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Proposed Committee Substitute by the Committee on Health and
Human Services Appropriations

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. 409.906,
7 F.S.; requiring the Agency for Health Care
8 Administration, in consultation with the Department of
9 Elderly Affairs, to phase out certain specified
10 programs and to transfer the Medicaid waiver
11 recipients to other appropriate home and community-
12 based service programs; prohibiting certain programs
13 from accepting new members after a specified date;
14 requiring community-based providers to assist in the
15 transition of enrollees and cease provision of certain
16 waiver services by a specified date; amending s.
17 409.9082, F.S.; revising the use of funds from nursing
18 home quality assessments and federal matching funds;
19 amending s. 409.9083, F.S.; revising the use of funds
20 from quality assessments on privately operated
21 intermediate care facility providers for the
22 developmentally disabled and federal matching funds;
23 amending s. 409.911, F.S.; calculating the
24 disproportionate share funds for provider service
25 network hospitals; amending s. 409.9112, F.S.;
26 continuing the prohibition against distributing moneys
27 under the perinatal intensive care centers



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28 disproportionate share program; amending s. 409.9113,
29 F.S.; continuing authorizing for the distribution of
30 moneys to teaching hospitals under the
31 disproportionate share program; amending s. 409.9117,
32 F.S.; continuing the prohibition against distributing
33 moneys for the primary care disproportionate share
34 program; providing an effective date.

35

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

37

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

40 395.701 Annual assessments on net operating revenues for
41 inpatient and outpatient services to fund public medical
42 assistance; administrative fines for failure to pay assessments
43 when due; exemption.—

44 (2) (a) There is imposed upon each hospital an assessment in
45 an amount equal to 2 ~~1.5~~ percent of the annual net operating
46 revenue for inpatient services for each hospital, such revenue
47 to be determined by the agency, based on the actual experience
48 of the hospital as reported to the agency. Within 6 months after
49 the end of each hospital fiscal year, the agency shall certify
50 the amount of the assessment for each hospital. The assessment
51 shall be payable to and collected by the agency in equal
52 quarterly amounts, on or before the first day of each calendar
53 quarter, beginning with the first full calendar quarter that
54 occurs after the agency certifies the amount of the assessment
55 for each hospital. All moneys collected pursuant to this
56 subsection shall be deposited into the Public Medical Assistance



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57 Trust Fund.

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

76 Section 2. Paragraph (d) is added to subsection (13) of
77 section 409.906, Florida Statutes, to read:

78 409.906 Optional Medicaid services.—Subject to specific
79 appropriations, the agency may make payments for services which
80 are optional to the state under Title XIX of the Social Security
81 Act and are furnished by Medicaid providers to recipients who
82 are determined to be eligible on the dates on which the services
83 were provided. Any optional service that is provided shall be
84 provided only when medically necessary and in accordance with
85 state and federal law. Optional services rendered by providers



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

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

101 (d) The agency, in consultation with the Department of
102 Elderly Affairs, shall phase out the adult day health care and
103 Channeling Services waiver programs and transfer existing waiver
104 enrollees to other appropriate home and community-based service
105 programs. Effective July 1, 2010, the adult day health care, and
106 Channeling waiver programs shall cease to enroll new members.
107 Existing enrollees in the adult day health care and Channeling
108 Services programs shall receive counseling regarding available
109 options and shall be offered an alternative home and community-
110 based services program based on eligibility and personal choice.
111 Each enrollee in the waiver program shall continue to receive
112 home and community-based services without interruption in the
113 enrollee's program of choice. The providers of the adult day
114 health care and Channeling Services waiver programs, in



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115 consultation with the Area Agencies on Aging, shall assist in
116 the transition of enrollees. Provision of adult day health care
117 and Channeling Services waiver services shall cease by December
118 31, 2010. The agency may seek federal waiver approval to
119 administer this change.

120 Section 3. Subsections (4) and (6) of section 409.9082,
121 Florida Statutes, are amended to read:

122 409.9082 Quality assessment on nursing home facility
123 providers; exemptions; purpose; federal approval required;
124 remedies.—

125 (4) The purpose of the nursing home facility quality
126 assessment is to ensure continued quality of care. Collected
127 assessment funds shall be used to obtain federal financial
128 participation through the Medicaid program to make Medicaid
129 payments for nursing home facility services up to the amount of
130 nursing home facility Medicaid rates as calculated in accordance
131 with the approved state Medicaid plan in effect on December 31,
132 2007. The quality assessment and federal matching funds shall be
133 used exclusively for the following purposes and in the following
134 order of priority:

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

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

141 (c) To increase to each nursing home facility's Medicaid
142 rate, as needed, up to an amount that restores any rate
143 reductions for the 2010-2011 ~~2009-2010~~ fiscal year; and



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

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

156 Section 4. Subsections (3) and (5) of section 409.9083,
157 Florida Statutes, are amended to read:

158 409.9083 Quality assessment on privately operated
159 intermediate care facilities for the developmentally disabled;
160 exemptions; purpose; federal approval required; remedies.-

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

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

172 (b) Increase each privately operated ICF/DD Medicaid rate,



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173 as needed, by an amount that restores the rate reductions
174 implemented on October 1, 2008.

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

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

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

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

190 Section 5. Paragraph (a) of subsection (2) of section
191 409.911, Florida Statutes, is amended to read:

192 409.911 Disproportionate share program.—Subject to specific
193 allocations established within the General Appropriations Act
194 and any limitations established pursuant to chapter 216, the
195 agency shall distribute, pursuant to this section, moneys to
196 hospitals providing a disproportionate share of Medicaid or
197 charity care services by making quarterly Medicaid payments as
198 required. Notwithstanding the provisions of s. 409.915, counties
199 are exempt from contributing toward the cost of this special
200 reimbursement for hospitals serving a disproportionate share of
201 low-income patients.



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

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

210 Section 6. Section 409.9112, Florida Statutes, is amended
211 to read:

212 409.9112 Disproportionate share program for regional
213 perinatal intensive care centers.—In addition to the payments
214 made under s. 409.911, the agency shall design and implement a
215 system for making disproportionate share payments to those
216 hospitals that participate in the regional perinatal intensive
217 care center program established pursuant to chapter 383. The
218 system of payments must conform to federal requirements and
219 distribute funds in each fiscal year for which an appropriation
220 is made by making quarterly Medicaid payments. Notwithstanding
221 s. 409.915, counties are exempt from contributing toward the
222 cost of this special reimbursement for hospitals serving a
223 disproportionate share of low-income patients. For the 2010-2011
224 ~~2009-2010~~ state fiscal year, the agency may not distribute
225 moneys under the regional perinatal intensive care centers
226 disproportionate share program.

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

230 TAE = HDSP/THDSP



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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:

$$TAP = TAE \times TA$$

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



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260 rule concerning staffing ratios, medical records, standards of
261 care, equipment, space, and such other standards and criteria as
262 the department and agency deem appropriate as specified by rule.

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

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

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

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

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

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

286 (h) Agree to arrange for transportation for high-risk
287 obstetrical patients and neonates in need of transfer from the
288 community to the hospital or from the hospital to another more



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289 appropriate facility.

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

298 Section 7. Section 409.9113, Florida Statutes, is amended
299 to read:

300 409.9113 Disproportionate share program for teaching
301 hospitals.—In addition to the payments made under ss. 409.911
302 and 409.9112, the agency shall make disproportionate share
303 payments to statutorily defined teaching hospitals for their
304 increased costs associated with medical education programs and
305 for tertiary health care services provided to the indigent. This
306 system of payments must conform to federal requirements and
307 distribute funds in each fiscal year for which an appropriation
308 is made by making quarterly Medicaid payments. Notwithstanding
309 s. 409.915, counties are exempt from contributing toward the
310 cost of this special reimbursement for hospitals serving a
311 disproportionate share of low-income patients. For the 2010-2011
312 ~~2009-2010~~ state fiscal year, the agency shall distribute the
313 moneys provided in the General Appropriations Act to statutorily
314 defined teaching hospitals and family practice teaching
315 hospitals under the teaching hospital disproportionate share
316 program. The funds provided for statutorily defined teaching
317 hospitals shall be distributed in the same proportion as the



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318 state fiscal year 2003-2004 teaching hospital disproportionate
319 share funds were distributed or as otherwise provided in the
320 General Appropriations Act. The funds provided for family
321 practice teaching hospitals shall be distributed equally among
322 family practice teaching hospitals.

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

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

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



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

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

369
370 The primary factor for full-time equivalent trainees is computed
371 as the sum of these two components, divided by two.

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

373 1. The Agency for Health Care Administration Service Index,
374 computed by applying the standard Service Inventory Scores
375 established by the agency to services offered by the given



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376 hospital, as reported on Worksheet A-2 for the last fiscal year
377 reported to the agency before the date on which the allocation
378 fraction is calculated. The numerical value of this factor is
379 the fraction that the given hospital represents of the total
380 Agency for Health Care Administration Service Index values,
381 where the total is computed for all state statutory teaching
382 hospitals.

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

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

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



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

$$TAP = THAF \times A$$

410
411 Where:

412 TAP = total additional payment.

413 THAF = teaching hospital allocation factor.

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

416 Section 8. Section 409.9117, Florida Statutes, is amended
417 to read:

418 409.9117 Primary care disproportionate share program.—For
419 the 2010-2011 ~~2009-2010~~ state fiscal year, the agency shall not
420 distribute moneys under the primary care disproportionate share
421 program.

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

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

$$TAE = HDSP/THDSP$$

430
431 Where:

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



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

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

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

441
$$\text{TAP} = \text{TAE} \times \text{TA}$$

442

443 Where:

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

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

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

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

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

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

458 (c) Coordinate and provide primary care services free of
459 charge, except copayments, to all persons with incomes up to 100
460 percent of the federal poverty level who are not otherwise
461 covered by Medicaid or another program administered by a
462 governmental entity, and to provide such services based on a



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

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

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

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

490 (g) Provide inpatient services to residents within the area
491 who are not eligible for Medicaid or Medicare, and who do not



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492 have private health insurance, regardless of ability to pay, on
493 the basis of available space, except that hospitals may not be
494 prevented from establishing bill collection programs based on
495 ability to pay.

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

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

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

511
512 Any hospital that fails to comply with any of the provisions of
513 this subsection, or any other contractual condition, may not
514 receive payments under this section until full compliance is
515 achieved.

516 Section 9. This act shall take effect July 1, 2010.