By the Committee on Fiscal Policy; and Senators Stargel, Gaetz, and Hays

594-04179-15 2015322c1

A bill to be entitled

An act relating to Medicaid reimbursement for hospital providers; amending s. 409.908, F.S.; defining terms; requiring the Agency for Health Care Administration to provide written notice, pursuant to ch. 120, F.S., of reimbursement rates to providers; specifying procedures and requirements to challenge the calculation of or the methodology used to calculate such rates; providing that the failure to timely file a certain challenge constitutes acceptance of the rates; specifying limits on and procedures for the correction or adjustment of the rates; providing applicability; prohibiting the agency from being compelled by an administrative body or a court to pay additional compensation that exceeds a certain amount to a hospital for specified matters unless an appropriation is made by law; prohibiting certain periods of time from being tolled under specified circumstances; specifying that an administrative proceeding is the exclusive means for challenging certain issues; reenacting ss. 383.18, 409.8132(4), and 409.905(5)(c) and (6)(b), F.S., relating to contracts for the regional perinatal intensive care centers program, the Medikids program component, and mandatory Medicaid services, respectively, to incorporate the amendment made to s. 409.908, F.S., in references thereto; providing that the act is remedial, intended to confirm and clarify law, and applies to proceedings pending on or commenced after

the effective date; providing an effective date.

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

Section 1. Paragraph (e) is added to subsection (1) of section 409.908, Florida Statutes, 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.

(e)1. As used in this paragraph, the term:

a. "Appropriation made by law" has the same meaning as provided in s. 11.066.

b. "Reimbursement rate" means the audited hospital cost-based per diem reimbursement rate for inpatient or outpatient care established by the agency.

2. Pursuant to chapter 120, the agency shall furnish written notice of a reimbursement rate to providers. The written notice constitutes final agency action. A substantially affected provider seeking to correct or adjust the calculation of a reimbursement rate, based on a challenge other than a challenge to a methodology used to calculate a reimbursement rate as described in subparagraph 3., may request an administrative hearing by filing a petition with the agency within 180 days after receipt of the written notice by the provider. The failure to timely file a petition in compliance with this subparagraph is deemed conclusive acceptance of the reimbursement rate.

3. An administrative proceeding pursuant to s. 120.569 or s. 120.57 which challenges a methodology that is specified in an agency rule or in a reimbursement plan incorporated by reference in such rule and that is used to calculate a reimbursement rate

may not result in a correction or an adjustment of a reimbursement rate for a rate period that occurred more than 5 years before the date the petition initiating the proceeding was filed.

4. This paragraph applies to any challenge described in subparagraph 2. or subparagraph 3., including a right to challenge which arose before July 1, 2015. A correction or adjustment of a reimbursement rate which is required by an administrative order or appellate decision:

a. Must be reconciled in the first rate period after the order or decision becomes final; and

b. May not serve as the basis for a challenge to correct or adjust hospital rates required to be paid by a Medicaid managed care provider pursuant to part IV of chapter 409.

5. The agency may not be compelled by an administrative body or a court to pay compensation that exceeds $5 million to a hospital relating to the establishment of reimbursement rates by the agency or for remedies relating to such rates, unless an appropriation made by law is enacted for the exclusive, specific purpose of paying such additional compensation.

6. A period of time specified in this paragraph is not tolled by the pendency of an administrative or appellate proceeding.

7. An administrative proceeding pursuant to chapter 120 is the exclusive means to challenge a reimbursement rate as described under subparagraph 2. before, on, or after July 1, 2015, and to challenge a methodology used to calculate a reimbursement rate as described under subparagraph 3.

Section 2. For the purpose of incorporating the amendment

made by this act to section 409.908, Florida Statutes, in a reference thereto, section 383.18, Florida Statutes, is reenacted to read:

383.18 Contracts; conditions.—Participation in the regional perinatal intensive care centers program under ss. 383.15-383.19 is contingent upon the department entering into a contract with a provider. The contract shall provide that patients will receive services from the center and that parents or guardians of patients who participate in the program and who are in compliance with Medicaid eligibility requirements as determined by the department are not additionally charged for treatment and care which has been contracted for by the department. Financial eligibility for the program is based on the Medicaid income guidelines for pregnant women and for children under 1 year of age. Funding shall be provided in accordance with ss. 383.19 and 409.908.

Section 3. For the purpose of incorporating the amendment made by this act to section 409.908, Florida Statutes, in a reference thereto, subsection (4) of section 409.8132, Florida Statutes, is reenacted to read:

409.8132 Medikids program component.—

(4) APPLICABILITY OF LAWS RELATING TO MEDICAID.—The provisions of ss. 409.902, 409.905, 409.906, 409.907, 409.908, 409.912, 409.9121, 409.9122, 409.9123, 409.9124, 409.9127, 409.9128, 409.913, 409.916, 409.919, 409.920, and 409.9205 apply to the administration of the Medikids program component of the Florida Kidcare program, except that s. 409.9122 applies to Medikids as modified by the provisions of subsection (7).

Section 4. For the purpose of incorporating the amendment

made by this act to section 409.908, Florida Statutes, in references thereto, paragraph (c) of subsection (5) and paragraph (b) of subsection (6) of section 409.905, Florida Statutes, are reenacted 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 reimbursement rates for inpatient hospital services. Rates shall be calculated annually and take effect July 1 of each year. The methodology shall categorize each inpatient admission into a diagnosis-related group 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 or 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 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 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 more than 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.

(6) HOSPITAL OUTPATIENT SERVICES.—

(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 more than 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 5. The amendment made by this act to s. 409.908, Florida Statutes, is remedial in nature, confirms and clarifies existing law, and applies to all proceedings pending on or commenced after this act takes effect.

Section 6. This act shall take effect upon becoming a law.