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LEGISLATIVE ACTION

Senate	.	House
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Floor: 1/AD/2R	.	
04/06/2010 10:19 AM	.	
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Senator Peaden moved the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

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

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

(2)(a) There is imposed upon each hospital an assessment in an amount equal to 2 ~~1.5~~ percent of the annual net operating revenue for inpatient services for each hospital, such revenue

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

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


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Section 2. 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 period for which the rate is computed, and expressed as a percentage.

c. The formula for determining staff stability is the total number of employees that have been employed for more than 12

months, divided by the total number of employees employed at the end of the most recent calendar quarter, and expressed as a percentage.

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

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

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

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

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

400.23 Rules; evaluation and deficiencies; licensure status.—

(3)(a)1. The agency shall adopt rules providing minimum


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staffing requirements for nursing homes. These requirements shall include, for each nursing home facility:

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

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

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

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

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

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

3. Each nursing home must document compliance with staffing

standards as required under this paragraph and post daily the names of staff on duty for the benefit of facility residents and the public.

4. The agency shall recognize the use of licensed nurses for compliance with minimum staffing requirements for certified nursing assistants, provided that the facility otherwise meets the minimum staffing requirements for licensed nurses and that the licensed nurses are performing the duties of a certified nursing assistant. Unless otherwise approved by the agency, licensed nurses counted toward the minimum staffing requirements for certified nursing assistants must exclusively perform the duties of a certified nursing assistant for the entire shift and not also be counted toward the minimum staffing requirements for licensed nurses. If the agency approved a facility's request to use a licensed nurse to perform both licensed nursing and certified nursing assistant duties, the facility must allocate the amount of staff time specifically spent on certified nursing assistant duties for the purpose of documenting compliance with minimum staffing requirements for certified and licensed nursing staff. In no event may the hours of a licensed nurse with dual job responsibilities be counted twice.

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

409.906 Optional Medicaid services.—Subject to specific appropriations, the agency may make payments for services which are optional to the state under Title XIX of the Social Security Act and are furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any optional service that is provided shall be


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

(13) HOME AND COMMUNITY-BASED SERVICES.—

(d) The agency, in consultation with the Department of Elderly Affairs, shall phase out the adult day health care and Channeling Services waiver programs and transfer existing waiver enrollees to other appropriate home and community-based service programs. Effective July 1, 2010, the adult day health care, and Channeling Services waiver programs shall cease to enroll new members. Existing enrollees in the adult day health care and Channeling Services programs shall receive counseling regarding available options and shall be offered an alternative home and community-based services program based on eligibility and personal choice. Each enrollee in the waiver program shall continue to receive home and community-based services without


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interruption in the enrollee's program of choice. The providers of the adult day health care and Channeling Services waiver programs, in consultation with the area agencies on aging, shall assist in the transition of enrollees. Provision of adult day health care and Channeling Services waiver services shall cease by December 31, 2010. The agency may seek federal waiver approval to administer this change.

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

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

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

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

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

(c) To increase to each nursing home facility's Medicaid

rate, as needed, up to an amount that restores any rate reductions for the 2010-2011 ~~2009-2010~~ fiscal year; and

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

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

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

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

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

(a) Reimburse the Medicaid share of the quality assessment

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as a pass-through, Medicaid-allowable cost.

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

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

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

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

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

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

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


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reimbursement for hospitals serving a disproportionate share of low-income patients.

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

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

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

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

(1) The following formula shall be used by the agency to calculate the total amount earned for hospitals that participate

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in the regional perinatal intensive care center program:

TAE = HDSP/THDSP

Where:

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

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

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

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

TAP = TAE x TA

Where:

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

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

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

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

(a) Agree to conform to all departmental and agency

requirements to ensure high quality in the provision of services, including criteria adopted by departmental and agency rule concerning staffing ratios, medical records, standards of care, equipment, space, and such other standards and criteria as the department and agency deem appropriate as specified by rule.

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

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

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

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

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

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

(h) Agree to arrange for transportation for high-risk


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obstetrical patients and neonates in need of transfer from the community to the hospital or from the hospital to another more appropriate facility.

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

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

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

program. The funds provided for statutorily defined teaching hospitals shall be distributed in the same proportion as the state fiscal year 2003-2004 teaching hospital disproportionate share funds were distributed or as otherwise provided in the General Appropriations Act. The funds provided for family practice teaching hospitals shall be distributed equally among family practice teaching hospitals.

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

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


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

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

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

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

(c) A service index that comprises three components:

1. The Agency for Health Care Administration Service Index,

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

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

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


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

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

TAP = THAF x A

Where:

TAP = total additional payment.

THAF = teaching hospital allocation factor.

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

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

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

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

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

TAE = HDSP/THDSP

Where:

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

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

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

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

TAP = TAE x TA

Where:

TAP = total additional payment for a primary care hospital.

TAE = total amount earned by a primary care hospital.

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

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

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

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

(c) Coordinate and provide primary care services free of charge, except copayments, to all persons with incomes up to 100 percent of the federal poverty level who are not otherwise

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

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

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

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

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

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

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

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

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

Section 11. Notwithstanding any other provision of law, each Medicaid managed care plan and provider service network shall include in its provider network any pharmacy that is


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licensed under chapter 465, Florida Statutes, located in a rural county, and willing to accept the reimbursement terms and conditions established by the Medicaid managed care plan or the provider service agreement. As used in this section, a "rural county" means a county that has a population of fewer than 200,000 residents, based upon the 2000 official census.

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

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

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to the Agency for Health Care Administration; amending s. 395.701, F.S.; increasing the assessments imposed on hospital inpatient and outpatient services and deposited into the Public Medical Assistance Trust Fund; amending s. 400.141, F.S.; conforming a cross-reference to changes made by the act; amending s. 400.23, F.S.; providing flexibility for nursing home facilities with respect to meeting minimum staffing requirements; amending s. 409.906, F.S.; requiring the Agency for Health Care Administration, in consultation with the Department of


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Elderly Affairs, to phase out certain specified programs and to transfer the Medicaid waiver recipients to other appropriate home and community-based service programs; prohibiting certain programs from accepting new members after a specified date; requiring community-based providers to assist in the transition of enrollees and cease provision of certain waiver services by a specified date; amending s. 409.9082, F.S.; revising requirements for the use of funds from nursing home quality assessments and federal matching funds; amending s. 409.9083, F.S.; revising requirements for the use of funds from quality assessments on privately operated intermediate care facility providers for the developmentally disabled and federal matching funds; amending s. 409.911, F.S.; continuing the requirements for calculating the disproportionate share funds for provider service network hospitals; amending s. 409.9112, F.S.; continuing the prohibition against distributing moneys under the perinatal intensive care centers disproportionate share program; amending s. 409.9113, F.S.; continuing authorization for the distribution of moneys to teaching hospitals under the disproportionate share program; amending s. 409.9117, F.S.; continuing the prohibition against distributing moneys for the primary care disproportionate share program; requiring each Medicaid managed care plan and provider service network to include in its provider network any pharmacy that is located in a rural county


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and willing to accept the reimbursement terms and conditions established by the managed care plan or provider service agreement; providing a contingent effective date.