Amendment No.

CHAMBER ACTION

Senate	House
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Representative(s) Bean offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. 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 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 2001, 2002, and 2003 ~~2000, 2001, and 2002~~ audited disproportionate share data to determine each hospital's Medicaid days and charity care for the 2007-2008 ~~2006-2007~~ state fiscal year.

(b) If the Agency for Health Care Administration does not have the prescribed 3 years of audited disproportionate share data as noted in paragraph (a) for a hospital, the agency shall use the average of the years of the audited disproportionate share data as noted in paragraph (a) which is available.

(c) In accordance with s. 1923(b) of the Social Security Act, a hospital with a Medicaid inpatient utilization rate greater than one standard deviation above the statewide mean or a hospital with a low-income utilization rate of 25 percent or greater shall qualify for reimbursement.

Section 2. 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 for Health Care Administration shall design and implement a system of making disproportionate share payments to those hospitals that participate in the regional perinatal intensive care center program established pursuant to chapter 383. This system of payments shall conform with federal requirements and shall distribute funds in each

fiscal year for which an appropriation is made by making quarterly Medicaid payments. Notwithstanding the provisions of 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 state fiscal year 2007-2008 ~~2005-2006~~, the agency shall 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 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 department's 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 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 shall 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 shall 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 3. 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 for Health Care Administration 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 shall conform with federal requirements and shall 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 state fiscal year 2007-2008 ~~2006-2007~~, 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. 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 for Health Care Administration 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 three primary factors, divided by three. The primary factors are:

(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.

(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, computed by applying the standard Service Inventory Scores established by the Agency for Health Care Administration 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.

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:

$$TAP = THAF \times A$$

Where:

TAP = total additional payment.

THAF = teaching hospital allocation factor.

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

Section 4. Section 409.9117, Florida Statutes, is amended to read:

409.9117 Primary care disproportionate share program.--For the state fiscal year 2007-2008 ~~2006-2007~~, 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:

$$TAP = TAE \times TA$$

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, 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.

(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 nothing shall prevent the hospital 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 5. Subsection (26) is added to 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 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:

(26) ANESTHESIOLOGIST ASSISTANT SERVICES.--The agency may pay for all services provided to a recipient by an anesthesiologist assistant licensed under s. 458.3475 or s. 459.023. Reimbursement for such services must be not less than 80 percent of the reimbursement that would be paid to a physician who provided the same services.

Section 6. Subsection (36) of section 393.063, Florida Statutes, is amended to read:

393.063 Definitions.--For the purposes of this chapter, the term:

(36) "Support coordinator" means a person who is designated by or under contract with the agency to serve as case manager for ~~assist~~ individuals served in programs administered by the agency, including, but not limited to, Medicaid waiver programs, and to identify individuals' ~~families in identifying their~~ capacities, needs, and resources, as well as finding and gaining access to necessary supports and services; coordinating the delivery of supports and services; ~~advocating on behalf of the individual and family;~~ maintaining relevant records; and monitoring and evaluating the delivery of supports and services. A support coordinator is responsible for assisting the agency in meeting the needs of individuals served while managing expenditures within available resources ~~to determine the extent to which they meet the needs and expectations identified by the individual, family, and others who participated in the development of the support plan~~.

Section 7. Paragraph (c) is added to subsection (1) of section 393.0661, Florida Statutes, to read:

393.0661 Home and community-based services delivery system; comprehensive redesign.--The Legislature finds that the home and community-based services delivery system for persons with developmental disabilities and the availability of appropriated funds are two of the critical elements in making services available. Therefore, it is the intent of the

Legislature that the Agency for Persons with Disabilities shall develop and implement a comprehensive redesign of the system.

(1) The redesign of the home and community-based services system shall include, at a minimum, all actions necessary to achieve an appropriate rate structure, client choice within a specified service package, appropriate assessment strategies, an efficient billing process that contains reconciliation and monitoring components, a redefined role for support coordinators that avoids potential conflicts of interest, and ensures that family/client budgets are linked to levels of need.

(c) By December 1, 2007, the Agency for Persons with Disabilities, in consultation with the Agency for Health Care Administration, shall create a model service delivery system pilot project for persons with developmental disabilities who receive services under the developmental disabilities waiver program administered by the Agency for Persons with Disabilities. Persons with developmental disabilities who receive services under the family and supported living waiver program or the consumer-directed care plus waiver program administered by the Agency for Persons with Disabilities may also be included in the system if the agency determines that such inclusion is feasible and will improve coordination of care and management of costs. The system must transfer and combine all services funded by Medicaid waiver programs and services funded only by the state, including room and board and supported living payments, for individuals who participate in the system. The pilot project shall document increased client outcomes that are known to be associated with a valid needs assessment of the

level of need of the client, rate setting based on the level of need, and encouragement of the use of community-centered services and supports. The pilot project shall implement strong utilization control, such as capped rates, in order to ensure predictable and controlled annual costs. Medicaid service delivery, including, but not limited to, service authorization, care management, and monitoring shall be managed locally through the area office of the Agency for Persons with Disabilities in order to encourage provider development. Support coordination services shall be available to individuals participating in the pilot program.

1. The Legislature intends that the service delivery system provide recipients in Medicaid waiver programs with a coordinated system of services, increased cost predictability, and a stabilized rate of increase in Medicaid expenditures while ensuring:

a. Consumer choice.

b. Opportunities for consumer-directed services.

c. Access to medically necessary services.

d. Coordination of community-based services.

e. Reductions in the unnecessary use of services.

2. The Agency for Persons with Disabilities shall implement the system on a pilot basis in Area 1 and may conduct a similar pilot in an urban area of the Agency for Persons with Disabilities, in consultation with the Agency for Health Care Administration. After completion of the development phase of the system, attainment of necessary federal approval, selection of qualified providers, and rate setting, the Agency for Persons

with Disabilities shall delegate administration of the system to the administrator of the agency's local area office. The Agency for Persons with Disabilities shall set standards for qualified providers and provide quality assurance, monitoring oversight, and other duties necessary for the system. The enrollment of Medicaid waiver recipients into the system in pilot areas shall be mandatory.

3. The local area office shall administer the pilot program and shall be responsible for ensuring that the costs of the program do not exceed the amount of funds allocated for the program. The agency area administrator shall also:

a. Identify the needs of the recipients using a standardized assessment process approved by the agency.

b. Allow a recipient to select any provider that has been qualified by the agency, provided that the service offered by the provider is appropriate to meet the needs of the recipient.

c. Make a good faith effort to select qualified providers currently providing Medicaid waiver services for the agency in the pilot area.

d. Develop and use a service provider qualification system approved by the agency that describes the quality of care standards that providers of service to persons with developmental disabilities must meet in order to provide services within the pilot area.

e. Exclude, when feasible, chronically poor-performing providers and facilities as determined by the agency.

f. Demonstrate a quality assurance system and a performance improvement system that are satisfactory to the agency.

4. The agency must ensure that the rate-setting methodology for the system reflects the intent to provide quality care in the least restrictive setting appropriate for the recipient and provide for choice by the recipient. The agency may choose to limit financial risk for the pilot area operating the system to cover high-cost recipients or to address the catastrophic care needs of recipients enrolled in the system.

5. Within 24 months after implementation, the agency shall contract for a comprehensive evaluation of the system. The evaluation must include assessments of cost savings, cost-effectiveness, recipient outcomes, consumer choice, access to services, coordination of care, and quality of care. The evaluation shall include, but not be limited to, an assessment of the following aspects:

a. A study of the funding patterns of the cost-prediction methodology before and after implementation of the pilot program;

b. A study of the service utilization patterns of the cost-prediction methodology before and after implementation of the pilot program;

c. The accuracy of the cost-prediction methodology in explaining and predicting funding levels for individuals receiving each of the three waivers in the pilot areas;

d. The accuracy of the cost-prediction methodology and a plan for dealing with cases involving individuals with the highest and lowest support needs and funding levels;

e. A survey of consumer satisfaction regarding consumer choice, scope of services, and proposed funding levels generated by the cost-prediction methodology in the pilot areas;

f. The applicability of the cost-prediction methodology to explain and predict funding levels for all individuals receiving the waivers;

g. The robustness of the cost-prediction methodology to withstand appeals and grievances; and

h. A systematic comparison of the outcomes in both pilot areas and the different models that are demonstrated.

6. Each pilot area shall form an advisory committee that includes representatives from the stakeholder community, including persons with disabilities, family members of persons with disabilities, members of disability advocacy groups, and representatives of program service providers to provide feedback and monitor the implementation of the pilot program on at least a quarterly basis.

7. The Agency for Persons with Disabilities shall form an advisory committee that includes representatives from the stakeholder community, including persons with disabilities, family members of persons with disabilities, members of disability advocacy groups, and representatives of program service providers to provide feedback and monitor the implementation of the pilot program from a statewide perspective.

8. The advisory committees shall submit reports evaluating the progress of the pilot programs to the President of the Senate and the Speaker of the House of Representatives on a quarterly basis.

9. The agency shall submit a report that describes the administrative or legal barriers to the implementation and operation of the system, including recommendations regarding statewide expansion of the system and a recommendation for the model service delivery system to be implemented statewide, to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than December 31, 2008.

10. The agency, in coordination with the Agency for Health Care Administration, may seek federal waivers or Medicaid state plan amendments and adopt rules as necessary to administer the system on a pilot basis. The agency must receive specific authorization from the Legislature prior to expanding beyond the area one pilot designated for the implementation of this system. Further expansion of this pilot project requires approval by the Legislature.

Section 8. The sum of $250,000 in nonrecurring funds from the General Revenue Fund and $250,000 in nonrecurring funds from the Administrative Trust Fund are appropriated to the Agency for Persons with Disabilities to implement the provisions of this act.

Section 9. This act shall take effect July 1, 2007.

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

Remove the entire title and insert:

Amendment No.

A bill to be entitled

An act relating to health care; amending s. 409.911, F.S.; revising the method for calculating disproportionate share payments to hospitals; amending s. 409.9112, F.S.; revising the time period during which the Agency for Health Care Administration is prohibited from distributing disproportionate share payments to regional perinatal intensive care centers; amending s. 409.9113, F.S.; revising the time period for distribution of disproportionate share payments to teaching hospitals; amending s. 409.9117, F.S.; revising the time period during which the agency is prohibited from distributing certain moneys under the primary care disproportionate share program; amending s. 409.906, F.S.; authorizing the agency to pay for certain services provided by an anesthesiologist assistant; amending s. 393.063, F.S.; revising the definition of the term "support coordinator"; amending s. 393.0661, F.S.; requiring the Agency for Persons with Disabilities, in consultation with the Agency for Health Care Administration, to implement federal waivers to create a model service delivery system pilot project for Medicaid recipients with developmental disabilities; providing legislative intent; providing for implementation of the system on a pilot basis in certain areas of the state; providing for administration of the system by the Agency for Persons with Disabilities; providing requirements for selection of service providers to operate the system; providing for mandatory enrollment

in pilot areas; requiring an evaluation of the system; providing for the formation of local and statewide advisory committees; requiring the committees to submit quarterly reports to the Legislature; requiring the agency to submit a report to the Governor and Legislature; authorizing the agency to seek federal waivers or Medicaid state plan amendments and adopt rules; requiring the agency to receive specific authorization from the Legislature before expanding the system; providing appropriations; providing an effective date.