FOR CONSIDERATION By the Committee on Appropriations

576-02880A-13 20137058__

A bill to be entitled

An act relating to Medicaid; amending s. 395.602, F.S.; providing that certain rural hospitals remain rural hospitals under specified circumstances; amending s. 409.905, F.S.; requiring the Agency for Health Care Administration to implement a prospective payment system for inpatient hospital services using diagnosis-related groups (DRGs); deleting provisions directing the agency to develop a plan to convert hospital reimbursement for inpatient services to a prospective payment system; requiring hospital reimbursement for outpatient services to be based on allowable costs; providing that adjustments may not be made after a certain date; providing for the reconciliation of errors in source data or calculations; amending s. 409.908, F.S.; revising exceptions to limitations on hospital reimbursement for inpatient services; providing parameters for submission of letters of agreement by local governmental entities to the agency relating to funds for special payments; creating s. 409.909, F.S.; establishing the Statewide Medicaid Residency Program; providing the purposes of the program; providing definitions; providing a formula and limitations for allocating funds to participating hospitals; authorizing the agency to adopt rules; amending s. 409.911, F.S.; updating references to data used for calculations in the disproportionate share program; amending s. 409.9118, F.S.; amending parameters for

the disproportionate share program for specialty hospitals; limiting reimbursement to tuberculosis services provided under contract with the Department of Health; providing an effective date.

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

Section 1. Paragraph (e) of subsection (2) of section 395.602, Florida Statutes, is amended to read:

395.602 Rural hospitals.—

(2) DEFINITIONS.—As used in this part:

(e) "Rural hospital" means an acute care hospital licensed under this chapter~~,~~ which has ~~having~~ 100 or fewer licensed beds and an emergency room~~,~~ and ~~which~~ is:

1. The sole provider within a county that has ~~with~~ a population density of up to ~~no greater than~~ 100 persons per square mile;

2. An acute care hospital, in a county that has ~~with~~ a population density of up to ~~no greater than~~ 100 persons per square mile, which is at least 30 minutes of travel time, on normally traveled roads under normal traffic conditions, from any other acute care hospital within the same county;

3. A hospital supported by a tax district or subdistrict whose boundaries encompass a population of 100 ~~persons~~ or fewer persons per square mile;

4. A hospital in a constitutional charter county that has ~~with~~ a population of more than ~~over~~ 1 million persons which ~~that~~ has imposed a local option health service tax pursuant to law and in an area that was directly impacted by a catastrophic

event on August 24, 1992, for which the Governor of Florida declared a state of emergency pursuant to chapter 125, and has 120 ~~beds~~ or fewer beds which ~~less that~~ serves an agricultural community that has ~~with~~ an emergency room utilization of at least ~~no less than~~ 20,000 visits and a Medicaid inpatient utilization rate greater than 15 percent;

5. A hospital that has ~~with~~ a service area that has a population of 100 ~~persons~~ or fewer persons per square mile. As used in this subparagraph, the term "service area" means the fewest number of zip codes that account for 75 percent of the hospital's discharges for the most recent 5-year period, based on information available from the hospital inpatient discharge database in the Florida Center for Health Information and Policy Analysis at the agency ~~for Health Care Administration~~; or

6. A hospital designated as a critical access hospital, as defined in s. 408.07~~(15)~~.

Population densities used in this paragraph must be based upon the most recently completed United States census. A hospital that received funds under s. 409.9116 for a quarter beginning no later than July 1, 2002, is deemed to have been and shall continue to be a rural hospital from that date through June 30, 2015, if the hospital continues to have 100 or fewer licensed beds and an emergency room, or meets the criteria of subparagraph 4. An acute care hospital that has not previously been designated as a rural hospital and that meets the criteria of this paragraph shall be granted such designation upon application, including supporting documentation, to the agency ~~for Health Care Administration~~. A hospital that was licensed as

a rural hospital during the 2010-2011 or 2011-2012 fiscal year shall continue to be a rural hospital from the date of designation through June 30, 2015, if the hospital continues to have 100 or fewer licensed beds and an emergency room.

Section 2. Paragraphs (c), (d), and (f) of subsection (5) and subsection (6) of section 409.905, Florida Statutes, are amended to read:

409.905 Mandatory Medicaid services.—The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law. Mandatory services rendered by providers in mobile units to Medicaid recipients may be restricted 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, number of services, or 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.

(5) HOSPITAL INPATIENT SERVICES.—The agency shall pay for all covered services provided for the medical care and treatment of a recipient who is admitted as an inpatient by a licensed physician or dentist to a hospital licensed under part I of chapter 395. However, the agency shall limit the payment for inpatient hospital services for a Medicaid recipient 21 years of age or older to 45 days or the number of days necessary to

comply with the General Appropriations Act. Effective August 1, 2012, the agency shall limit payment for hospital emergency department visits for a nonpregnant Medicaid recipient 21 years of age or older to six visits per fiscal year.

(c) The agency shall implement a prospective payment methodology for establishing ~~base~~ reimbursement rates for inpatient hospital services ~~each hospital based on allowable costs, as defined by the agency~~. Rates shall be calculated annually and take effect July 1 of each year ~~based on the most recent complete and accurate cost report submitted by each hospital~~. The methodology shall categorize each inpatient admission into a diagnosis-related group (DRG) and assign a relative payment weight to be used to adjust the base rate according to the average relative amount of hospital resources used to treat a patient in a specific DRG category. The agency may adopt the most recent relative weights calculated and made available by the Nationwide Inpatient Sample maintained by the Agency for Healthcare Research and Quality or may adopt alternative weights if the agency finds that Florida-specific weights deviate with statistical significance from national weights for high-volume DRGs. The agency shall establish a single, uniform base rate for all hospitals unless specifically exempt pursuant to s. 409.908(1). The uniform base rate is limited by the hospital inpatient appropriation specified in the General Appropriations Act before the inclusion of intergovernmental transfers, authorized under s. 409.908(1) or under the General Appropriations Act, which may be provided in order to adjust inpatient reimbursement.

1. Adjustments may not be made to the rates after October

31 of the state fiscal year in which the rates take effect, except for cases of insufficient collections of intergovernmental transfers authorized under s. 409.908(1) or the General Appropriations Act. In such cases, the agency shall submit a budget amendment or amendments under chapter 216 requesting approval of rate reductions by amounts necessary for the aggregate reduction to equal the dollar amount of intergovernmental transfers not collected and the corresponding federal match. Notwithstanding the $1 million limitation on increases to an approved operating budget contained in ss. 216.181(11) and 216.292(3), a budget amendment exceeding that dollar amount is subject to notice and objection procedures set forth in s. 216.177.

2. Errors in source data or calculations ~~cost reporting or calculation of rates~~ discovered after October 31 must be reconciled in a subsequent rate period. However, the agency may not make any adjustment to a hospital's reimbursement ~~rate~~ more than 5 years after a hospital is notified of an audited rate established by the agency. The prohibition against adjustments ~~requirement that the agency may not make any adjustment to a hospital's reimbursement rate more than~~ 5 years after notification ~~a hospital is notified of an audited rate established by the agency~~ is remedial and applies to actions by providers involving Medicaid claims for hospital services. Hospital reimbursement is ~~rates are~~ subject to such limits or ceilings as may be established in law or described in the agency's hospital reimbursement plan. Specific exemptions to the limits or ceilings may be provided in the General Appropriations Act.

(d) The agency shall implement a comprehensive utilization management program for hospital neonatal intensive care stays in certain high-volume participating hospitals, select counties, or statewide, and replace existing hospital inpatient utilization management programs for neonatal intensive care admissions. The program shall be designed to manage appropriate admissions and discharges ~~the lengths of stay~~ for children being treated in neonatal intensive care units and must seek ~~the earliest~~ medically appropriate discharge to the child's home or other less costly treatment setting. The agency may competitively bid a contract for the selection of a qualified organization to provide neonatal intensive care utilization management services. The agency may seek federal waivers to implement this initiative.

~~(f) The agency shall develop a plan to convert Medicaid inpatient hospital rates to a prospective payment system that categorizes each case into diagnosis-related groups (DRG) and assigns a payment weight based on the average resources used to treat Medicaid patients in that DRG. To the extent possible, the agency shall propose an adaptation of an existing prospective payment system, such as the one used by Medicare, and shall propose such adjustments as are necessary for the Medicaid population and to maintain budget neutrality for inpatient hospital expenditures.~~

~~1. The plan must:~~

~~a. Define and describe DRGs for inpatient hospital care specific to Medicaid in this state;~~

~~b. Determine the use of resources needed for each DRG;~~

~~c. Apply current statewide levels of funding to DRGs based~~

~~on the associated resource value of DRGs. Current statewide funding levels shall be calculated both with and without the use of intergovernmental transfers;~~

~~d. Calculate the current number of services provided in the Medicaid program based on DRGs defined under this subparagraph;~~

~~e. Estimate the number of cases in each DRG for future years based on agency data and the official workload estimates of the Social Services Estimating Conference;~~

~~f. Calculate the expected total Medicaid payments in the current year for each hospital with a Medicaid provider agreement, based on the DRGs and estimated workload;~~

~~g. Propose supplemental DRG payments to augment hospital reimbursements based on patient acuity and individual hospital characteristics, including classification as a children's hospital, rural hospital, trauma center, burn unit, and other characteristics that could warrant higher reimbursements, while maintaining budget neutrality; and~~

~~h. Estimate potential funding for each hospital with a Medicaid provider agreement for DRGs defined pursuant to this subparagraph and supplemental DRG payments using current funding levels, calculated both with and without the use of intergovernmental transfers.~~

~~2. The agency shall engage a consultant with expertise and experience in the implementation of DRG systems for hospital reimbursement to develop the DRG plan under subparagraph 1.~~

~~3. The agency shall submit the DRG plan, identifying all steps necessary for the transition and any costs associated with plan implementation, to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later~~

~~than January 1, 2013. The plan shall include a timeline necessary to complete full implementation by July 1, 2013. If, during implementation of this paragraph, the agency determines that these timeframes might not be achievable, the agency shall report to the Legislative Budget Commission the status of its implementation efforts, the reasons the timeframes might not be achievable, and proposals for new timeframes.~~

(6) HOSPITAL OUTPATIENT SERVICES.—

(a) The agency shall pay for preventive, diagnostic, therapeutic, or palliative care and other services provided to a recipient in the outpatient portion of a hospital licensed under part I of chapter 395, and provided under the direction of a licensed physician or licensed dentist, except that payment for such care and services is limited to $1,500 per state fiscal year per recipient, unless an exception has been made by the agency, or the services were provided to ~~and with the exception of~~ a Medicaid recipient under age 21, in which case the only limitation is medical necessity.

(b) The agency shall implement a methodology for establishing base reimbursement rates for outpatient services for each hospital based on allowable costs, as defined by the agency. Rates shall be calculated annually and take effect July 1 of each year based on the most recent complete and accurate cost report submitted by each hospital.

1. Adjustments may not be made to the rates after October 31 of the state fiscal year in which the rates take effect, except for cases of insufficient collections of intergovernmental transfers authorized under s. 409.908(1) or the General Appropriations Act. In such cases, the agency shall

submit a budget amendment or amendments under chapter 216 requesting approval of rate reductions by amounts necessary for the aggregate reduction to equal the dollar amount of intergovernmental transfers not collected and the corresponding federal match. Notwithstanding the $1 million limitation on increases to an approved operating budget under ss. 216.181(11) and 216.292(3), a budget amendment exceeding that dollar amount is subject to notice and objection procedures set forth in s. 216.177.

2. Errors in source data or calculations discovered after October 31 must be reconciled in a subsequent rate period. However, the agency may not make any adjustment to a hospital's reimbursement more than 5 years after a hospital is notified of an audited rate established by the agency. The prohibition against adjustments 5 years after notification is remedial and applies to actions by providers involving Medicaid claims for hospital services. Hospital reimbursement is subject to such limits or ceilings as may be established in law or described in the agency's hospital reimbursement plan. Specific exemptions to the limits or ceilings may be provided in the General Appropriations Act.

Section 3. Paragraph (a) of subsection (1) of section 409.908, Florida Statutes, is amended to read:

409.908 Reimbursement of Medicaid providers.—Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement

methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. If a provider is reimbursed based on cost reporting and submits a cost report late and that cost report would have been used to set a lower reimbursement rate for a rate semester, then the provider's rate for that semester shall be retroactively calculated using the new cost report, and full payment at the recalculated rate shall be effected retroactively. Medicare-granted extensions for filing cost reports, if applicable, shall also apply to Medicaid cost reports. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, 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, provided the adjustment is consistent with legislative intent.

(1) Reimbursement to hospitals licensed under part I of chapter 395 must be made prospectively or on the basis of negotiation.

(a) Reimbursement for inpatient care is limited as provided ~~for~~ in s. 409.905(5), except for the following:

1. If authorized by the General Appropriations Act, the agency may modify reimbursement for specific types of services

or diagnoses, recipient ages, and hospital provider types ~~The raising of rate reimbursement caps, excluding rural hospitals~~.

2. While maintaining budget neutrality, the agency may modify reimbursement to any provider determined to be a long-term acute care hospital ~~Recognition of the costs of graduate medical education~~.

3. The agency may establish an alternative methodology to the DRG-based prospective payment system to set reimbursement rates for:

a. State-owned psychiatric hospitals.

b. Newborn hearing screening services.

c. Transplant services for which the agency has established a global fee.

d. Recipients who have tuberculosis that is resistant to therapy who are in need of long-term, hospital-based treatment ~~Other methodologies recognized in the General Appropriations Act~~.

During the years funds are transferred from the Department of Health, any reimbursement supported by such funds is ~~shall be~~ subject to certification by the Department of Health that the hospital has complied with s. 381.0403. The agency may ~~is authorized to~~ receive funds from state entities, including, but not limited to, the Department of Health, local governments, and other local political subdivisions, for the purpose of making special exception payments, including federal matching funds, through the Medicaid inpatient reimbursement methodologies. Funds received ~~from state entities or local governments~~ for this purpose shall be separately accounted for and may ~~shall~~ not be

commingled with other state or local funds in any manner. The agency may certify all local governmental funds used as state match under Title XIX of the Social Security Act, to the extent and in the manner authorized under ~~that the identified local health care provider that is otherwise entitled to and is contracted to receive such local funds is the benefactor under the state's Medicaid program as determined under~~ the General Appropriations Act and pursuant to an agreement between the agency ~~for Health Care Administration~~ and the local governmental entity. In order for the agency to certify such local governmental funds, a local governmental entity must submit a final, executed letter of agreement to the agency, which must be received by October 1 of each fiscal year and provide the total amount of local governmental funds authorized by the entity for that fiscal year under this paragraph, paragraph (b), or the General Appropriations Act. The local governmental entity shall use a certification form prescribed by the agency. At a minimum, the certification form must ~~shall~~ identify the amount being certified and describe the relationship between the certifying local governmental entity and the local health care provider. The agency shall prepare an annual statement of impact which documents the specific activities undertaken during the previous fiscal year pursuant to this paragraph, to be submitted to the Legislature annually by ~~no later than~~ January 1~~, annually~~.

Section 4. Section 409.909, Florida Statutes, is created to read:

409.909 Statewide Medicaid Residency Program.—

(1) The Statewide Medicaid Residency Program is established to improve the quality of care and access to care for Medicaid

recipients, expand graduate medical education on an equitable basis, and increase the supply of highly trained physicians statewide. The agency shall make payments to hospitals licensed under part I of chapter 395 for graduate medical education associated with the Medicaid program. This system of payments is designed to generate federal matching funds under Medicaid and distribute the resulting funds to participating hospitals on a quarterly basis in each fiscal year for which an appropriation is made.

(2) On or before September 15 of each year, the agency shall calculate an allocation fraction to be used for distributing funds to participating hospitals. On the final business day of each quarter of a state fiscal year, the agency shall distribute to each participating hospital one-fourth of that hospital's annual allocation calculated under subsection (4). The allocation fraction for each participating hospital is based on the hospital's number of full-time equivalent residents and the amount of its Medicaid payments. As used in this section, the term:

(a) "Full-time equivalent," or "FTE," means a resident who is in his or her initial residency period, which is defined as the minimum number of years of training required before the resident may become eligible for board certification by the American Osteopathic Association Bureau of Osteopathic Specialists or the American Board of Medical Specialties in the specialty in which he or she first began training, not to exceed 5 years. A resident training beyond the initial residency period is counted as half of one FTE, unless his or her chosen specialty is in general surgery or primary care, in which case

the resident is counted as 1.0 FTE. For the purposes of this section, primary care specialties include:

1. Family medicine;

2. General internal medicine;

3. General pediatrics;

4. Preventive medicine;

5. Geriatric medicine;

6. Osteopathic general practice;

7. Obstetrics and gynecology; and

8. Emergency medicine.

(b) "Medicaid payments" means payments made to reimburse a hospital for direct inpatient services during the fiscal year preceding the date on which the allocation factor is calculated, as determined by the agency.

(c) "Resident" means a medical intern, fellow, or resident enrolled in a program accredited by the Accreditation Council for Graduate Medical Education, the American Association of Colleges of Osteopathic Medicine, or the American Osteopathic Association at the beginning of the state fiscal year during which the allocation fraction is calculated, as reported by the hospital to the agency.

(3) The agency shall use the following formula to calculate a participating hospital's allocation fraction:

$$HAF=[0.9 \times (HFTE/TFTE)] + [0.1 \times (HMP/TMP)]$$

Where:

HAF=A hospital's allocation fraction.

HFTE=A hospital's total number of FTE residents.

TFTE=The total FTE residents for all participating hospitals.

HMP=A hospital's Medicaid payments.

TMP=The total Medicaid payments for all participating hospitals.

(4) A hospital's annual allocation shall be calculated by multiplying the funds appropriated for the Statewide Medicaid Residency Program in the General Appropriations Act by that hospital's allocation fraction. If the calculation results in an annual allocation that exceeds $50,000 per FTE resident, the hospital's annual allocation shall be reduced to a sum equaling no more than $50,000 per FTE resident. The funds calculated for that hospital in excess of $50,000 per FTE resident shall be redistributed to participating hospitals whose annual allocation does not exceed $50,000 per FTE resident, using the same methodology and payment schedule specified in this section.

(5) The agency may adopt rules to administer this section.

Section 5. 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 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 ~~2004,~~ 2005, ~~and~~ 2006, and 2007 audited disproportionate share data to determine each hospital's Medicaid days and charity care for the 2013-2014 ~~2012-2013~~ state fiscal year.

Section 6. Section 409.9118, Florida Statutes, is amended to read:

409.9118 Disproportionate share program for specialty hospitals.—The agency ~~for Health Care Administration~~ shall design and implement a system of making disproportionate share payments to ~~those~~ hospitals under contract with the Department of Health to provide ~~licensed in accordance with part I of chapter 395 as a~~ specialty hospital services and which meet all requirements specified ~~listed~~ in subsection (2). Notwithstanding s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for patients.

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

$$TAE=(MD/TMD) \times TA$$

Where:

TAE=total amount earned by a specialty hospital.

TA=total appropriation for payments to hospitals that

qualify under this program.

MD=total Medicaid days for each qualifying hospital.

TMD=total Medicaid days for all hospitals that qualify under this program.

(2) In order to receive payments under this section, a hospital must be licensed in accordance with part I of chapter 395, to participate in the Florida Title XIX program, and meet the following requirements:

(a) Be certified or certifiable to be a provider of Title XVIII services.

(b) Restrict services to tuberculosis services for patients who were initially referred to the Department of Health's tuberculosis control services program ~~Receive all of its inpatient clients through referrals or admissions~~ from county public health departments, as defined in chapter 154, and which are provided pursuant to a contract with the department for admissions and treatment.

(c) Require a diagnosis for the control of a communicable disease for all admissions for inpatient tuberculosis treatment provided pursuant to a contract with the Department of Health.

Section 7. This act shall take effect July 1, 2013.