By Senator Harrell

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1 A bill to be entitled
2 An act relating to regional perinatal intensive care
3 centers; amending s. 383.16, F.S.; defining and
4 revising terms; amending s. 383.17, F.S.; authorizing
5 the Department of Health to designate regional
6 perinatal intensive care centers; amending s. 383.18,
7 F.S.; providing that designation by the department is
8 required for participation in the regional perinatal
9 intensive care centers program; amending s. 383.19,
10 F.S.; specifying standards that must be included in
11 department rules relating to the designation,
12 development, and operation of a regional perinatal
13 intensive care center; authorizing the department to
14 designate two regional perinatal intensive care
15 centers in a district under certain circumstances;
16 specifying reimbursement parameters for certain
17 services provided in a regional perinatal intensive
18 care center setting; providing parameters for removal
19 of a regional perinatal intensive care center's
20 designation; specifying criteria centers must meet for
21 the department's selection and designation as regional
22 perinatal intensive care centers; requiring the
23 department, in consultation with the agency, to
24 develop and implement a process by a specified date to
25 determine levels of maternal care provided by regional
26 perinatal intensive care centers; revising the
27 contents of certain annual reports that regional
28 perinatal intensive care centers are required to
29 submit to the department; requiring the department to

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30 conduct an onsite review of each center at least once
31 every 3 years; amending s. 409.908, F.S.; conforming
32 provisions to changes made by the act; amending s.
33 409.975, F.S.; conforming a cross-reference; providing
34 an effective date.
35
36 Be It Enacted by the Legislature of the State of Florida:
37
38 Section 1. Present subsections (1), (2), and (3) of section
39 383.16, Florida Statutes, are redesignated as subsections (2),
40 (4), and (5), respectively, new subsections (1) and (3) are
41 added to that section, and present subsection (2) of that
42 section is amended, to read:
43 383.16 Definitions; ss. 383.15-383.19.—As used in ss.
44 383.15-383.19, the term:
45 (1) “Agency” means the Agency for Health Care
46 Administration.
47 (3) “District” has the same meaning as in s. 408.032.
48 (4) ~~(2)~~ “Regional perinatal intensive care center” or
49 “center” means a unit designated by the department, located
50 within a hospital, and specifically designed to provide a full
51 range of perinatal health services to its patients.
52 Section 2. Section 383.17, Florida Statutes, is amended to
53 read:
54 383.17 Regional perinatal intensive care centers program;
55 authority.—The department may designate and contract with health
56 care providers in establishing and maintaining centers in
57 accordance with ss. 383.15-383.19. The cost of administering the
58 regional perinatal intensive care centers program shall be paid

59 by the department from funds appropriated for this purpose.
60 Section 3. Section 383.18, Florida Statutes, is amended to
61 read:
62 383.18 Designations; contracts; conditions.—Participation
63 in the regional perinatal intensive care centers program under
64 ss. 383.15-383.19 is contingent upon the department designating
65 and entering into a contract with a provider. The contract must
66 ~~shall~~ provide that patients will receive services from the
67 center and that parents or guardians of patients who participate
68 in the program and who are in compliance with Medicaid
69 eligibility requirements as determined by the department are not
70 additionally charged for treatment and care that ~~which~~ has been
71 contracted for by the department. Financial eligibility for the
72 program is based on the Medicaid income guidelines for pregnant
73 women and for children younger than ~~under~~ 1 year of age. Funding
74 must ~~shall~~ be provided in accordance with ss. 383.19 and
75 409.908.
76 Section 4. Section 383.19, Florida Statutes, is amended to
77 read:
78 383.19 Standards; funding; ineligibility.—
79 (1) The department shall adopt rules that specify standards
80 for designation, development, and operation of a center which
81 must include, but need not be ~~are not~~ limited to:
82 (a) The need to provide services through a regional
83 perinatal intensive care center and the requirements of the
84 population to be served.
85 (b) Equipment.
86 (c) Facilities.
87 (d) Staffing and qualifications of personnel.

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88 (e) Transportation services.
89 (f) Data collection.
90 (g) Levels of care.
91 (h) Educational outreach.
92 (i) Access to consultative specialist services.
93 (j) Participation in quality collaborations, both within
94 and outside of the center's district.
95 (k) Support of rural hospitals, as defined in s. 395.602.
96 (l) ~~(g)~~ Definitions of terms.
97 (2) The department shall designate at least one center to
98 serve a geographic area representing each district ~~region~~ of the
99 state, and one additional center may be designated in any
100 district in which at least 20,000 resident ~~10,000~~ live births
101 occur per year, as reported by the department's Bureau of Vital
102 Statistics, but in no case may there be more than 22 ~~11~~ regional
103 perinatal intensive care centers established unless specifically
104 authorized in the General Appropriations Act or in this
105 subsection.
106 (3) Medicaid reimbursement must ~~shall~~ be made for services
107 provided to patients who are Medicaid recipients. Medicaid
108 reimbursement for in-center and outpatient obstetrical and
109 neonatal physician services must be paid as follows:
110 (a) Reimbursement for such services provided at centers to
111 members of a managed care plan as defined in s. 409.962 must be
112 paid in accordance with the provider payment provisions of part
113 IV of chapter 409; or
114 (b) Reimbursement for such services provided at centers on
115 a fee-for-service basis must ~~shall~~ be based upon the obstetrical
116 care group payment system or~~. Medicaid reimbursement for in-~~

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117 ~~center neonatal physician services shall be based upon~~ the
118 neonatal care group payment system, as applicable. These
119 prospective payment systems, developed by the department, must
120 place patients into homogeneous groups based on clinical
121 factors, severity of illness, and intensity of care. ~~Outpatient~~
122 ~~obstetrical services and other~~ Related services provided on a
123 fee-for-service basis, such as consultations, must ~~shall~~ be
124 reimbursed based on the usual Medicaid method of fee-for-service
125 payment for such ~~outpatient~~ medical services.
126 (4)~~(3)~~ Failure to comply with any standard ~~the standards~~
127 established under this section, department rules, or the terms
128 of the contract between the department and a center constitutes
129 grounds for terminating the contract and removal of the center's
130 designation.
131 (5)~~(4)~~ The department shall select and designate centers
132 that do all of the following: ~~give priority to establishing~~
133 ~~centers in hospitals that~~
134 (a) Demonstrate an interest in perinatal intensive care by
135 meeting program standards established in this section and by the
136 department.
137 (b) Demonstrate a commitment to improving access to health
138 services, including the timely use of personal health services
139 to achieve the best health outcomes.
140 (c) Maintain a facility birth volume of at least 3,000 live
141 births per year.
142 (d) Actively participate in one or more perinatal quality
143 collaborations as defined by department rule.
144 (6) No later than July 1, 2023, the department, in
145 consultation with the agency, shall develop and implement a

146 statewide process to engage perinatal stakeholders for the
147 purpose of determining appropriate and efficacious levels of
148 maternal care provided by centers. The statewide process must
149 seek to standardize the centers’ internal assessments of levels
150 of maternal care guided by methodologies and tools developed by
151 the federal Centers for Disease Control and Prevention.
152 (7)~~(5)~~ A private, for-profit hospital that does not accept
153 county, state, or federal funds or indigent patients is not
154 eligible to participate under ss. 383.15-383.19.
155 (8)~~(6)~~ Each hospital that is designated by and contracts
156 with the department to provide services under the terms of ss.
157 383.15-383.19 shall prepare and submit to the department an
158 annual report that includes, but is not limited to, the number
159 of clients served, quality improvement measures and projects
160 that the center has engaged in, and the costs of services in the
161 center. The department shall annually conduct a programmatic and
162 financial evaluation of each center and shall conduct an onsite
163 review of each center at least once every 3 years.
164 Section 5. Paragraph (c) of subsection (12) of section
165 409.908, Florida Statutes, is amended to read:
166 409.908 Reimbursement of Medicaid providers.—Subject to
167 specific appropriations, the agency shall reimburse Medicaid
168 providers, in accordance with state and federal law, according
169 to methodologies set forth in the rules of the agency and in
170 policy manuals and handbooks incorporated by reference therein.
171 These methodologies may include fee schedules, reimbursement
172 methods based on cost reporting, negotiated fees, competitive
173 bidding pursuant to s. 287.057, and other mechanisms the agency
174 considers efficient and effective for purchasing services or

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175 goods on behalf of recipients. If a provider is reimbursed based
176 on cost reporting and submits a cost report late and that cost
177 report would have been used to set a lower reimbursement rate
178 for a rate semester, then the provider’s rate for that semester
179 shall be retroactively calculated using the new cost report, and
180 full payment at the recalculated rate shall be effected
181 retroactively. Medicare-granted extensions for filing cost
182 reports, if applicable, shall also apply to Medicaid cost
183 reports. Payment for Medicaid compensable services made on
184 behalf of Medicaid eligible persons is subject to the
185 availability of moneys and any limitations or directions
186 provided for in the General Appropriations Act or chapter 216.
187 Further, nothing in this section shall be construed to prevent
188 or limit the agency from adjusting fees, reimbursement rates,
189 lengths of stay, number of visits, or number of services, or
190 making any other adjustments necessary to comply with the
191 availability of moneys and any limitations or directions
192 provided for in the General Appropriations Act, provided the
193 adjustment is consistent with legislative intent.
194 (12)
195 (c) Notwithstanding paragraph (b), reimbursement fees to
196 physicians for providing total obstetrical services to Medicaid
197 recipients, which include prenatal, delivery, and postpartum
198 care, shall be at least $1,500 per delivery for a pregnant woman
199 with low medical risk and at least $2,000 per delivery for a
200 pregnant woman with high medical risk. However, reimbursement to
201 physicians working in regional perinatal intensive care centers
202 designated pursuant to chapter 383, for services to certain
203 pregnant Medicaid recipients with a high medical risk, must ~~may~~

204 be made according to <u>s. 383.19(3)</u> ~~obstetrical care and neonatal~~
205 ~~care groupings and rates established by the agency~~. Nurse
206 midwives licensed under part I of chapter 464 or midwives
207 licensed under chapter 467 shall be reimbursed at no less than
208 80 percent of the low medical risk fee. The agency shall by rule
209 determine, for the purpose of this paragraph, what constitutes a
210 high or low medical risk pregnant woman and shall not pay more
211 based solely on the fact that a caesarean section was performed,
212 rather than a vaginal delivery. The agency shall by rule
213 determine a prorated payment for obstetrical services in cases
214 where only part of the total prenatal, delivery, or postpartum
215 care was performed. The Department of Health shall adopt rules
216 for appropriate insurance coverage for midwives licensed under
217 chapter 467. Prior to the issuance and renewal of an active
218 license, or reactivation of an inactive license for midwives
219 licensed under chapter 467, such licensees shall submit proof of
220 coverage with each application.
221 Section 6. Paragraph (b) of subsection (1) of section
222 409.975, Florida Statutes, is amended to read:
223 409.975 Managed care plan accountability.—In addition to
224 the requirements of s. 409.967, plans and providers
225 participating in the managed medical assistance program shall
226 comply with the requirements of this section.
227 (1) PROVIDER NETWORKS.—Managed care plans must develop and
228 maintain provider networks that meet the medical needs of their
229 enrollees in accordance with standards established pursuant to
230 s. 409.967(2)(c). Except as provided in this section, managed
231 care plans may limit the providers in their networks based on
232 credentials, quality indicators, and price.

233 (b) Certain providers are statewide resources and essential
234 providers for all managed care plans in all regions. All managed
235 care plans must include these essential providers in their
236 networks. Statewide essential providers include:
237 1. Faculty plans of Florida medical schools.
238 2. Regional perinatal intensive care centers as defined in
239 s. 383.16(4) ~~s. 383.16(2)~~.
240 3. Hospitals licensed as specialty children's hospitals as
241 defined in s. 395.002(27).
242 4. Accredited and integrated systems serving medically
243 complex children which comprise separately licensed, but
244 commonly owned, health care providers delivering at least the
245 following services: medical group home, in-home and outpatient
246 nursing care and therapies, pharmacy services, durable medical
247 equipment, and Prescribed Pediatric Extended Care.
248
249 Managed care plans that have not contracted with all statewide
250 essential providers in all regions as of the first date of
251 recipient enrollment must continue to negotiate in good faith.
252 Payments to physicians on the faculty of nonparticipating
253 Florida medical schools shall be made at the applicable Medicaid
254 rate. Payments for services rendered by regional perinatal
255 intensive care centers shall be made at the applicable Medicaid
256 rate as of the first day of the contract between the agency and
257 the plan. Except for payments for emergency services, payments
258 to nonparticipating specialty children's hospitals shall equal
259 the highest rate established by contract between that provider
260 and any other Medicaid managed care plan.
261 Section 7. This act shall take effect July 1, 2020.

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