The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	SB 1374
INTRODUCER:	Senator Harrell
SUBJECT:	Regional Perinatal Intensive Care Centers
DATE:	January 27, 2020
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Brown	HP	**Favorable**
2.			AHS	
3.			AP	

I. Summary:

SB 1374 amends several sections of law governing the designation of, and requirements for, regional perinatal intensive care centers (RPICC). The bill expands the maximum number of RPICCs that the Department of Health (DOH) may designate from 11 to 22. The bill also adds additional criteria that the DOH must use when adopting rules for the designation, development, and operation of a RPICC and when selecting and designating new RPICCs.

The bill takes effect July 1, 2020.

II. Present Situation:

Regional Perinatal Intensive Care Centers

History of RPICCs

RPICCs are hospitals that are designated by the DOH to work to improve the outcome of pregnancy and the quality of life from birth. RPICCs provide obstetrical services to women who have a high-risk pregnancy and care for newborns with special health needs, such as critical illness or low birth weight.

The goals of a RPICC include reducing the risk of serious illness for pregnant women and newborns and providing the best medical care to women with high-risk pregnancies and newborns who are sick or born prematurely. Currently, RPICC services are provided at 11 hospitals around the state located in Pensacola, Jacksonville, Gainesville, Orlando, Tampa, St. Petersburg, West Palm, Hollywood, Ft. Lauderdale, Miami, and Ft. Myers, and two obstetrical satellite clinics.[1]

[1] See http://www.floridahealth.gov/programs-and-services/childrens-health/cms-specialty-programs/regional-perinatal-intensive-care-centers-program/index.html (last visited Jan. 16, 2020).

RPICCs were established by the Legislature in 1976 with the intent to prevent neonatal diseases and disabilities that have debilitating, costly, and often fatal consequences.[2] At that time, the Legislature authorized 10 such centers in a geographic area which experiences at least 10,000 live births per year. In 1994, the Legislature added one additional RPICC, bringing the total to 11, and the number of RPICCs has not been increased since.[3]

Current RPICC Requirements

Currently, ss. 383.15-383.19, F.S., establish the requirements for RPICCs. Section 383.17, F.S., allows the DOH to contract with health care providers to establish RPICCs. Section 383.18, F.S., requires that such contracts provide that patients will receive services from the RPICC and that parents or guardians of patients who participate in the program and who comply with Medicaid eligibility requirements, as determined by the DOH, are not additionally charged for treatment and care that has been provided by the RPICC. When determining which hospitals to contract with, the DOH must give priority to establishing RPICCs in hospitals that demonstrate an interest in perinatal intensive care by meeting program standards and may not contract with a private, for-profit hospital that does not accept county, state, or federal funds or indigent patients.[4]

Section 383.19, F.S., requires the DOH to adopt rules to specify standards for RPICCs, including:

- The need to provide services through a RPICC and the requirements of the population to be served.
- Equipment.
- Facilities.
- Staffing and qualifications of personnel.
- Transportation services.
- Data collection.
- Definitions of terms.[5]

Failure to comply with these standards is grounds for the DOH to terminate a RPICC's contract.

RPICC Medicaid Reimbursement

Fee-for-service reimbursement for RPICC services provided to Medicaid recipients is paid according to Medicaid fee schedules (neonatal and obstetrical).

Statute requires that Medicaid reimbursement for in-center obstetrical physician services be based upon the obstetrical care group payment system. Medicaid reimbursement for in-center neonatal physician services is based upon the neonatal care group payment system. These prospective payment systems, developed by the DOH, must place patients into homogeneous groups based on clinical factors, severity of illness, and intensity of care. Payment for outpatient

[2] Chapter 76-54, L.O.F.
[3] Chapter 94-140
[4] Section 383.19(4) and (5), F.S.
[5] See Rules 64C-6.001-6.003, F.A.C.

obstetrical services and other related services, such as consultations, are determined based on the usual Medicaid method of payment for outpatient medical services.[6]

- The payment systems used to fulfill the statute were created and administered by the University of Florida.
- The University of Florida (UF) held a long-running contract with the Agency for Health Care Administration (AHCA) to operate a payment system for physician specialists who provide obstetrical services to women with high-risk pregnancy or who provide care for newborns with special health needs, such as critical illness or low birth weight. UF also hosted a data system to maintain demographic and medical information of Medicaid recipients receiving services in RPICCs.
- The contract with UF ended June 30, 2019, and the AHCA is working with UF to establish a new contract to fulfill the statutory mandate.[7]

In State Fiscal Year 2018-2019, RPICCs were added as an eligible hospital group in the Low Income Pool (LIP). The AHCA created a RPICC-only tier in the LIP model, which allowed a number of hospitals to increase the percentage of their charity care that may be reimbursed under the LIP. This creates an incentive for more hospitals to obtain the RPICC designation.

The base fees for physician services provided in RPICCs are higher than the fees on the non-RPICC physician fee schedule for the same procedure codes. For example, the RPICC base rates for C-sections and vaginal deliveries are 56 percent higher than the physician fee schedule for those procedures.[8]

Comparison				
Procd	Description	Practitioner	RPICC	Percent Difference
59515	C-Section	$ 1,144	$1,785	56.03%
59614	Vaginal Delivery	$ 1,444	$1,785	56.03%

III. Effect of Proposed Changes:

SB 1374 amends various statutes related to RPICCs as follows:

Section 1 of the bill amends s. 383.16, F.S., to add definitions for "agency," meaning the AHCA, and "district," meaning AHCA planning districts as established in s. 408.032, F.S.

Section 4 of the bill amends s. 383.19, F.S., to include levels of care, educational outreach, participation in quality collaborations within and outside a RPICC's district, and support of rural hospitals to the list of standards for which the DOH must adopt rules. The bill also adds additional criteria that the DOH must use to select and designate RPICCs, including:

- Demonstrating a commitment to improving access to health services, including timely use of personal health services to achieve the best health outcomes;

[6] *See* s. 383.19(2), F.S.
[7] Agency for Health Care Administration, Medicaid Comments on Draft RPICC Bill (on file with the Senate Committee on Health Policy).
[8] Id.

- Maintaining a facility birth volume of at least 3,000 live births per year; and
- Actively participating in one or more perinatal quality collaborations as defined by the DOH in rule.

The bill increases the maximum number of RPICCs allowed to be designated from 11 to 22. The DOH is required to designate at least one RPICC in each of the AHCA planning districts[9] and one additional RPICC in any district in which 20,000 or more resident live births occur per year.[10]

The bill also specifies that Medicaid reimbursements for services provided to members of a managed care plan must be paid in accordance with the provider payment provisions of part IV of ch. 409, F.S. (Medicaid Managed Care) and that fee-for-service reimbursements must be based upon obstetrical or neonatal group payment systems developed by the DOH, as applicable.

The bill also requires the DOH, in consultation with the AHCA, to develop and implement a statewide process to engage perinatal stakeholders for the purpose of determining appropriate and efficacious levels of maternal care provided by RPICCs. The process must be completed no later than July 1, 2023, and must seek to standardize RPICCs internal assessments of levels of maternal care guided by methodologies and tools developed by the federal Centers for Disease Control and Prevention.

Sections 2, 3, 5, and 6 of the bill amend ss. 383.17, 383.18, 409.908, and 409.967, F.S., to make clarifying, conforming, and technical changes.

The bill takes effect July 1, 2020.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

[9] AHCA planning districts are established in s. 408.032, F.S.
[10] Based on 2018 birth rates, available from the DOH (http://www.flhealthcharts.com/charts/default.aspx), AHCA districts 4, 6, 7, 9, 10, and 11 have a sufficient volume of births to require the DOH to designate a second RPICC in those districts.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

SB 1374 may have an indeterminate positive fiscal impact on facilities and providers that are newly designated to provide RPICC services.

C. Government Sector Impact:

The bill may have an indeterminate negative fiscal impact on the state since the bill increases the number of RPICCs that may be designated and which may receive enhanced reimbursement rates from the Medicaid program.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 383.16, 383.17, 383.18, 383.19, 409.908, and 409.975.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.