

By the Policy and Steering Committee on Ways and Means; the Committee on Health and Human Services Appropriations; and Senator Peaden

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1                                   A bill to be entitled  
2           An act relating to the Agency for Health Care  
3           Administration; amending s. 395.701, F.S.; increasing  
4           the assessments imposed on hospital inpatient and  
5           outpatient services and deposited into the Public  
6           Medical Assistance Trust Fund; amending s. 400.141,  
7           F.S.; conforming a cross-reference to changes made by  
8           the act; amending s. 400.23, F.S.; providing  
9           flexibility for nursing home facilities with respect  
10          to meeting minimum staffing requirements; amending s.  
11          409.906, F.S.; requiring the Agency for Health Care  
12          Administration, in consultation with the Department of  
13          Elderly Affairs, to phase out certain specified  
14          programs and to transfer the Medicaid waiver  
15          recipients to other appropriate home and community-  
16          based service programs; prohibiting certain programs  
17          from accepting new members after a specified date;  
18          requiring community-based providers to assist in the  
19          transition of enrollees and cease provision of certain  
20          waiver services by a specified date; amending s.  
21          409.9082, F.S.; revising requirements for the use of  
22          funds from nursing home quality assessments and  
23          federal matching funds; amending s. 409.9083, F.S.;  
24          revising requirements for the use of funds from  
25          quality assessments on privately operated intermediate  
26          care facility providers for the developmentally  
27          disabled and federal matching funds; amending s.  
28          409.911, F.S.; continuing the requirements for  
29          calculating the disproportionate share funds for

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30 provider service network hospitals; amending s.  
31 409.9112, F.S.; continuing the prohibition against  
32 distributing moneys under the perinatal intensive care  
33 centers disproportionate share program; amending s.  
34 409.9113, F.S.; continuing authorization for the  
35 distribution of moneys to teaching hospitals under the  
36 disproportionate share program; amending s. 409.9117,  
37 F.S.; continuing the prohibition against distributing  
38 moneys for the primary care disproportionate share  
39 program; requiring each Medicaid managed care plan and  
40 provider service network to include in its provider  
41 network any pharmacy that is located in a rural county  
42 and willing to accept the reimbursement terms and  
43 conditions established by the managed care plan or  
44 provider service agreement; providing a contingent  
45 effective date.

46  
47 Be It Enacted by the Legislature of the State of Florida:

48  
49 Section 1. Subsection (2) of section 395.701, Florida  
50 Statutes, is amended to read:

51 395.701 Annual assessments on net operating revenues for  
52 inpatient and outpatient services to fund public medical  
53 assistance; administrative fines for failure to pay assessments  
54 when due; exemption.—

55 (2) (a) There is imposed upon each hospital an assessment in  
56 an amount equal to 2 ~~1.5~~ percent of the annual net operating  
57 revenue for inpatient services for each hospital, such revenue  
58 to be determined by the agency, based on the actual experience

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59 of the hospital as reported to the agency. Within 6 months after  
60 the end of each hospital fiscal year, the agency shall certify  
61 the amount of the assessment for each hospital. The assessment  
62 shall be payable to and collected by the agency in equal  
63 quarterly amounts, on or before the first day of each calendar  
64 quarter, beginning with the first full calendar quarter that  
65 occurs after the agency certifies the amount of the assessment  
66 for each hospital. All moneys collected pursuant to this  
67 subsection shall be deposited into the Public Medical Assistance  
68 Trust Fund.

69 (b) There is imposed upon each hospital an assessment in an  
70 amount equal to 1.5 ± percent of the annual net operating  
71 revenue for outpatient services for each hospital, such revenue  
72 to be determined by the agency, based on the actual experience  
73 of the hospital as reported to the agency. While prior year  
74 report worksheets may be reconciled to the hospital's audited  
75 financial statements, no additional audited financial components  
76 may be required for the purposes of determining the amount of  
77 the assessment imposed pursuant to this section other than those  
78 in effect on July 1, 2000. Within 6 months after the end of each  
79 hospital fiscal year, the agency shall certify the amount of the  
80 assessment for each hospital. The assessment shall be payable to  
81 and collected by the agency in equal quarterly amounts, on or  
82 before the first day of each calendar quarter, beginning with  
83 the first full calendar quarter that occurs after the agency  
84 certifies the amount of the assessment for each hospital. All  
85 moneys collected pursuant to this subsection shall be deposited  
86 into the Public Medical Assistance Trust Fund.

87 Section 2. Paragraph (o) of subsection (1) of section

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88 400.141, Florida Statutes, is amended to read:

89 400.141 Administration and management of nursing home  
90 facilities.—

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

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

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

103 b. Staff turnover must be reported for the most recent 12-  
104 month period ending on the last workday of the most recent  
105 calendar quarter prior to the date the information is submitted.  
106 The turnover rate must be computed quarterly, with the annual  
107 rate being the cumulative sum of the quarterly rates. The  
108 turnover rate is the total number of terminations or separations  
109 experienced during the quarter, excluding any employee  
110 terminated during a probationary period of 3 months or less,  
111 divided by the total number of staff employed at the end of the  
112 period for which the rate is computed, and expressed as a  
113 percentage.

114 c. The formula for determining staff stability is the total  
115 number of employees that have been employed for more than 12  
116 months, divided by the total number of employees employed at the

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117 end of the most recent calendar quarter, and expressed as a  
118 percentage.

119 d. A nursing facility that has failed to comply with state  
120 minimum-staffing requirements for 2 consecutive days is  
121 prohibited from accepting new admissions until the facility has  
122 achieved the minimum-staffing requirements for a period of 6  
123 consecutive days. For the purposes of this sub-subparagraph, any  
124 person who was a resident of the facility and was absent from  
125 the facility for the purpose of receiving medical care at a  
126 separate location or was on a leave of absence is not considered  
127 a new admission. Failure to impose such an admissions moratorium  
128 constitutes a class II deficiency.

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

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

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

140 Section 3. Paragraph (a) of subsection (3) of section  
141 400.23, Florida Statutes, is amended to read:

142 400.23 Rules; evaluation and deficiencies; licensure  
143 status.—

144 (3)(a)1. The agency shall adopt rules providing minimum  
145 staffing requirements for nursing homes. These requirements

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146 shall include, for each nursing home facility:

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

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

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

157 ~~a. A minimum certified nursing assistant staffing of 2.6~~  
158 ~~hours of direct care per resident per day beginning January 1,~~  
159 ~~2003, and increasing to 2.7 hours of direct care per resident~~  
160 ~~per day beginning January 1, 2007. Beginning January 1, 2002, no~~  
161 ~~facility shall staff below one certified nursing assistant per~~  
162 ~~20 residents, and a minimum licensed nursing staffing of 1.0~~  
163 ~~hour of direct care per resident per day but never below one~~  
164 ~~licensed nurse per 40 residents.~~

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

169 2. Nursing assistants employed under s. 400.211(2) may be  
170 included in computing the staffing ratio for certified nursing  
171 assistants only if their job responsibilities include only  
172 nursing-assistant-related duties.

173 3. Each nursing home must document compliance with staffing  
174 standards as required under this paragraph and post daily the

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175 names of staff on duty for the benefit of facility residents and  
176 the public.

177 4. The agency shall recognize the use of licensed nurses  
178 for compliance with minimum staffing requirements for certified  
179 nursing assistants, provided that the facility otherwise meets  
180 the minimum staffing requirements for licensed nurses and that  
181 the licensed nurses are performing the duties of a certified  
182 nursing assistant. Unless otherwise approved by the agency,  
183 licensed nurses counted toward the minimum staffing requirements  
184 for certified nursing assistants must exclusively perform the  
185 duties of a certified nursing assistant for the entire shift and  
186 not also be counted toward the minimum staffing requirements for  
187 licensed nurses. If the agency approved a facility's request to  
188 use a licensed nurse to perform both licensed nursing and  
189 certified nursing assistant duties, the facility must allocate  
190 the amount of staff time specifically spent on certified nursing  
191 assistant duties for the purpose of documenting compliance with  
192 minimum staffing requirements for certified and licensed nursing  
193 staff. In no event may the hours of a licensed nurse with dual  
194 job responsibilities be counted twice.

195 Section 4. Paragraph (d) is added to subsection (13) of  
196 section 409.906, Florida Statutes, to read:

197 409.906 Optional Medicaid services.—Subject to specific  
198 appropriations, the agency may make payments for services which  
199 are optional to the state under Title XIX of the Social Security  
200 Act and are furnished by Medicaid providers to recipients who  
201 are determined to be eligible on the dates on which the services  
202 were provided. Any optional service that is provided shall be  
203 provided only when medically necessary and in accordance with

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204 state and federal law. Optional services rendered by providers  
205 in mobile units to Medicaid recipients may be restricted or  
206 prohibited by the agency. Nothing in this section shall be  
207 construed to prevent or limit the agency from adjusting fees,  
208 reimbursement rates, lengths of stay, number of visits, or  
209 number of services, or making any other adjustments necessary to  
210 comply with the availability of moneys and any limitations or  
211 directions provided for in the General Appropriations Act or  
212 chapter 216. If necessary to safeguard the state's systems of  
213 providing services to elderly and disabled persons and subject  
214 to the notice and review provisions of s. 216.177, the Governor  
215 may direct the Agency for Health Care Administration to amend  
216 the Medicaid state plan to delete the optional Medicaid service  
217 known as "Intermediate Care Facilities for the Developmentally  
218 Disabled." Optional services may include:

219 (13) HOME AND COMMUNITY-BASED SERVICES.—

220 (d) The agency, in consultation with the Department of  
221 Elderly Affairs, shall phase out the adult day health care and  
222 Channeling Services waiver programs and transfer existing waiver  
223 enrollees to other appropriate home and community-based service  
224 programs. Effective July 1, 2010, the adult day health care, and  
225 Channeling Services waiver programs shall cease to enroll new  
226 members. Existing enrollees in the adult day health care and  
227 Channeling Services programs shall receive counseling regarding  
228 available options and shall be offered an alternative home and  
229 community-based services program based on eligibility and  
230 personal choice. Each enrollee in the waiver program shall  
231 continue to receive home and community-based services without  
232 interruption in the enrollee's program of choice. The providers



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233 of the adult day health care and Channeling Services waiver  
234 programs, in consultation with the area agencies on aging, shall  
235 assist in the transition of enrollees. Provision of adult day  
236 health care and Channeling Services waiver services shall cease  
237 by December 31, 2010. The agency may seek federal waiver  
238 approval to administer this change.

239 Section 5. Subsections (4) and (6) of section 409.9082,  
240 Florida Statutes, are amended to read:

241 409.9082 Quality assessment on nursing home facility  
242 providers; exemptions; purpose; federal approval required;  
243 remedies.—

244 (4) The purpose of the nursing home facility quality  
245 assessment is to ensure continued quality of care. Collected  
246 assessment funds shall be used to obtain federal financial  
247 participation through the Medicaid program to make Medicaid  
248 payments for nursing home facility services up to the amount of  
249 nursing home facility Medicaid rates as calculated in accordance  
250 with the approved state Medicaid plan in effect on December 31,  
251 2007. The quality assessment and federal matching funds shall be  
252 used exclusively for the following purposes and in the following  
253 order of priority:

254 (a) To reimburse the Medicaid share of the quality  
255 assessment as a pass-through, Medicaid-allowable cost;

256 (b) To increase to each nursing home facility's Medicaid  
257 rate, as needed, up to an amount that restores the rate  
258 reductions implemented January 1, 2008; January 1, 2009; ~~and~~  
259 March 1, 2009; and July 1, 2009;

260 (c) To increase to each nursing home facility's Medicaid  
261 rate, as needed, up to an amount that restores any rate

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262 reductions for the 2010-2011 ~~2009-2010~~ fiscal year; and

263 (d) To increase each nursing home facility's Medicaid rate  
264 that accounts for the portion of the total assessment not  
265 included in paragraphs (a)-(c) which begins a phase-in to a  
266 pricing model for the operating cost component.

267 (6) The quality assessment shall terminate and the agency  
268 shall discontinue the imposition, assessment, and collection of  
269 the nursing facility quality assessment if the agency does not  
270 obtain necessary federal approval for the nursing home facility  
271 quality assessment ~~or the payment rates required by subsection~~  
272 ~~(4)~~. Upon termination, all collected assessment revenues, less  
273 any amounts expended by the agency, shall be returned on a pro  
274 rata basis to the nursing facilities that paid them.

275 Section 6. Subsections (3) and (5) of section 409.9083,  
276 Florida Statutes, are amended to read:

277 409.9083 Quality assessment on privately operated  
278 intermediate care facilities for the developmentally disabled;  
279 exemptions; purpose; federal approval required; remedies.-

280 (3) The purpose of the facility quality assessment is to  
281 ensure continued quality of care. Collected assessment funds  
282 shall be used to obtain federal financial participation through  
283 the Medicaid program to make Medicaid payments for ICF/DD  
284 services up to the amount of the Medicaid rates for such  
285 facilities as calculated in accordance with the approved state  
286 Medicaid plan in effect on April 1, 2008. The quality assessment  
287 and federal matching funds shall be used exclusively for the  
288 following purposes and in the following order of priority to:

289 (a) Reimburse the Medicaid share of the quality assessment  
290 as a pass-through, Medicaid-allowable cost.

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291 (b) Increase each privately operated ICF/DD Medicaid rate,  
292 as needed, by an amount that restores the rate reductions  
293 implemented on October 1, 2008.

294 (c) Increase each ICF/DD Medicaid rate, as needed, by an  
295 amount that restores any rate reductions for the 2008-2009  
296 fiscal year, ~~and~~ the 2009-2010 fiscal year, and the 2010-2011  
297 fiscal year.

298 (d) Increase payments to such facilities to fund covered  
299 services to Medicaid beneficiaries.

300 (5) (a) The quality assessment shall terminate and the  
301 agency shall discontinue the imposition, assessment, and  
302 collection of the quality assessment if the agency does not  
303 obtain necessary federal approval for the facility quality  
304 assessment ~~or the payment rates required by subsection (3).~~

305 (b) Upon termination of the quality assessment, all  
306 collected assessment revenues, less any amounts expended by the  
307 agency, shall be returned on a pro rata basis to the facilities  
308 that paid such assessments.

309 Section 7. Paragraph (a) of subsection (2) of section  
310 409.911, Florida Statutes, is amended to read:

311 409.911 Disproportionate share program.—Subject to specific  
312 allocations established within the General Appropriations Act  
313 and any limitations established pursuant to chapter 216, the  
314 agency shall distribute, pursuant to this section, moneys to  
315 hospitals providing a disproportionate share of Medicaid or  
316 charity care services by making quarterly Medicaid payments as  
317 required. Notwithstanding the provisions of s. 409.915, counties  
318 are exempt from contributing toward the cost of this special  
319 reimbursement for hospitals serving a disproportionate share of

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320 low-income patients.

321 (2) The Agency for Health Care Administration shall use the  
322 following actual audited data to determine the Medicaid days and  
323 charity care to be used in calculating the disproportionate  
324 share payment:

325 (a) The average of the 2003, 2004, and 2005 audited  
326 disproportionate share data to determine each hospital's  
327 Medicaid days and charity care for the 2010-2011 ~~2009-2010~~ state  
328 fiscal year.

329 Section 8. Section 409.9112, Florida Statutes, is amended  
330 to read:

331 409.9112 Disproportionate share program for regional  
332 perinatal intensive care centers.—In addition to the payments  
333 made under s. 409.911, the agency shall design and implement a  
334 system for making disproportionate share payments to those  
335 hospitals that participate in the regional perinatal intensive  
336 care center program established pursuant to chapter 383. The  
337 system of payments must conform to federal requirements and  
338 distribute funds in each fiscal year for which an appropriation  
339 is made by making quarterly Medicaid payments. Notwithstanding  
340 s. 409.915, counties are exempt from contributing toward the  
341 cost of this special reimbursement for hospitals serving a  
342 disproportionate share of low-income patients. For the 2010-2011  
343 ~~2009-2010~~ state fiscal year, the agency may not distribute  
344 moneys under the regional perinatal intensive care centers  
345 disproportionate share program.

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

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349 TAE = HDSP/THDSP

350

351 Where:

352 TAE = total amount earned by a regional perinatal intensive  
353 care center.

354 HDSP = the prior state fiscal year regional perinatal  
355 intensive care center disproportionate share payment to the  
356 individual hospital.

357 THDSP = the prior state fiscal year total regional  
358 perinatal intensive care center disproportionate share payments  
359 to all hospitals.

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

363 TAP = TAE x TA

364

365 Where:

366 TAP = total additional payment for a regional perinatal  
367 intensive care center.

368 TAE = total amount earned by a regional perinatal intensive  
369 care center.

370 TA = total appropriation for the regional perinatal  
371 intensive care center disproportionate share program.

372 (3) In order to receive payments under this section, a  
373 hospital must be participating in the regional perinatal  
374 intensive care center program pursuant to chapter 383 and must  
375 meet the following additional requirements:

376 (a) Agree to conform to all departmental and agency  
377 requirements to ensure high quality in the provision of

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378 services, including criteria adopted by departmental and agency  
379 rule concerning staffing ratios, medical records, standards of  
380 care, equipment, space, and such other standards and criteria as  
381 the department and agency deem appropriate as specified by rule.

382 (b) Agree to provide information to the department and  
383 agency, in a form and manner to be prescribed by rule of the  
384 department and agency, concerning the care provided to all  
385 patients in neonatal intensive care centers and high-risk  
386 maternity care.

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

390 (d) Agree to develop arrangements with other maternity and  
391 neonatal care providers in the hospital's region for the  
392 appropriate receipt and transfer of patients in need of  
393 specialized maternity and neonatal intensive care services.

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

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

400 (g) Agree to provide backup and referral services to the  
401 county health departments and other low-income perinatal  
402 providers within the hospital's region, including the  
403 development of written agreements between these organizations  
404 and the hospital.

405 (h) Agree to arrange for transportation for high-risk  
406 obstetrical patients and neonates in need of transfer from the

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407 community to the hospital or from the hospital to another more  
408 appropriate facility.

409 (4) Hospitals which fail to comply with any of the  
410 conditions in subsection (3) or the applicable rules of the  
411 department and agency may not receive any payments under this  
412 section until full compliance is achieved. A hospital which is  
413 not in compliance in two or more consecutive quarters may not  
414 receive its share of the funds. Any forfeited funds shall be  
415 distributed by the remaining participating regional perinatal  
416 intensive care center program hospitals.

417 Section 9. Section 409.9113, Florida Statutes, is amended  
418 to read:

419 409.9113 Disproportionate share program for teaching  
420 hospitals.—In addition to the payments made under ss. 409.911  
421 and 409.9112, the agency shall make disproportionate share  
422 payments to statutorily defined teaching hospitals for their  
423 increased costs associated with medical education programs and  
424 for tertiary health care services provided to the indigent. This  
425 system of payments must conform to federal requirements and  
426 distribute funds in each fiscal year for which an appropriation  
427 is made by making quarterly Medicaid payments. Notwithstanding  
428 s. 409.915, counties are exempt from contributing toward the  
429 cost of this special reimbursement for hospitals serving a  
430 disproportionate share of low-income patients. For the 2010-2011  
431 ~~2009-2010~~ state fiscal year, the agency shall distribute the  
432 moneys provided in the General Appropriations Act to statutorily  
433 defined teaching hospitals and family practice teaching  
434 hospitals under the teaching hospital disproportionate share  
435 program. The funds provided for statutorily defined teaching

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436 hospitals shall be distributed in the same proportion as the  
437 state fiscal year 2003-2004 teaching hospital disproportionate  
438 share funds were distributed or as otherwise provided in the  
439 General Appropriations Act. The funds provided for family  
440 practice teaching hospitals shall be distributed equally among  
441 family practice teaching hospitals.

442 (1) On or before September 15 of each year, the agency  
443 shall calculate an allocation fraction to be used for  
444 distributing funds to state statutory teaching hospitals.  
445 Subsequent to the end of each quarter of the state fiscal year,  
446 the agency shall distribute to each statutory teaching hospital,  
447 as defined in s. 408.07, an amount determined by multiplying  
448 one-fourth of the funds appropriated for this purpose by the  
449 Legislature times such hospital's allocation fraction. The  
450 allocation fraction for each such hospital shall be determined  
451 by the sum of the following three primary factors, divided by  
452 three:

453 (a) The number of nationally accredited graduate medical  
454 education programs offered by the hospital, including programs  
455 accredited by the Accreditation Council for Graduate Medical  
456 Education and the combined Internal Medicine and Pediatrics  
457 programs acceptable to both the American Board of Internal  
458 Medicine and the American Board of Pediatrics at the beginning  
459 of the state fiscal year preceding the date on which the  
460 allocation fraction is calculated. The numerical value of this  
461 factor is the fraction that the hospital represents of the total  
462 number of programs, where the total is computed for all state  
463 statutory teaching hospitals.

464 (b) The number of full-time equivalent trainees in the



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465 hospital, which comprises two components:

466 1. The number of trainees enrolled in nationally accredited  
467 graduate medical education programs, as defined in paragraph  
468 (a). Full-time equivalents are computed using the fraction of  
469 the year during which each trainee is primarily assigned to the  
470 given institution, over the state fiscal year preceding the date  
471 on which the allocation fraction is calculated. The numerical  
472 value of this factor is the fraction that the hospital  
473 represents of the total number of full-time equivalent trainees  
474 enrolled in accredited graduate programs, where the total is  
475 computed for all state statutory teaching hospitals.

476 2. The number of medical students enrolled in accredited  
477 colleges of medicine and engaged in clinical activities,  
478 including required clinical clerkships and clinical electives.  
479 Full-time equivalents are computed using the fraction of the  
480 year during which each trainee is primarily assigned to the  
481 given institution, over the course of the state fiscal year  
482 preceding the date on which the allocation fraction is  
483 calculated. The numerical value of this factor is the fraction  
484 that the given hospital represents of the total number of full-  
485 time equivalent students enrolled in accredited colleges of  
486 medicine, where the total is computed for all state statutory  
487 teaching hospitals.

488  
489 The primary factor for full-time equivalent trainees is computed  
490 as the sum of these two components, divided by two.

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

492 1. The Agency for Health Care Administration Service Index,  
493 computed by applying the standard Service Inventory Scores

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494 established by the agency to services offered by the given  
495 hospital, as reported on Worksheet A-2 for the last fiscal year  
496 reported to the agency before the date on which the allocation  
497 fraction is calculated. The numerical value of this factor is  
498 the fraction that the given hospital represents of the total  
499 Agency for Health Care Administration Service Index values,  
500 where the total is computed for all state statutory teaching  
501 hospitals.

502 2. A volume-weighted service index, computed by applying  
503 the standard Service Inventory Scores established by the Agency  
504 for Health Care Administration to the volume of each service,  
505 expressed in terms of the standard units of measure reported on  
506 Worksheet A-2 for the last fiscal year reported to the agency  
507 before the date on which the allocation factor is calculated.  
508 The numerical value of this factor is the fraction that the  
509 given hospital represents of the total volume-weighted service  
510 index values, where the total is computed for all state  
511 statutory teaching hospitals.

512 3. Total Medicaid payments to each hospital for direct  
513 inpatient and outpatient services during the fiscal year  
514 preceding the date on which the allocation factor is calculated.  
515 This includes payments made to each hospital for such services  
516 by Medicaid prepaid health plans, whether the plan was  
517 administered by the hospital or not. The numerical value of this  
518 factor is the fraction that each hospital represents of the  
519 total of such Medicaid payments, where the total is computed for  
520 all state statutory teaching hospitals.

521  
522 The primary factor for the service index is computed as the sum

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523 of these three components, divided by three.

524 (2) By October 1 of each year, the agency shall use the  
525 following formula to calculate the maximum additional  
526 disproportionate share payment for statutorily defined teaching  
527 hospitals:

$$528 \quad \text{TAP} = \text{THAF} \times \text{A}$$

529

530 Where:

531 TAP = total additional payment.

532 THAF = teaching hospital allocation factor.

533 A = amount appropriated for a teaching hospital  
534 disproportionate share program.

535 Section 10. Section 409.9117, Florida Statutes, is amended  
536 to read:

537 409.9117 Primary care disproportionate share program.—For  
538 the 2010-2011 ~~2009-2010~~ state fiscal year, the agency shall not  
539 distribute moneys under the primary care disproportionate share  
540 program.

541 (1) If federal funds are available for disproportionate  
542 share programs in addition to those otherwise provided by law,  
543 there shall be created a primary care disproportionate share  
544 program.

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

$$548 \quad \text{TAE} = \text{HDSP}/\text{THDSP}$$

549

550 Where:

551 TAE = total amount earned by a hospital participating in

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552 the primary care disproportionate share program.

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

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

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

560 
$$TAP = TAE \times TA$$

561

562 Where:

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

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

565 TA = total appropriation for the primary care  
566 disproportionate share program.

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

571 (a) Cooperate with a Medicaid prepaid health plan, if one  
572 exists in the community.

573 (b) Ensure the availability of primary and specialty care  
574 physicians to Medicaid recipients who are not enrolled in a  
575 prepaid capitated arrangement and who are in need of access to  
576 such physicians.

577 (c) Coordinate and provide primary care services free of  
578 charge, except copayments, to all persons with incomes up to 100  
579 percent of the federal poverty level who are not otherwise  
580 covered by Medicaid or another program administered by a

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581 governmental entity, and to provide such services based on a  
582 sliding fee scale to all persons with incomes up to 200 percent  
583 of the federal poverty level who are not otherwise covered by  
584 Medicaid or another program administered by a governmental  
585 entity, except that eligibility may be limited to persons who  
586 reside within a more limited area, as agreed to by the agency  
587 and the hospital.

588 (d) Contract with any federally qualified health center, if  
589 one exists within the agreed geopolitical boundaries, concerning  
590 the provision of primary care services, in order to guarantee  
591 delivery of services in a nonduplicative fashion, and to provide  
592 for referral arrangements, privileges, and admissions, as  
593 appropriate. The hospital shall agree to provide at an onsite or  
594 offsite facility primary care services within 24 hours to which  
595 all Medicaid recipients and persons eligible under this  
596 paragraph who do not require emergency room services are  
597 referred during normal daylight hours.

598 (e) Cooperate with the agency, the county, and other  
599 entities to ensure the provision of certain public health  
600 services, case management, referral and acceptance of patients,  
601 and sharing of epidemiological data, as the agency and the  
602 hospital find mutually necessary and desirable to promote and  
603 protect the public health within the agreed geopolitical  
604 boundaries.

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

609 (g) Provide inpatient services to residents within the area

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610 who are not eligible for Medicaid or Medicare, and who do not  
611 have private health insurance, regardless of ability to pay, on  
612 the basis of available space, except that hospitals may not be  
613 prevented from establishing bill collection programs based on  
614 ability to pay.

615 (h) Work with the Florida Healthy Kids Corporation, the  
616 Florida Health Care Purchasing Cooperative, and business health  
617 coalitions, as appropriate, to develop a feasibility study and  
618 plan to provide a low-cost comprehensive health insurance plan  
619 to persons who reside within the area and who do not have access  
620 to such a plan.

621 (i) Work with public health officials and other experts to  
622 provide community health education and prevention activities  
623 designed to promote healthy lifestyles and appropriate use of  
624 health services.

625 (j) Work with the local health council to develop a plan  
626 for promoting access to affordable health care services for all  
627 persons who reside within the area, including, but not limited  
628 to, public health services, primary care services, inpatient  
629 services, and affordable health insurance generally.

630  
631 Any hospital that fails to comply with any of the provisions of  
632 this subsection, or any other contractual condition, may not  
633 receive payments under this section until full compliance is  
634 achieved.

635 Section 11. Notwithstanding any other provision of law,  
636 each Medicaid managed care plan and provider service network  
637 shall include in its provider network any pharmacy that is  
638 licensed under chapter 465, Florida Statutes, located in a rural

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639 county, and willing to accept the reimbursement terms and  
640 conditions established by the Medicaid managed care plan or the  
641 provider service agreement. As used in this section, a "rural  
642 county" means a county that has a population of fewer than  
643 200,000 residents, based upon the 2000 official census.

644 Section 12. This act shall take effect July 1, 2010;  
645 however, the amendments made by section 1 of this act do not  
646 take effect if federal law extends the enhanced Federal Medicaid  
647 Assistance Percentage rate, as provided under the American  
648 Reinvestment and Recovery Act (Pub. L. No. 111-5), from December  
649 31, 2010, through June 30, 2011.