

By the Committee on Appropriations

576-03520-13

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1 A bill to be entitled
2 An act relating to Medicaid; amending s. 395.602,
3 F.S.; providing that certain rural hospitals remain
4 rural hospitals under specified circumstances;
5 amending s. 409.905, F.S.; requiring the Agency for
6 Health Care Administration to implement a prospective
7 payment system for inpatient hospital services using
8 diagnosis-related groups (DRGs); deleting provisions
9 directing the agency to develop a plan to convert
10 hospital reimbursement for inpatient services to a
11 prospective payment system; requiring hospital
12 reimbursement for outpatient services to be based on
13 allowable costs; providing that adjustments may not be
14 made after a certain date; providing for the
15 reconciliation of errors in source data or
16 calculations; amending s. 409.908, F.S.; revising
17 exceptions to limitations on hospital reimbursement
18 for inpatient services; providing parameters for
19 submission of letters of agreement by local
20 governmental entities to the agency relating to funds
21 for special payments; creating s. 409.909, F.S.;
22 establishing the Statewide Medicaid Residency Program;
23 providing the purposes of the program; providing
24 definitions; providing a formula and limitations for
25 allocating funds to participating hospitals;
26 authorizing the agency to adopt rules; amending s.
27 409.911, F.S.; updating references to data used for
28 calculations in the disproportionate share program;
29 amending s. 409.9118, F.S.; amending parameters for

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

34
 35 Be It Enacted by the Legislature of the State of Florida:

36
 37 Section 1. Paragraph (e) of subsection (2) of section
 38 395.602, Florida Statutes, is amended to read:

39 395.602 Rural hospitals.—

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

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

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

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

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

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

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59 event on August 24, 1992, for which the Governor of Florida
60 declared a state of emergency pursuant to chapter 125, and has
61 ~~120 beds~~ or fewer beds which less than serves an agricultural
62 community that has ~~with~~ an emergency room utilization of at
63 least ~~no less than~~ 20,000 visits and a Medicaid inpatient
64 utilization rate greater than 15 percent;

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

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

75
76 Population densities used in this paragraph must be based upon
77 the most recently completed United States census. A hospital
78 that received funds under s. 409.9116 for a quarter beginning no
79 later than July 1, 2002, is deemed to have been and shall
80 continue to be a rural hospital from that date through June 30,
81 2015, if the hospital continues to have 100 or fewer licensed
82 beds and an emergency room, or meets the criteria of
83 subparagraph 4. An acute care hospital that has not previously
84 been designated as a rural hospital and that meets the criteria
85 of this paragraph shall be granted such designation upon
86 application, including supporting documentation, to the agency
87 ~~for Health Care Administration~~. A hospital that was licensed as

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

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

95 409.905 Mandatory Medicaid services.—The agency may make
96 payments for the following services, which are required of the
97 state by Title XIX of the Social Security Act, furnished by
98 Medicaid providers to recipients who are determined to be
99 eligible on the dates on which the services were provided. Any
100 service under this section shall be provided only when medically
101 necessary and in accordance with state and federal law.
102 Mandatory services rendered by providers in mobile units to
103 Medicaid recipients may be restricted by the agency. Nothing in
104 this section shall be construed to prevent or limit the agency
105 from adjusting fees, reimbursement rates, lengths of stay,
106 number of visits, number of services, or any other adjustments
107 necessary to comply with the availability of moneys and any
108 limitations or directions provided for in the General
109 Appropriations Act or chapter 216.

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

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117 comply with the General Appropriations Act. Effective August 1,
118 2012, the agency shall limit payment for hospital emergency
119 department visits for a nonpregnant Medicaid recipient 21 years
120 of age or older to six visits per fiscal year.

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

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

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146 31 of the state fiscal year in which the rates take effect,
147 except for cases of insufficient collections of
148 intergovernmental transfers authorized under s. 409.908(1) or
149 the General Appropriations Act. In such cases, the agency shall
150 submit a budget amendment or amendments under chapter 216
151 requesting approval of rate reductions by amounts necessary for
152 the aggregate reduction to equal the dollar amount of
153 intergovernmental transfers not collected and the corresponding
154 federal match. Notwithstanding the \$1 million limitation on
155 increases to an approved operating budget contained in ss.
156 216.181(11) and 216.292(3), a budget amendment exceeding that
157 dollar amount is subject to notice and objection procedures set
158 forth in s. 216.177.

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

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

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

199 1. The plan must:

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

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

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

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

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

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

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

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

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

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

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

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

240 (6) HOSPITAL OUTPATIENT SERVICES.—

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

251 (b) The agency shall implement a methodology for
252 establishing base reimbursement rates for outpatient services
253 for each hospital based on allowable costs, as defined by the
254 agency. Rates shall be calculated annually and take effect July
255 1 of each year based on the most recent complete and accurate
256 cost report submitted by each hospital.

257 1. Adjustments may not be made to the rates after October
258 31 of the state fiscal year in which the rates take effect,
259 except for cases of insufficient collections of
260 intergovernmental transfers authorized under s. 409.908(1) or
261 the General Appropriations Act. In such cases, the agency shall

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262 submit a budget amendment or amendments under chapter 216
263 requesting approval of rate reductions by amounts necessary for
264 the aggregate reduction to equal the dollar amount of
265 intergovernmental transfers not collected and the corresponding
266 federal match. Notwithstanding the \$1 million limitation on
267 increases to an approved operating budget under ss. 216.181(11)
268 and 216.292(3), a budget amendment exceeding that dollar amount
269 is subject to notice and objection procedures set forth in s.
270 216.177.

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

283 Section 3. Paragraph (a) of subsection (1) of section
284 409.908, Florida Statutes, is amended to read:

285 409.908 Reimbursement of Medicaid providers.—Subject to
286 specific appropriations, the agency shall reimburse Medicaid
287 providers, in accordance with state and federal law, according
288 to methodologies set forth in the rules of the agency and in
289 policy manuals and handbooks incorporated by reference therein.
290 These methodologies may include fee schedules, reimbursement

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291 methods based on cost reporting, negotiated fees, competitive
292 bidding pursuant to s. 287.057, and other mechanisms the agency
293 considers efficient and effective for purchasing services or
294 goods on behalf of recipients. If a provider is reimbursed based
295 on cost reporting and submits a cost report late and that cost
296 report would have been used to set a lower reimbursement rate
297 for a rate semester, then the provider's rate for that semester
298 shall be retroactively calculated using the new cost report, and
299 full payment at the recalculated rate shall be effected
300 retroactively. Medicare-granted extensions for filing cost
301 reports, if applicable, shall also apply to Medicaid cost
302 reports. Payment for Medicaid compensable services made on
303 behalf of Medicaid eligible persons is subject to the
304 availability of moneys and any limitations or directions
305 provided for in the General Appropriations Act or chapter 216.
306 Further, nothing in this section shall be construed to prevent
307 or limit the agency from adjusting fees, reimbursement rates,
308 lengths of stay, number of visits, or number of services, or
309 making any other adjustments necessary to comply with the
310 availability of moneys and any limitations or directions
311 provided for in the General Appropriations Act, provided the
312 adjustment is consistent with legislative intent.

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

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

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

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

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

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

329 a. State-owned psychiatric hospitals.

330 b. Newborn hearing screening services.

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

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

337
 338 During the years funds are transferred from the Department of
 339 Health, any reimbursement supported by such funds is ~~shall be~~
 340 subject to certification by the Department of Health that the
 341 hospital has complied with s. 381.0403. The agency may ~~is~~
 342 ~~authorized to~~ receive funds from state entities, including, but
 343 not limited to, the Department of Health, local governments, and
 344 other local political subdivisions, for the purpose of making
 345 special exception payments, including federal matching funds,
 346 through the Medicaid inpatient reimbursement methodologies.
 347 Funds received ~~from state entities or local governments~~ for this
 348 purpose shall be separately accounted for and may ~~shall~~ not be

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

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

375 409.909 Statewide Medicaid Residency Program.—

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

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

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

397 (a) "Full-time equivalent," or "FTE," means a resident who
398 is in his or her initial residency period, which is defined as
399 the minimum number of years of training required before the
400 resident may become eligible for board certification by the
401 American Osteopathic Association Bureau of Osteopathic
402 Specialists or the American Board of Medical Specialties in the
403 specialty in which he or she first began training, not to exceed
404 5 years. A resident training beyond the initial residency period
405 is counted as half of one FTE, unless his or her chosen
406 specialty is in general surgery or primary care, in which case

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

- 409 1. Family medicine;
 410 2. General internal medicine;
 411 3. General pediatrics;
 412 4. Preventive medicine;
 413 5. Geriatric medicine;
 414 6. Osteopathic general practice;
 415 7. Obstetrics and gynecology; and
 416 8. Emergency medicine.

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

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

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

$$431 \quad \text{HAF} = [0.9 \times (\text{HFTE}/\text{TFTE})] + [0.1 \times (\text{HMP}/\text{TMP})]$$

432
 433 Where:

434 HAF=A hospital's allocation fraction.

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

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436 TFTE=The total FTE residents for all participating
437 hospitals.

438 HMP=A hospital's Medicaid payments.

439 TMP=The total Medicaid payments for all participating
440 hospitals.

441
442 (4) A hospital's annual allocation shall be calculated by
443 multiplying the funds appropriated for the Statewide Medicaid
444 Residency Program in the General Appropriations Act by that
445 hospital's allocation fraction. If the calculation results in an
446 annual allocation that exceeds \$50,000 per FTE resident, the
447 hospital's annual allocation shall be reduced to a sum equaling
448 no more than \$50,000 per FTE resident. The funds calculated for
449 that hospital in excess of \$50,000 per FTE resident shall be
450 redistributed to participating hospitals whose annual allocation
451 does not exceed \$50,000 per FTE resident, using the same
452 methodology and payment schedule specified in this section.

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

454 Section 5. Paragraph (a) of subsection (2) of section
455 409.911, Florida Statutes, is amended to read:

456 409.911 Disproportionate share program.—Subject to specific
457 allocations established within the General Appropriations Act
458 and any limitations established pursuant to chapter 216, the
459 agency shall distribute, pursuant to this section, moneys to
460 hospitals providing a disproportionate share of Medicaid or
461 charity care services by making quarterly Medicaid payments as
462 required. Notwithstanding the provisions of s. 409.915, counties
463 are exempt from contributing toward the cost of this special
464 reimbursement for hospitals serving a disproportionate share of

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465 low-income patients.

466 (2) The Agency for Health Care Administration shall use the
467 following actual audited data to determine the Medicaid days and
468 charity care to be used in calculating the disproportionate
469 share payment:

470 (a) The average of the ~~2004,~~ 2005, ~~and 2006,~~ and 2007
471 audited disproportionate share data to determine each hospital's
472 Medicaid days and charity care for the 2013-2014 ~~2012-2013~~ state
473 fiscal year.

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

476 409.9118 Disproportionate share program for specialty
477 hospitals.—The agency ~~for Health Care Administration~~ shall
478 design and implement a system of making disproportionate share
479 payments to ~~these~~ hospitals under contract with the Department
480 of Health to provide licensed in accordance with part I of
481 ~~chapter 395 as a specialty hospital services and~~ which meet all
482 requirements specified ~~listed~~ in subsection (2). Notwithstanding
483 s. 409.915, counties are exempt from contributing toward the
484 cost of this special reimbursement for patients.

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

$$488 \qquad \qquad \qquad \text{TAE} = (\text{MD}/\text{TMD}) \times \text{TA}$$

491 Where:

492 TAE=total amount earned by a specialty hospital.

493 TA=total appropriation for payments to hospitals that

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494 qualify under this program.

495 MD=total Medicaid days for each qualifying hospital.

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

498

499 (2) In order to receive payments under this section, a
500 hospital must be licensed in accordance with part I of chapter
501 395, to participate in the Florida Title XIX program, and meet
502 the following requirements:

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

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

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

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