A bill to be entitled

An act relating to Medicaid; repealing s. 381.0403, F.S., relating to the Community Hospital Education Act; amending s. 395.602, F.S.; modifying the timeframe and requirements for the designation of a rural hospital; amending s. 409.905, F.S.; providing a prospective payment methodology for establishing hospital reimbursement rates; specifying dates by which local governmental entities must submit letters of agreement for intergovernmental transfers; deleting a requirement to develop a plan to convert Medicaid inpatient hospital rates to diagnosis-related groups; specifying dates by which the Agency for Health Care Administration must correct errors in rate calculations for inpatient and outpatient reimbursement rates; amending s. 409.908, F.S.; revising the current hospital inpatient reimbursement system to a diagnosis-related group system; amending s. 409.911, F.S.; revising the years of audited data used to determine Medicaid and charity care days for hospitals in the disproportionate share program; continuing Medicaid disproportionate share program distributions for nonstate government-owned or operated hospitals eligible for payment on a specified date; creating s. 409.9111, F.S.; establishing the Statewide Medicaid Graduate Medical Education program; requiring hospitals participating in the program to provide certain information to the agency; requiring

the agency to allocate funds to hospitals based on certain criteria; providing a formula for calculating a participating hospital's allocation; authorizing the Agency for Health Care Administration to adopt rules; amending s. 409.9118, F.S.; revising the Medicaid disproportionate share program distribution criteria for specialty hospitals related to tuberculosis patient services; providing an effective date.

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

Section 1. Section 381.0403, Florida Statutes, is repealed.

Section 2. 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, having 100 or fewer licensed beds and an emergency room, which is:

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

2. An acute care hospital, in a county with a population density of 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 per square mile;

4. A hospital in a constitutional charter county with a population of over 1 million persons 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 less that serves an agricultural community with an emergency room utilization of no less than 20,000 visits and a Medicaid inpatient utilization rate greater than 15 percent;

5. A hospital with a service area that has a population of 100 persons or fewer 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 years is deemed to 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 3. Paragraphs (c) through (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~~. The reimbursement rate ~~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 agency's methodology shall categorize each inpatient admission into diagnosis-related groups and assign a relative payment weight to the base rate according to the average relative amount of hospital resources used to treat a patient in a specific diagnosis-related group 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. The agency may adopt alternative weights if the agency finds that Florida-specific weights deviate with statistical significance from national weights for high volume diagnosis-

related groups. The agency shall establish a single, uniform base rate for all hospitals unless specifically exempt pursuant to s. 409.908(1).

1. Adjustments may not be made to the rates after October 31 of the state fiscal year in which the rates take effect, except as defined in subparagraph 2. and 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. Local governmental entities must submit to the agency, by no later than October 15 of each year, a final executed letter of agreement containing the total amount of intergovernmental transfers authorized by the entity for consideration in the reimbursement methodology.

2. Errors in source data ~~cost reporting~~ or calculation of rates discovered by November 7 must be corrected by the agency subsequent to November 15. Errors in source data or calculation of rates discovered after November 7 ~~after October 31~~ must be reconciled in a subsequent rate period. 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 requirement that 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 is remedial and applies to actions by providers involving Medicaid claims for hospital services. Hospital 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.

(e) The agency may develop and implement a program to reduce the number of hospital readmissions among the non-Medicare population eligible in areas 9, 10, and 11.

~~(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, 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 each hospital based on allowable costs, as defined by the agency. Rates shall be calculated annually and take effect July 1 of each year. The agency may periodically adjust the outpatient reimbursement rate using aggregate cost report data based on the most recent complete and accurate cost reports 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 as defined in subparagraph 2., and 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 the $1 million limitation is subject to notice and objection procedures set forth in s. 216.177. Local governmental entities must submit to the agency, by no later than October 15 of each year, a final executed letter of agreement containing the total amount of intergovernmental

transfers authorized by the entity for consideration in the reimbursement methodology.

2. Any amendment to previously submitted cost reports must be submitted by a hospital no later than September 1 in order for the amended report to be considered by the agency, for the final rates set by October 31 of the current state fiscal year in which the rates take effect. Any errors in the calculation of rates discovered by November 7 must be corrected by the agency by November 15. Any errors in cost reporting or calculation of rates discovered after November 7 must be reconciled in a subsequent rate period. 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 requirement that 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 is remedial and applies to actions by providers involving Medicaid claims for hospital services. Hospital 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.

Section 4. 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 as otherwise provided in this subsection. ~~for:~~

1. When authorized by the General Appropriations Act, the agency may modify reimbursement rates for specific types of services or diagnoses, patient ages, and hospital provider types.

a. Unless otherwise provided in this section, the agency may not modify reimbursement rates for any individual hospital providing specialized services if those services are accounted for or reflected in the existing diagnosis-related groups used by the agency. The agency may modify reimbursement rates for specialized diagnosis-related group categories.

b. The agency may not modify reimbursement rates for statutory teaching hospitals as defined in s. 408.07(45) or the costs associated with graduate medical education if hospitals licensed under part I of chapter 395 receive funding through the Statewide Medicaid Graduate Medical Education program under s. 409.9111 or the disproportionate share program for teaching hospitals under s. 409.9113.

2. The agency may establish an alternative system of reimbursement for the diagnosis-related group-based prospective payment system for:

a. State-owned psychiatric hospitals.

b. Newborn hearing screening services.

c. Transplant services for which the agency may establish a global fee.

d. Patients with tuberculosis who have been resistant to therapy and are in need of long-term hospital-based treatment

pursuant to a contract established under s. 392.62.

3. The agency shall modify reimbursement according to other methodologies recognized in the General Appropriations Act.

~~1. The raising of rate reimbursement caps, excluding rural hospitals.~~

~~2. Recognition of the costs of graduate medical education.~~

~~3. 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 shall be subject to certification by the Department of Health that the hospital has complied with s. 381.0403.~~ The agency 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 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 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. The local governmental entity shall use a certification form prescribed by the agency. At a minimum, the certification form 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 no later than January 1, annually.

Section 5. Paragraph (a) of subsection (2) and paragraph (d) of subsection (4) of section 409.911, Florida Statutes, are 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 2005 ~~2004~~, 2006 ~~2005~~, and 2007 ~~2006~~

audited disproportionate share data to determine each hospital's Medicaid days and charity care for the 2013-2014 ~~2012-2013~~ state fiscal year.

(4) The following formulas shall be used to pay disproportionate share dollars to public hospitals:

(d) Any nonstate government owned or operated hospital eligible for payments under this section on July 1, 2011, remains eligible for payments during the 2013-2014 ~~2012-2013~~ state fiscal year.

Section 6. Section 409.9111, Florida Statutes, is created to read:

409.9111 Statewide Medicaid Graduate Medical Education program.—The Statewide Medicaid Graduate Medical Education program is established to improve access to and quality of care for Medicaid beneficiaries, support graduate medical education on an equitable basis, and increase the supply of highly-trained physicians statewide. The agency shall make quarterly Medicaid payments to hospitals, licensed under part I of chapter 395, for their costs associated with providing graduate medical education in each fiscal year that an appropriation is made for this purpose.

(1) On or before July 15 of each year a hospital participating in the Statewide Medicaid Graduate Medical Education program shall provide the agency with the number of medical interns, residents, and fellows reported in the hospital's most recently filed CMS-2522-10 Medicare cost report; the number and type of graduate medical education programs accredited by the Accreditation Council for Graduate Medical

Education or the Council on Postdoctoral Training of the American Osteopathic Association in which the medical interns, residents, and fellows participate; and the direct graduate medical education costs as reported for Medicaid in the hospital's most recently filed CMS-2522-10 Medicare cost report.

(2) The agency shall calculate an allocation fraction to be used for distributing funds to participating hospitals. The allocation fraction for each hospital shall be determined by the following primary factors:

(a) The number of full-time equivalent residents. For purposes of this section, the term "resident" means the number of unweighted full-time equivalent allopathic and osteopathic medical interns, residents, and fellows enrolled in a program accredited by the Accreditation Council for Graduate Medical Education or the Council on Postdoctoral Training of the American Osteopathic Association as reported in the hospital's most recently filed CMS-2522-10 Medicare cost report.

(b) Medicaid payments. For purposes of this section, the term "Medicaid payments" means a hospital's direct medical education costs divided by total facility costs as reported in the most recently filed CMS-2522-10 Medicare cost report multiplied by the sum of the hospital's total Medicaid inpatient reimbursements.

(3) On or before October 1 of each year, the agency shall use the following formula to calculate a participating hospital's allocation fraction:

THAF=[(HFTE/TFTE) x 0.5] + [(HGMP/TGMP) x 0.5]

Where:

THAF = A hospital's total allocation fraction.

HFTE = A hospital's total number of full-time equivalent residents.

TFTE = The sum of all participating hospitals' full-time equivalent residents.

HGMP = A hospital's total Graduate Medical Education payments attributable to Medicaid.

TGMP = The sum of all participating hospitals' total Graduate Medical Education payments attributable to Medicaid.

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

Section 7. Paragraphs (b) and (c) of subsection (2) of section 409.9118, Florida Statutes, are amended, and paragraph (d) is added to that subsection, 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 licensed in accordance with part I of chapter 395 as a specialty hospital which meet all requirements listed in subsection (2). Notwithstanding s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for patients.

(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:

(b) Receive ~~all of its~~ inpatient clients through referrals

or admissions from county public health departments, as defined in chapter 154.

(c) Require a diagnosis for the control of active tuberculosis or a history of noncompliance with prescribed drug regimens for treatment of tuberculosis ~~a communicable disease~~ for ~~all~~ admissions for inpatient treatment.

(d) Retain a contract with the Department of Health to accept clients for admission and inpatient treatment pursuant to s. 392.62.

Section 8. This act shall take effect July 1, 2013.