatient and outpatient care for the purpose of correcting or
243 adjusting such rate before, on, or after July 1, 2015, or to
244 challenge the methodologies set forth in the rules of the agency
245 and in reimbursement plans incorporated by reference therein
246 used to calculate the reimbursement rate for inpatient and
247 outpatient care is through an administrative proceeding pursuant
248 to chapter 120.
249 Section 3. For the purpose of incorporating paragraph (f)
250 of subsection (1) of section 409.908, Florida Statutes, as
251 created by this act, in a reference thereto, section 383.18,
252 Florida Statutes, is reenacted to read:
253 383.18 Contracts; conditions.—Participation in the regional
254 perinatal intensive care centers program under ss. 383.15-383.19
255 is contingent upon the department entering into a contract with
256 a provider. The contract shall provide that patients will
257 receive services from the center and that parents or guardians
258 of patients who participate in the program and who are in
259 compliance with Medicaid eligibility requirements as determined
260 by the department are not additionally charged for treatment and
261 care which has been contracted for by the department. Financial

262 eligibility for the program is based on the Medicaid income
263 guidelines for pregnant women and for children under 1 year of
264 age. Funding shall be provided in accordance with ss. 383.19 and
265 409.908.
266 Section 4. For the purpose of incorporating paragraph (f)
267 of subsection (1) of section 409.908, Florida Statutes, as
268 created by this act, in a reference thereto, subsection (4) of
269 section 409.8132, Florida Statutes, is reenacted to read:
270 409.8132 Medikids program component.—
271 (4) APPLICABILITY OF LAWS RELATING TO MEDICAID.—The
272 provisions of ss. 409.902, 409.905, 409.906, 409.907, 409.908,
273 409.912, 409.9121, 409.9122, 409.9123, 409.9124, 409.9127,
274 409.9128, 409.913, 409.916, 409.919, 409.920, and 409.9205 apply
275 to the administration of the Medikids program component of the
276 Florida Kidcare program, except that s. 409.9122 applies to
277 Medikids as modified by the provisions of subsection (7).
278 Section 5. For the purpose of incorporating paragraph (f)
279 of subsection (1) of section 409.908, Florida Statutes, as
280 created by this act, in references thereto, paragraph (c) of
281 subsection (5) and paragraph (b) of subsection (6) of section
282 409.905, Florida Statutes, are reenacted to read:
283 409.905 Mandatory Medicaid services.—The agency may make
284 payments for the following services, which are required of the
285 state by Title XIX of the Social Security Act, furnished by
286 Medicaid providers to recipients who are determined to be
287 eligible on the dates on which the services were provided. Any
288 service under this section shall be provided only when medically
289 necessary and in accordance with state and federal law.
290 Mandatory services rendered by providers in mobile units to

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291 Medicaid recipients may be restricted by the agency. Nothing in
292 this section shall be construed to prevent or limit the agency
293 from adjusting fees, reimbursement rates, lengths of stay,
294 number of visits, number of services, or any other adjustments
295 necessary to comply with the availability of moneys and any
296 limitations or directions provided for in the General
297 Appropriations Act or chapter 216.
298 (5) HOSPITAL INPATIENT SERVICES.—The agency shall pay for
299 all covered services provided for the medical care and treatment
300 of a recipient who is admitted as an inpatient by a licensed
301 physician or dentist to a hospital licensed under part I of
302 chapter 395. However, the agency shall limit the payment for
303 inpatient hospital services for a Medicaid recipient 21 years of
304 age or older to 45 days or the number of days necessary to
305 comply with the General Appropriations Act. Effective August 1,
306 2012, the agency shall limit payment for hospital emergency
307 department visits for a nonpregnant Medicaid recipient 21 years
308 of age or older to six visits per fiscal year.
309 (c) The agency shall implement a prospective payment
310 methodology for establishing reimbursement rates for inpatient
311 hospital services. Rates shall be calculated annually and take
312 effect July 1 of each year. The methodology shall categorize
313 each inpatient admission into a diagnosis-related group and
314 assign a relative payment weight to the base rate according to
315 the average relative amount of hospital resources used to treat
316 a patient in a specific diagnosis-related group category. The
317 agency may adopt the most recent relative weights calculated and
318 made available by the Nationwide Inpatient Sample maintained by
319 the Agency for Healthcare Research and Quality or may adopt

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320 alternative weights if the agency finds that Florida-specific
321 weights deviate with statistical significance from national
322 weights for high-volume diagnosis-related groups. The agency
323 shall establish a single, uniform base rate for all hospitals
324 unless specifically exempt pursuant to s. 409.908(1).
325 1. Adjustments may not be made to the rates after October
326 31 of the state fiscal year in which the rates take effect,
327 except for cases of insufficient collections of
328 intergovernmental transfers authorized under s. 409.908(1) or
329 the General Appropriations Act. In such cases, the agency shall
330 submit a budget amendment or amendments under chapter 216
331 requesting approval of rate reductions by amounts necessary for
332 the aggregate reduction to equal the dollar amount of
333 intergovernmental transfers not collected and the corresponding
334 federal match. Notwithstanding the $1 million limitation on
335 increases to an approved operating budget contained in ss.
336 216.181(11) and 216.292(3), a budget amendment exceeding that
337 dollar amount is subject to notice and objection procedures set
338 forth in s. 216.177.
339 2. Errors in source data or calculations discovered after
340 October 31 must be reconciled in a subsequent rate period.
341 However, the agency may not make any adjustment to a hospital's
342 reimbursement more than 5 years after a hospital is notified of
343 an audited rate established by the agency. The prohibition
344 against adjustments more than 5 years after notification is
345 remedial and applies to actions by providers involving Medicaid
346 claims for hospital services. Hospital reimbursement is subject
347 to such limits or ceilings as may be established in law or
348 described in the agency's hospital reimbursement plan. Specific

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349 exemptions to the limits or ceilings may be provided in the
350 General Appropriations Act.
351 (6) HOSPITAL OUTPATIENT SERVICES.—
352 (b) The agency shall implement a methodology for
353 establishing base reimbursement rates for outpatient services
354 for each hospital based on allowable costs, as defined by the
355 agency. Rates shall be calculated annually and take effect July
356 1 of each year based on the most recent complete and accurate
357 cost report submitted by each hospital.
358 1. Adjustments may not be made to the rates after October
359 31 of the state fiscal year in which the rates take effect,
360 except for cases of insufficient collections of
361 intergovernmental transfers authorized under s. 409.908(1) or
362 the General Appropriations Act. In such cases, the agency shall
363 submit a budget amendment or amendments under chapter 216
364 requesting approval of rate reductions by amounts necessary for
365 the aggregate reduction to equal the dollar amount of
366 intergovernmental transfers not collected and the corresponding
367 federal match. Notwithstanding the $1 million limitation on
368 increases to an approved operating budget under ss. 216.181(11)
369 and 216.292(3), a budget amendment exceeding that dollar amount
370 is subject to notice and objection procedures set forth in s.
371 216.177.
372 2. Errors in source data or calculations discovered after
373 October 31 must be reconciled in a subsequent rate period.
374 However, the agency may not make any adjustment to a hospital's
375 reimbursement more than 5 years after a hospital is notified of
376 an audited rate established by the agency. The prohibition
377 against adjustments more than 5 years after notification is

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378 remedial and applies to actions by providers involving Medicaid
379 claims for hospital services. Hospital reimbursement is subject
380 to such limits or ceilings as may be established in law or
381 described in the agency's hospital reimbursement plan. Specific
382 exemptions to the limits or ceilings may be provided in the
383 General Appropriations Act.
384 Section 6. Paragraph (c) of subsection (23) of section
385 409.908, Florida Statutes, is amended to read:
386 409.908 Reimbursement of Medicaid providers.—Subject to
387 specific appropriations, the agency shall reimburse Medicaid
388 providers, in accordance with state and federal law, according
389 to methodologies set forth in the rules of the agency and in
390 policy manuals and handbooks incorporated by reference therein.
391 These methodologies may include fee schedules, reimbursement
392 methods based on cost reporting, negotiated fees, competitive
393 bidding pursuant to s. 287.057, and other mechanisms the agency
394 considers efficient and effective for purchasing services or
395 goods on behalf of recipients. If a provider is reimbursed based
396 on cost reporting and submits a cost report late and that cost
397 report would have been used to set a lower reimbursement rate
398 for a rate semester, then the provider's rate for that semester
399 shall be retroactively calculated using the new cost report, and
400 full payment at the recalculated rate shall be effected
401 retroactively. Medicare-granted extensions for filing cost
402 reports, if applicable, shall also apply to Medicaid cost
403 reports. Payment for Medicaid compensable services made on
404 behalf of Medicaid eligible persons is subject to the
405 availability of moneys and any limitations or directions
406 provided for in the General Appropriations Act or chapter 216.

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407 Further, nothing in this section shall be construed to prevent
408 or limit the agency from adjusting fees, reimbursement rates,
409 lengths of stay, number of visits, or number of services, or
410 making any other adjustments necessary to comply with the
411 availability of moneys and any limitations or directions
412 provided for in the General Appropriations Act, provided the
413 adjustment is consistent with legislative intent.
414 (23)
415 (c) This subsection applies to the following provider
416 types:
417 1. Inpatient hospitals.
418 2. Outpatient hospitals.
419 3. Nursing homes.
420 4. County health departments.
421 ~~5. Community intermediate care facilities for the~~
422 ~~developmentally disabled.~~
423 5.~~6.~~ Prepaid health plans.
424 Section 7. Subsection (2) of section 409.9082, Florida
425 Statutes, is amended to read:
426 409.9082 Quality assessment on nursing home facility
427 providers; exemptions; purpose; federal approval required;
428 remedies.—
429 (2) A quality assessment is imposed upon each nursing home
430 facility. The aggregated amount of assessments for all nursing
431 home facilities in a given year shall be an amount not exceeding
432 the maximum percentage allowed under federal law of the total
433 aggregate net patient service revenue of assessed facilities.
434 The agency shall calculate the quality assessment rate annually
435 on a per-resident-day basis, exclusive of those resident days

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436 funded by the Medicare program, as reported by the facilities.
437 The per-resident-day assessment rate must be uniform except as
438 prescribed in subsection (3). Each facility shall report monthly
439 to the agency its total number of resident days, exclusive of
440 Medicare Part A resident days, and remit an amount equal to the
441 assessment rate times the reported number of days. The agency
442 shall collect, and each facility shall pay, the quality
443 assessment each month. The agency shall collect the assessment
444 from nursing home facility providers by the 20th ~~15th~~ day of the
445 next succeeding calendar month. The agency shall notify
446 providers of the quality assessment and provide a standardized
447 form to complete and submit with payments. The collection of the
448 nursing home facility quality assessment shall commence no
449 sooner than 5 days after the agency’s initial payment of the
450 Medicaid rates containing the elements prescribed in subsection
451 (4). Nursing home facilities may not create a separate line-item
452 charge for the purpose of passing the assessment through to
453 residents.
454 Section 8. Section 409.909, Florida Statutes, is amended to
455 read:
456 409.909 Statewide Medicaid Residency Program.—
457 (1) The Statewide Medicaid Residency Program is established
458 to improve the quality of care and access to care for Medicaid
459 recipients, expand graduate medical education on an equitable
460 basis, and increase the supply of highly trained physicians
461 statewide. The agency shall make payments to hospitals licensed
462 under part I of chapter 395 for graduate medical education
463 associated with the Medicaid program. This system of payments is
464 designed to generate federal matching funds under Medicaid and

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465 distribute the resulting funds to participating hospitals on a
466 quarterly basis in each fiscal year for which an appropriation
467 is made.
468 (2) On or before September 15 of each year, the agency
469 shall calculate an allocation fraction to be used for
470 distributing funds to participating hospitals. On or before the
471 final business day of each quarter of a state fiscal year, the
472 agency shall distribute to each participating hospital one-
473 fourth of that hospital's annual allocation calculated under
474 subsection (4). The allocation fraction for each participating
475 hospital is based on the hospital's number of full-time
476 equivalent residents and the amount of its Medicaid payments. As
477 used in this section, the term:
478 (a) "Full-time equivalent," or "FTE," means a resident who
479 is in his or her <u>residency period, with the</u> initial residency
480 period~~, which is~~ defined as the minimum number of years of
481 training required before the resident may become eligible for
482 board certification by the American Osteopathic Association
483 Bureau of Osteopathic Specialists or the American Board of
484 Medical Specialties in the specialty in which he or she first
485 began training, not to exceed 5 years. <u>The residency specialty</u>
486 <u>is defined as reported using the current residency type codes in</u>
487 <u>the Intern and Resident Information System (IRIS), required by</u>
488 <u>Medicare.</u> A resident training beyond the initial residency
489 period is counted as 0.5 FTE, unless his or her chosen specialty
490 is in ~~general surgery or~~ primary care, in which case the
491 resident is counted as 1.0 FTE. For the purposes of this
492 section, primary care specialties include:
493 1. Family medicine;

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494 2. General internal medicine;
495 3. General pediatrics;
496 4. Preventive medicine;
497 5. Geriatric medicine;
498 6. Osteopathic general practice;
499 7. Obstetrics and gynecology; ~~and~~
500 8. Emergency medicine; and
501 9. General surgery.
502 (b) "Medicaid payments" means the estimated total payments
503 for reimbursing a hospital for direct inpatient services for the
504 fiscal year in which the allocation fraction is calculated based
505 on the hospital inpatient appropriation and the parameters for
506 the inpatient diagnosis-related group base rate, including
507 applicable intergovernmental transfers, specified in the General
508 Appropriations Act, as determined by the agency.
509 (c) "Resident" means a medical intern, fellow, or resident
510 enrolled in a program accredited by the Accreditation Council
511 for Graduate Medical Education, the American Association of
512 Colleges of Osteopathic Medicine, or the American Osteopathic
513 Association at the beginning of the state fiscal year during
514 which the allocation fraction is calculated, as reported by the
515 hospital to the agency.
516 (3) The agency shall use the following formula to calculate
517 a participating hospital's allocation fraction:
518
519 HAF=[0.9 x (HFTE/TFTE)] + [0.1 x (HMP/TMP)]
520
521 Where:
522 HAF=A hospital's allocation fraction.

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523 HFTE=A hospital’s total number of FTE residents.
524 TFTE=The total FTE residents for all participating
525 hospitals.
526 HMP=A hospital’s Medicaid payments.
527 TMP=The total Medicaid payments for all participating
528 hospitals.
529
530 (4) A hospital’s annual allocation shall be calculated by
531 multiplying the funds appropriated for the Statewide Medicaid
532 Residency Program in the General Appropriations Act by that
533 hospital’s allocation fraction. If the calculation results in an
534 annual allocation that exceeds two times the average ~~$50,000~~ per
535 FTE resident amount for all hospitals, the hospital’s annual
536 allocation shall be reduced to a sum equaling no more than two
537 times the average ~~$50,000~~ per FTE resident. The funds calculated
538 for that hospital in excess of two times the average ~~$50,000~~ per
539 FTE resident amount for all hospitals shall be redistributed to
540 participating hospitals whose annual allocation does not exceed
541 two times the average ~~$50,000~~ per FTE resident amount for all
542 hospitals, using the same methodology and payment schedule
543 specified in this section.
544 (5) The Graduate Medical Education Startup Bonus Program is
545 established to provide resources for the education and training
546 of physicians in specialties which are in a statewide supply-
547 and-demand deficit. Hospitals eligible for participation in
548 subsection (1) are eligible to participate in the Graduate
549 Medical Education Startup Bonus Program established under this
550 subsection. Notwithstanding subsection (4) or an FTE’s residency
551 period, and in any state fiscal year in which funds are

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552 appropriated for the startup bonus program, the agency shall
553 allocate a $100,000 startup bonus for each newly created
554 resident position that is authorized by the Accreditation
555 Council for Graduate Medical Education or Osteopathic
556 Postdoctoral Training Institution in an initial or established
557 accredited training program that is in a physician specialty in
558 statewide supply-and-demand deficit. In any year in which
559 funding is not sufficient to provide $100,000 for each newly
560 created resident position, funding shall be reduced pro rata
561 across all newly created resident positions in physician
562 specialties in statewide supply-and-demand deficit.
563 (a) Hospitals applying for a startup bonus must submit to
564 the agency by March 1 their Accreditation Council for Graduate
565 Medical Education or Osteopathic Postdoctoral Training
566 Institution approval validating the new resident positions
567 approved in physician specialties in statewide supply-and-demand
568 deficit in the current fiscal year. An applicant hospital may
569 validate a change in the number of residents by comparing the
570 number in the prior period Accreditation Council for Graduate
571 Medical Education or Osteopathic Postdoctoral Training
572 Institution approval to the number in the current year.
573 (b) Any unobligated startup bonus funds on April 15 of each
574 fiscal year shall be proportionally allocated to hospitals
575 participating under subsection (3) for existing FTE residents in
576 the physician specialties in statewide supply-and-demand
577 deficit. This nonrecurring allocation shall be in addition to
578 the funds allocated in subsection (4). Notwithstanding
579 subsection (4), the allocation under this subsection may not
580 exceed $100,000 per FTE resident.

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581 (c) For purposes of this subsection, physician specialties
582 and subspecialties, both adult and pediatric, in statewide
583 supply-and-demand deficit are those identified in the General
584 Appropriations Act.
585 (d) The agency shall distribute all funds authorized under
586 the Graduate Medical Education Startup Bonus Program on or
587 before the final business day of the fourth quarter of a state
588 fiscal year.
589 (6) ~~(5)~~ Beginning in the 2015-2016 state fiscal year, the
590 agency shall reconcile each participating hospital's total
591 number of FTE residents calculated for the state fiscal year 2
592 years before ~~prior~~ with its most recently available Medicare
593 cost reports covering the same time period. Reconciled FTE
594 counts shall be prorated according to the portion of the state
595 fiscal year covered by a Medicare cost report. Using the same
596 definitions, methodology, and payment schedule specified in this
597 section, the reconciliation shall apply any differences in
598 annual allocations calculated under subsection (4) to the
599 current year's annual allocations.
600 (7) ~~(6)~~ The agency may adopt rules to administer this
601 section.
602 Section 9. Paragraph (a) of subsection (2) and paragraph
603 (d) of subsection (4) of section 409.911, Florida Statutes, are
604 amended to read:
605 409.911 Disproportionate share program.—Subject to specific
606 allocations established within the General Appropriations Act
607 and any limitations established pursuant to chapter 216, the
608 agency shall distribute, pursuant to this section, moneys to
609 hospitals providing a disproportionate share of Medicaid or

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610 charity care services by making quarterly Medicaid payments as
611 required. Notwithstanding the provisions of s. 409.915, counties
612 are exempt from contributing toward the cost of this special
613 reimbursement for hospitals serving a disproportionate share of
614 low-income patients.
615 (2) The Agency for Health Care Administration shall use the
616 following actual audited data to determine the Medicaid days and
617 charity care to be used in calculating the disproportionate
618 share payment:
619 (a) The average of the ~~2005, 2006, and~~ 2007, 2008, and 2009
620 audited disproportionate share data to determine each hospital's
621 Medicaid days and charity care for the 2015-2016 ~~2014-2015~~ state
622 fiscal year.
623 (4) The following formulas shall be used to pay
624 disproportionate share dollars to public hospitals:
625 (d) Any nonstate government owned or operated hospital
626 eligible for payments under this section on July 1, 2011,
627 remains eligible for payments during the 2015-2016 ~~2014-2015~~
628 state fiscal year.
629 Section 10. Paragraph (f) of subsection (3) and paragraph
630 (c) of subsection (4) of section 409.967, Florida Statutes, are
631 amended to read:
632 409.967 Managed care plan accountability.—
633 (3) ACHIEVED SAVINGS REBATE.—
634 (f) Achieved savings rebates validated by the certified
635 public accountant are due within 30 days after the report is
636 submitted. Except as provided in paragraph (h), the achieved
637 savings rebate is established by determining pretax income as a
638 percentage of revenues and applying the following income sharing

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639 ratios:
640 1. One hundred percent of income up to and including 5
641 percent of revenue shall be retained by the plan.
642 2. Fifty percent of income above 5 percent and up to 10
643 percent shall be retained by the plan, and the other 50 percent
644 refunded to the state and transferred to the General Revenue
645 Fund, unallocated.
646 3. One hundred percent of income above 10 percent of
647 revenue shall be refunded to the state and transferred to the
648 General Revenue Fund, unallocated.
649 (4) MEDICAL LOSS RATIO.—If required as a condition of a
650 waiver, the agency may calculate a medical loss ratio for
651 managed care plans. The calculation shall use uniform financial
652 data collected from all plans and shall be computed for each
653 plan on a statewide basis. The method for calculating the
654 medical loss ratio shall meet the following criteria:
655 (c) Before ~~Prior to~~ final determination of the medical loss
656 ratio for any period, a plan may contribute to a designated
657 state trust fund for the purpose of supporting Medicaid and
658 indigent care and have the contribution counted as a medical
659 expenditure for the period. Funds contributed for this purpose
660 shall be deposited into the Grants and Donations Trust Fund.
661 Section 11. Section 409.97, Florida Statutes, is repealed.
662 Section 12. Paragraph (a) of subsection (4) of section
663 409.975, Florida Statutes, is amended to read:
664 409.975 Managed care plan accountability.—In addition to
665 the requirements of s. 409.967, plans and providers
666 participating in the managed medical assistance program shall
667 comply with the requirements of this section.

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668 (4) MOMCARE NETWORK.—
669 (a) The agency shall contract with an administrative
670 services organization representing all Healthy Start Coalitions
671 providing risk appropriate care coordination and other services
672 in accordance with a federal waiver and pursuant to s. 409.906.
673 The contract shall require the network of coalitions to provide
674 counseling, education, risk-reduction and case management
675 services, and quality assurance for all enrollees of the waiver.
676 The agency shall evaluate the impact of the MomCare network by
677 monitoring each plan's performance on specific measures to
678 determine the adequacy, timeliness, and quality of services for
679 pregnant women and infants. ~~The agency shall support this~~
680 ~~contract with certified public expenditures of general revenue~~
681 ~~appropriated for Healthy Start services and any earned federal~~
682 ~~matching funds.~~
683 Section 13. Subsection (6) of section 409.983, Florida
684 Statutes, is amended to read:
685 409.983 Long-term care managed care plan payment.—In
686 addition to the payment provisions of s. 409.968, the agency
687 shall provide payment to plans in the long-term care managed
688 care program pursuant to this section.
689 (6) The agency shall establish nursing-facility-specific
690 payment rates for each licensed nursing home based on facility
691 costs adjusted for inflation and other factors as authorized in
692 the General Appropriations Act. Payments to long-term care
693 managed care plans shall be reconciled to reimburse actual
694 payments to nursing facilities resulting from changes in nursing
695 home per diem rates, but may not be reconciled to actual days
696 experienced by the long-term care managed care plans.

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697 Section 14. Effective upon this act becoming a law, the
698 Agency for Health Care Administration may partner with any other
699 state or territory for the purposes of providing Medicaid fiscal
700 agent operations only if any resulting agreement or contract
701 provides for termination when the State of Florida decides it is
702 not in the best interest of the state. Any such agreement or
703 contract may not impact Florida's current Medicaid Management
704 Information System and each state or territory shall deal
705 directly with the federal Centers for Medicare and Medicaid
706 Services independently regarding any billing or matching
707 requirements.
708 Section 15. Subsection (43) of section 408.07, Florida
709 Statutes, is amended to read:
710 408.07 Definitions.—As used in this chapter, with the
711 exception of ss. 408.031-408.045, the term:
712 (43) "Rural hospital" means an acute care hospital licensed
713 under chapter 395, having 100 or fewer licensed beds and an
714 emergency room, and which is:
715 (a) The sole provider within a county with a population
716 density of no greater than 100 persons per square mile;
717 (b) An acute care hospital, in a county with a population
718 density of no greater than 100 persons per square mile, which is
719 at least 30 minutes of travel time, on normally traveled roads
720 under normal traffic conditions, from another acute care
721 hospital within the same county;
722 (c) A hospital supported by a tax district or subdistrict
723 whose boundaries encompass a population of 100 persons or fewer
724 per square mile;
725 (d) A hospital with a service area that has a population of

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726 100 persons or fewer per square mile. As used in this paragraph,
727 the term “service area” means the fewest number of zip codes
728 that account for 75 percent of the hospital’s discharges for the
729 most recent 5-year period, based on information available from
730 the hospital inpatient discharge database in the Florida Center
731 for Health Information and Policy Analysis at the Agency for
732 Health Care Administration; or
733 (e) A critical access hospital.
734
735 Population densities used in this subsection must be based upon
736 the most recently completed United States census. A hospital
737 that received funds under s. 409.9116 for a quarter beginning no
738 later than July 1, 2002, is deemed to have been and shall
739 continue to be a rural hospital from that date through June 30,
740 2015, if the hospital continues to have 100 or fewer licensed
741 beds and an emergency room~~, or meets the criteria of s.~~
742 ~~395.602(2)(e)4~~. An acute care hospital that has not previously
743 been designated as a rural hospital and that meets the criteria
744 of this subsection shall be granted such designation upon
745 application, including supporting documentation, to the Agency
746 for Health Care Administration.
747 Section 16. The model, methodology, and framework for
748 hospital funding programs contained in the document titled
749 “Medicaid Hospital Funding Programs,” dated June 16, 2015, and
750 filed with the Secretary of the Senate, are incorporated by
751 reference for the purpose of displaying, demonstrating, and
752 explaining the calculations used by the Legislature, consistent
753 with the requirements of state law, when making appropriations
754 in the General Appropriations Act for the 2015-2016 fiscal year

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755 for the Rural Hospital Financial Assistance Program, Hospital
756 Inpatient Services, Hospital Outpatient Services, Low-Income
757 Pool, the Disproportionate Share Hospital Program, Graduate
758 Medical Education, and Prepaid Health Plans. The document titled
759 "Medicaid Hospital Funding Programs" does not allocate or
760 appropriate any funds. The Agency for Health Care Administration
761 shall rely solely on the model, methodology, and framework
762 displayed, demonstrated, and explained in the document titled
763 "Medicaid Hospital Funding Programs" and the proviso applicable
764 to appropriations for Medicaid funding when setting hospital
765 rates, calculating the hospital components of prepaid health
766 plan capitation rates, and making payments to hospitals and
767 other providers. This section expires July 1, 2016.
768 Section 17. The Legislature has determined that this act,
769 including the document titled "Medicaid Hospital Funding
770 Programs," together with the specific appropriations contained
771 in the fiscal year 2015-2016 General Appropriations Act for the
772 Rural Hospital Financial Assistance Program, Hospital Inpatient
773 Services, Hospital Outpatient Services, Low-Income Pool, the
774 Disproportionate Share Hospital Program, Graduate Medical
775 Education, and Prepaid Health Plans, are interdependent and
776 interrelated, are directly and rationally related to the overall
777 purposes of the state's Medicaid program, and are advisable only
778 if considered together and balanced when allocating the state's
779 resources, especially considering the complexities of Florida's
780 Statewide Medicaid Managed Care program; how hospital rates are
781 determined in the marketplace, including Medicaid; how the
782 individual component Medicaid appropriations impact the rates
783 Florida's Medicaid managed care entities pay for services; and

784 the large amounts of uncompensated care provided by Florida's
785 Medicaid hospital service providers and the relative potential
786 impact of that uncompensated care on the overall economic
787 viability of those institutions. If this act, or any portion of
788 this act, including the document titled "Medicaid Hospital
789 Funding Programs," or any portion thereof, is determined to be
790 unconstitutional or the applicability thereof to any person or
791 circumstance is held invalid, then: (1) such determination shall
792 render all other provisions or applications of this act invalid;
793 (2) the provisions of this act are not severable; and (3) this
794 entire act shall be deemed never to have become law. This
795 section expires July 1, 2016.
796 Section 18. Section 409.908(1)(f), Florida Statutes, as
797 created by this act, is remedial in nature, confirms and
798 clarifies existing law, and applies to all proceedings pending
799 on or commenced after this act takes effect.
800 Section 19. If any law amended by this act was also amended
801 by a law enacted during the 2015 Regular Session of the
802 Legislature, such laws shall be construed as if enacted during
803 the same session of the Legislature, and full effect shall be
804 given to each if possible.
805 Section 20. Except as otherwise expressly provided in this
806 act and except for this section, which shall take effect upon
807 this act becoming a law, this act shall take effect July 1,
808 2015, or, if this act fails to become a law until after that
809 date, it shall take effect upon becoming a law and operate
810 retroactively to July 1, 2015.

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