



Health Care Appropriations Subcommittee

January 12, 2016
1:30 PM – 3:30 PM
Webster Hall (212 Knott)

Meeting Packet



The Florida House of Representatives

Appropriations Committee

Health Care Appropriations Subcommittee

Steve Crisafulli
Speaker

Matt Hudson
Chair

January 12, 2016

AGENDA

1:30 PM – 3:30 PM

Webster Hall

- I. Call to Order/Roll Call
- II. HB 85—Recovery Care Services by Fitzenhagen
- III. CS/HB 595—Reimbursement to Health Access Settings for Dental Hygiene Services for Children by Plasencia
- IV. HB 423—Drug Prescription by Advanced Registered Nurse Practitioners & Physician Assistants by Pigman
- V. HB 581—State Veterans’ Nursing Homes by Magar
- VI. HB 437—Certificates of Need for Hospitals by Sprowls
- VII. Update by OPPAGA on Maintenance Adoption Subsidies Forecasting Methodology
 - *Justin Graham, Chief Legislative Analyst, OPPAGA*
- VIII. Presentation of Navigant report “Outpatient Prospective Payment System Design for Medicaid”
 - *Malcolm Ferguson, Associate Director, Navigant Consulting*

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IX. Closing/Adjourn

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 85 Recovery Care Services
SPONSOR(S): Fitzenhagen
TIED BILLS: IDEN./SIM. **BILLS:** SB 212

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Select Committee on Affordable Healthcare Access	10 Y, 4 N	Guzzo	Calamas
2) Health Care Appropriations Subcommittee		Clark 	Pridgeon 
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Pursuant to s. 395.002, F.S., an ambulatory surgical center (ASC) is a facility, that is not part of a hospital, the primary purpose of which is to provide elective surgical care, in which the patient is admitted and discharged within the same working day and is not permitted to stay overnight.

Federal Medicare reimbursement is generally limited to stays of no more than 24 hours. The bill changes the allowable length of stay in an ASC from less than one working day to no more than 24 hours, which is the federal Medicare length of stay standard.

The bill creates a new license for a Recovery Care Center (RCC), defined as a facility the primary purpose of which is to provide recovery care services, to which a patient is admitted and discharged within 72 hours, and which is not part of a hospital. The bill defines recovery care services as:

- Postsurgical and post-diagnostic medical and general nursing care to patients for whom acute hospitalization is not required and an uncomplicated recovery is reasonably expected; and
- Postsurgical rehabilitation services.

Recovery care services do not include intensive care services, coronary care services, or critical care services.

The bill requires all patients to be certified as medically stable and not in need of acute hospitalization by their attending or referring physician prior to admission to a RCC. A patient may receive recovery care services in a RCC upon:

- Discharge from an ASC after surgery;
- Discharge from a hospital after surgery or other treatment; or
- Receiving out-patient medical treatment such as chemotherapy.

The new RCC license is modeled after the current licensing procedures for hospitals and ASCs, subjecting RCCs to similar regulatory standards, inspections, and rules. RCCs must have emergency care and transfer protocols, including transportation arrangements, and a referral or admission agreement with at least one hospital.

The bill has an indeterminate, but likely insignificant fiscal impact that can be managed within existing Agency for Health Care Administration resources.

The bill provides an effective date of July 1, 2016.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Ambulatory Surgical Centers (ASCs)

An ASC is a facility, that is not a part of a hospital, the primary purpose of which is to provide elective surgical care, in which the patient is admitted and discharged within the same working day and is not permitted to stay overnight.¹

In Florida, outpatient surgery is performed in two settings, hospital outpatient surgery departments (HOPDs) and ASCs. Currently, there are 429 ASCs in Florida and 204 HOPDs.²

In 2014, there were 2,933,087 visits to ASCs and HOPDs in Florida.³ HOPDs accounted for 46 percent and ASCs accounted for 54 percent of the total number of visits. Of the \$33.8 billion in total combined charges in HOPDs and ASCs in 2014, HOPDs accounted for 77 percent of the charges, while ASCs accounted for 23 percent.⁴ The average charge at the HOPDs (\$19,140) was larger than the average charge at the ASCs (\$5,018).⁵ Two procedures, colonoscopy and gastrointestinal endoscopy, are consistently in the top 10 procedures performed by both facility types.⁶ In 2014, the average charge for a colonoscopy by site was \$6,694 for HOPDs and \$2,391 for ASCs.⁷ The average charge for gastrointestinal endoscopy by site was \$9,537 for HOPDs and \$2,269 for ASCs.⁸ This data was not adjusted for acuity, so it may reflect higher acuity levels in hospital patients.

In 2014, the charges for visits to ASCs and HOPDs were paid mainly by commercial Insurance and Medicare. Commercial insurance paid for 40 percent of charges (\$13.6 billion), while Medicare paid for 30 percent of charges (\$10.1 billion).⁹ The next three top payer groups (Medicare Managed Care, Medicaid, and Medicaid Managed Care) accounted for a combined 21.6 percent (\$7.3 billion) of charges.¹⁰

ASC Licensure

ASCs are licensed and regulated by the Agency for Health Care Administration (AHCA) under the same regulatory framework as hospitals.¹¹ Applicants for ASC licensure must submit certain information to AHCA prior to accepting patients for care or treatment, including:

- An affidavit of compliance with fictitious name;
- Proof of registration of articles of incorporation; and
- A zoning certificate or proof of compliance with zoning requirements.¹²

¹ S. 395.002(3), F.S.

² AHCA Agency Bill Analysis, dated September 18, 2015, pg. 3 (on file with Select Committee on Affordable Healthcare Access staff).

³ Agency for Health Care Administration, *Ambulatory (Outpatient) Surgery Query Results; By Facility Type and Average Charges*, available at <http://www.floridahealthfinder.gov/QueryTool/QTResults.aspx?T=O> (last viewed on November 12, 2015).

⁴ Id.

⁵ Id.

⁶ Agency for Health Care Administration, *Ambulatory (Outpatient) Surgery Query Results; By Current Procedural Terminology Code and Facility Type*, available at <http://www.floridahealthfinder.gov/QueryTool/QTResults.aspx?T=O> (last viewed on November 12, 2015).

⁷ Id.

⁸ Id.

⁹ Agency for Health Care Administration, *Ambulatory (Outpatient) Surgery Query Results; By Patient, Primary Payer, and Average Charges* <http://www.floridahealthfinder.gov/QueryTool/QTResults.aspx> (last viewed on November 10, 2015).

¹⁰ Id.

¹¹ SS. 395.001-1065, F.S., and Part II, Chapter 408, F.S.

Upon receipt of an initial application, AHCA is required to conduct a survey to determine compliance with all laws and rules. ASCs are required to provide certain information during the initial inspection, including:

- Governing body bylaws, rules and regulations;
- A roster of registered nurses and licensed practical nurses with current license numbers;
- A fire plan; and
- The comprehensive Emergency Management Plan.¹³

AHCA is authorized to adopt rules for hospitals and ASCs.¹⁴ Separate standards may be provided for general and specialty hospitals, ASCs, mobile surgical facilities, and statutory rural hospitals,¹⁵ but the rules for all hospitals and ASCs must include minimum standards for ensuring that:

- A sufficient number of qualified types of personnel and occupational disciplines are on duty and available at all times to provide necessary and adequate patient care;
- Infection control, housekeeping, sanitary conditions, and medical record procedures are established and implemented to adequately protect patients;
- A comprehensive emergency management plan is prepared and updated annually;
- Licensed facilities are established, organized, and operated consistent with established standards and rules; and
- Licensed facility beds conform to minimum space, equipment, and furnishing standards

The minimum standards for ASCs are contained in Chapter 59A-5, F.A.C.

Staff and Personnel Rules

ASCs are required to have written policies and procedures for surgical services, anesthesia services, nursing services, pharmaceutical services, and laboratory and radiologic services.¹⁶ In providing these services, ACSs are required to have certain professional staff available, including:

- A registered nurse to serve as operating room circulating nurse;¹⁷
- An Anesthesiologist or other physician, or a certified registered nurse anesthetist under the on-site medical direction of a licensed physician in the ASC during the anesthesia and post-anesthesia recovery period until all patients are alert or discharged;¹⁸ and
- A Registered professional nurse in the recovery area during the patient's recovery period.¹⁹

Infection Control Rules

ASCs are required to establish an infection control program, which must include written policies and procedures reflecting the scope of the program.²⁰ The written policies and procedures must be reviewed at least every two years by the infection control program members.²¹ The infection control program must include:

¹² Rule 59A-5.003(4), F.A.C.

¹³ Rule 59A-5.003(5), F.A.C.

¹⁴ S. 395.1055, F.S.

¹⁵ S. 395.1055(2), F.S.

¹⁶ Rule 59A-5.0085, F.A.C.

¹⁷ Rule 59A-5.0085(3)(c), F.A.C.

¹⁸ Rule 59A-5.0085(2)(b), F.A.C.

¹⁹ Rule 59A-5.0085(3)(d), F.A.C.

²⁰ Rule 59A-5.011(1), F.A.C.

²¹ Rule 59A-5.011(2), F.A.C.

- Surveillance, prevention, and control of infection among patients and personnel;²²
- A system for identifying, reporting, evaluating and maintaining records of infections;²³
- Ongoing review and evaluation of aseptic, isolation and sanitation techniques employed by the ASC;²⁴ and
- Development and coordination of training programs in infection control for all personnel.²⁵

Emergency Management Plan Rules

ASCs are required to develop and adopt a written comprehensive emergency management plan for emergency care during an internal or external disaster or emergency.²⁶ The ASC must review the plan and update it annually.²⁷

Accreditation

ASCs may seek voluntary accreditation by the Joint Commission for Health Care Organizations, the Accreditation Association for Ambulatory Health Care, and the American Osteopathic Association Healthcare Facilities Accreditation Program.²⁸ AHCA is required to conduct an annual licensure inspection survey for non-accredited ASCs.²⁹ AHCA must accept survey reports of accredited ASCs from accrediting organizations if the standards included in the survey report are determined to document that the ASC is in substantial compliance with state licensure requirements.³⁰ AHCA is required to conduct annual validation inspections on a minimum of 5 percent of the ASCs which were inspected by an accreditation organization.³¹

AHCA is required to conduct annual life safety inspections of all ASCs to ensure compliance with life safety codes and disaster preparedness requirements.³² However, the life-safety inspection may be waived if an accreditation inspection was conducted on an ASC by a certified life safety inspector and the ASC was found to be in compliance with the life safety requirements.³³

In 2014, 373 licensed ASCs in Florida were accredited by a national accrediting organization.³⁴

Federal Requirements

Medicare

ASCs are required to have an agreement with the Centers for Medicare and Medicaid Services (CMS) to participate in Medicare. ASCs are also required to comply with specific conditions for coverage. CMS defines "ASC" as any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and in which the expected duration of services would not exceed 24 hours³⁵ following an admission.³⁶

²² Rule 59A-5.011(1)(a), F.A.C.

²³ Rule 59A-5.011(1)(b), F.A.C.

²⁴ Rule 59A-5.011(1)(c), F.A.C.

²⁵ Rule 59A-5.011(1)(d), F.A.C.

²⁶ Rule 59A-5.018(1), F.A.C.

²⁷ Id.

²⁸ Rule 59A-5.004(3), F.A.C., and AHCA Ambulatory Surgical Center; *Accrediting Organizations for Ambulatory Surgical Centers*, available at http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Hospital_Outpatient/ambulatory.shtml (last viewed November 13, 2015).

²⁹ Rule 59A-5.004(1) and (2), F.A.C.

³⁰ Rule 59A-5.004(3), F.A.C.

³¹ Rule 59A-5.004(5), F.A.C.

³² Rule 59A-5.004(1), F.S., and s. 395.0161, F.S.

³³ S. 395.0161(2), F.S.

³⁴ Agency for Health Care Administration, *Ambulatory Surgical Center Regulatory Overview*, March 2015 (on file with Select Committee on Affordable Healthcare Access staff).

³⁵ State Operations Manual Appendix L, *Guidance for Surveyors: Ambulatory Surgical Centers* (Rev. 99, 01-31-14) exceeding the 24-hour time frame is expected to be a rare occurrence, and each rare occurrence is expected to be demonstrated to have been

CMS may deem an ASC to be in compliance with all of the conditions for coverage if the ASC is accredited by a national accrediting body, or licensed by a state agency, that CMS determines provides reasonable assurance that the conditions are met.³⁷ All of the CMS conditions for coverage requirements are included in Chapter 59A-5, F.A.C., and apply to all ASCs in Florida. The conditions for coverage require:

- A governing body that assumes full legal responsibility for determining, implementing, and monitoring policies governing the ASC's total operation;
- A quality assessment and performance improvement program;
- A transfer agreement with one or more acute care general hospitals, which will admit any patient referred who requires continuing care;
- A disaster preparedness plan;
- An organized medical staff;
- A fire control plan;
- A sanitary environment;
- An infection control program; and
- A procedure for patient admission, assessment and discharge.

Recovery Care Centers

Recovery care centers (RCCs) are entities that provide short-term nursing care, support, and pain control for patients that do not require acute hospitalization.³⁸ RCC patients are typically healthy persons that have had elective surgery. RCCs can be either freestanding or attached to an ASC or hospital. In practice, RCCs typically provide care to patients transferred from ASCs following surgery, which allows ASCs to perform more complex procedures.³⁹

RCCs are not eligible for Medicare reimbursement.⁴⁰ However, RCCs may receive payments from Medicaid programs. One 1999 survey noted that RCCs received payment in the following breakdown: 41% from managed care plans, 29% from self-pay, 16% from indemnity plans, and 9% from workers' compensation.⁴¹

Three states, Arizona, Connecticut, and Illinois, have specific licenses for "recovery care centers."⁴² Other states license RCCs as nursing facilities or hospitals.⁴³ One study found that eighteen states allow RCCs to have stays over 24 hours, usually with a maximum stay of 72 hours.⁴⁴

something which ordinarily could not have been foreseen. Not meeting this requirement constitutes condition-level noncompliance with §416.25. In addition, review of the cases that exceed the time frame may also reveal noncompliance with CfCs related to surgical services, patient admission and assessment, and quality assurance/performance improvement.

³⁶ 42 C.F.R. §416.2

³⁷ 42 C.F.R. §416.26(1)

³⁸ Medicare Payment Advisory Comm'n, Report to the Congress: Medicare Payment for Post-Surgical Recovery Care Centers, (2000).

³⁹ Id. at 4.

⁴⁰ See Medicare Payment Advisory Comm'n, Supra FN 20.

⁴¹ Medicare Payment Advisory Comm'n, Supra FN 20, at 6 (citing Federated Ambulatory Surgery Association, Post-Surgical Recovery Care, (2000)).

⁴² Ariz. Rev. Stat. Ann. §§ 36-448.51-36-448.55; Conn. Conn. Agencies Regs § 19A-495-571; 210 Ill. Comp. Stat. Ann. 3/35.

⁴³ Sandra Lee Breisch, *Profits in Short Stays*, Am. Acad. of Orthopaedic Surgeons Bulletin (June, 1999), available at <http://www2.aaos.org/bulletin/jun99/asc.htm>

⁴⁴ Medicare Payment Advisory Comm'n, supra FN 20, at 4 (citing Federated Ambulatory Surgery Association, Post-Surgical Recovery Care, (2000)).

Comparison of RCC Regulations in Arizona, Connecticut, and Illinois

Regulation	Arizona ⁴⁵	Connecticut ⁴⁶	Illinois ⁴⁷
Licensure Required	X	X	X
Written Policies	X	X	X
Maintain Medical Records	X	X	X
Patient's Bill of Rights	X	X	X
Allows Freestanding Facility or Attached	Not Addressed.	X	X
Length of Stay	Not Addressed.	Expected 3 days Maximum 21 days	Expected 48 hours Maximum 72 hours
Emergency Care Transfer Agreement	For care not provided by the recovery care center.	With a hospital and an ambulance service.	With a hospital within 15 minutes travel time.
Prohibited Patients	Patients needing: <ul style="list-style-type: none"> • Intensive care • Coronary care • Critical care 	Patients needing: <ul style="list-style-type: none"> • Intensive care • Coronary care • Critical care 	<ul style="list-style-type: none"> • Patients with chronic infectious conditions • Children under age 3
Prohibited Services	<ul style="list-style-type: none"> • Surgical • Radiological • Pediatric • Obstetrical 	<ul style="list-style-type: none"> • Surgical • Radiological • Pre-adolescent pediatric • Hospice • Obstetrical services over 24 week gestation • Intravenous therapy for non-hospital based RCC 	<ul style="list-style-type: none"> • Blood administration (only blood products allowed)
Required Services	<ul style="list-style-type: none"> • Laboratory • Pharmaceutical • Food 	<ul style="list-style-type: none"> • Pharmaceutical • Dietary • Personal care • Rehabilitation • Therapeutic • Social work 	<ul style="list-style-type: none"> • Laboratory • Pharmaceutical • Food • Radiological
Bed Limitation	Not Addressed.	Not Addressed.	20
Required Staff	<ul style="list-style-type: none"> • Governing authority • Administrator 	<ul style="list-style-type: none"> • Governing body • Administrator 	<ul style="list-style-type: none"> • Consulting committee
Required Medical Personnel	<ul style="list-style-type: none"> • At least two physicians • Director of nursing 	<ul style="list-style-type: none"> • Medical advisory board • Medical director • Director of nursing 	<ul style="list-style-type: none"> • Medical director • Nursing supervisor
Required Personnel When Patients Are Present	<ul style="list-style-type: none"> • Director of nursing 40 hours per week • One registered nurse • One other nurse 	<ul style="list-style-type: none"> • Two persons for patient care 	<ul style="list-style-type: none"> • One registered nurse • One other nurse

⁴⁵ Ariz. Rev. Stat. Ann. §§ 36-448.51-36-448.55; Ariz. Admin. Code §§ R9-10-501-R9-10-518 (updated in 2013, formerly R9-10-1401-R9-10-1412).

⁴⁶ Conn. Agencies Regs. § 19A-495-571.

⁴⁷ 210 Ill. Comp. Stat. Ann. 3/35; Ill. Admin. Code tit. 77, §§ 210.2500 & 210.2800.

Effect of Proposed Changes

Pursuant to s. 395.002(3), F.S., patients receiving services in an ASC must be discharged on the same working day that they were admitted and cannot stay overnight. Federal Medicare reimbursement policy limits the length of stay in an ASC to 24 hours following admission. The bill amends s. 395.002(3), F.S., to permit a patient to stay at an ASC for no longer than 24 hours. The change conforms to the Medicare length of stay requirement.

The bill creates a new license for a Recovery Care Center (RCC). The new RCC license is modeled after the current licensure program for hospitals and ASCs in Chapters 395 and 408, F.S. The bill adds RCCs to the list of facilities subject to the provisions of Chapter 395, Part I. An applicant for RCC licensure must follow the general licensing procedures in Chapter 408, Part II. Additionally, the applicant will be subject to the license, inspection, safety, facility and other requirements of Chapter 395, Part I.

The bill defines a RCC as a facility whose primary purpose is to provide recovery care services, to which the patient is admitted and discharged within 72 hours, and is not part of a hospital. The bill defines recovery care services as:

- Postsurgical and post-diagnostic medical and general nursing care to patients for whom acute hospitalization is not required and an uncomplicated recovery is reasonably expected; and
- Postsurgical rehabilitation services.

Recovery care services do not include intensive care services, coronary care services, or critical care services.

The bill requires all patients to be certified as medically stable and not in need of acute hospitalization by their attending or referring physician prior to admission to an RCC. A patient may receive recovery care services in an RCC upon:

- Discharge from an ASC after surgery;
- Discharge from a hospital after surgery or other treatment; or
- Receiving an out-patient medical treatment such as chemotherapy.

A RCC must have emergency care and transfer protocols, including transportation arrangements, and a referral or admission agreement with at least one hospital. Further, AHCA is authorized to adopt rules regarding RCC admission and discharge procedures.

Section 395.1055, F.S., directs AHCA to adopt rules for hospitals and ASCs that set standards to ensure patient safety. The bill directs AHCA to adopt rules for RCCs that address all the same regulatory areas currently addressed in rules for hospitals and ASCs, including requirements for:

- Staffing;
- Infection control;
- Housekeeping;
- Medical records;
- Emergency management;
- Inspections;
- Accreditation;
- Organization, including a governing body and organized medical staff;
- Departments and services;
- Quality assessment and improvement;
- Minimum space; and
- Equipment and furnishings.

In addition, the bill requires AHCA to adopt rules to set standards for dietetic departments, proper use of medications, and pharmacies in RCCs.

The license fee for a RCC will be set by rule by AHCA and must be at least \$1,500.⁴⁸

The bill provides an effective date of July 1, 2016.

B. SECTION DIRECTORY:

Section 1: Amends s. 395.001, F.S., related to legislative intent.

Section 2: Amends s. 395.002, F.S., related to definitions.

Section 3: Amends s. 395.003, F.S., related to licensure; denial, suspension, and revocation.

Section 4: Creates s. 395.0171, F.S., related to recovery care center admissions; emergency and transfer protocols; discharge planning and protocols.

Section 5: Amends s. 395.1055, F.S., related to rules and enforcement.

Section 6: Amends s. 395.10973, F.S., related to powers and duties of the agency.

Section 7: Amends s. 395.301, F.S., related to itemized patient bill; form and content prescribed by the agency.

Section 8: Amends s. 408.802, F.S., related to applicability.

Section 9: Amends s. 408.820, F.S., related to exemptions.

Section 10: Amends s. 394.4787, F.S., related to definitions.

Section 11: Amends s. 409.975, F.S., related to managed care plan accountability.

Section 12: Provides an effective date of July 1, 2016.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

Section 408.805, F.S., requires AHCA to set license fees that are reasonably calculated to cover the cost of regulation. AHCA estimates that five entities may apply for licensure. Applicants for licensure as a RCC will be subject to a Plans and Construction project review fee of \$2,000 plus \$100 per hour for building plan reviews, an application fee of at least \$1,500, and a licensure inspection fee of \$400.⁴⁹

2. Expenditures:

The creation of the RCC license will require AHCA to regulate these facilities in accordance with Chapters 395 and 408, F.S., and any rules adopted by AHCA. The fees associated with the new license are anticipated to cover the expenses incurred by AHCA in enforcement and regulation of the new license. No additional staff will be required as existing regulatory staff is sufficient to absorb the workload associated with up to 10 licenses.⁵⁰

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

⁴⁸ Section 395.004, F.S.

⁴⁹ AHCA Agency Bill Analysis, dated September 18, 2015, pg. 3 (on file with Select Committee on Affordable Healthcare Access staff).

⁵⁰ *Id.*

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Individuals needing surgery may save money by being able to stay longer in an ASC or stay in a RCC rather than having the original procedure in a hospital merely because the recovery time will be longer than the ASC limit would allow.

Being able to keep patients longer in an ASC may have a positive fiscal impact on the ASC by being able to perform more complex procedures.

Hospitals may experience a negative fiscal impact if more patients receive care in an ASC or RCC.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. The bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

Not applicable.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled

2 An act relating to recovery care services; amending s.
3 395.001, F.S.; providing legislative intent regarding
4 recovery care centers; amending s. 395.002, F.S.;
5 revising and providing definitions; amending s.
6 395.003, F.S.; including recovery care centers as
7 facilities licensed under chapter 395, F.S.; creating
8 s. 395.0171, F.S.; providing admission criteria for a
9 recovery care center; requiring emergency care,
10 transfer, and discharge protocols; authorizing the
11 Agency for Health Care Administration to adopt rules;
12 amending s. 395.1055, F.S.; authorizing the agency to
13 establish separate standards for the care and
14 treatment of patients in recovery care centers;
15 amending s. 395.10973, F.S.; directing the agency to
16 enforce special-occupancy provisions of the Florida
17 Building Code applicable to recovery care centers;
18 amending s. 395.301, F.S.; providing for format and
19 content of a patient bill from a recovery care center;
20 amending s. 408.802, F.S.; providing applicability of
21 the Health Care Licensing Procedures Act to recovery
22 care centers; amending s. 408.820, F.S.; exempting
23 recovery care centers from specified minimum licensure
24 requirements; amending ss. 394.4787 and 409.975, F.S.;
25 conforming cross-references; providing an effective
26 date.

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

Section 1. Section 395.001, Florida Statutes, is amended to read:

395.001 Legislative intent.—It is the intent of the Legislature to provide for the protection of public health and safety in the establishment, construction, maintenance, and operation of hospitals, ambulatory surgical centers, recovery care centers, and mobile surgical facilities by providing for licensure of same and for the development, establishment, and enforcement of minimum standards with respect thereto.

Section 2. Subsections (3), (16), and (23) of section 395.002, Florida Statutes, are amended, subsections (25) through (33) are renumbered as subsections (27) through (35), respectively, and new subsections (25) and (26) are added to that section, to read:

395.002 Definitions.—As used in this chapter:

(3) "Ambulatory surgical center" or "mobile surgical facility" means a facility the primary purpose of which is to provide elective surgical care, in which the patient is admitted to and discharged from such facility within 24 hours ~~the same working day and is not permitted to stay overnight,~~ and which is not part of a hospital. However, a facility existing for the primary purpose of performing terminations of pregnancy, an office maintained by a physician for the practice of medicine,

53 | or an office maintained for the practice of dentistry shall not
54 | be construed to be an ambulatory surgical center, provided that
55 | any facility or office which is certified or seeks certification
56 | as a Medicare ambulatory surgical center shall be licensed as an
57 | ambulatory surgical center pursuant to s. 395.003. Any structure
58 | or vehicle in which a physician maintains an office and
59 | practices surgery, and which can appear to the public to be a
60 | mobile office because the structure or vehicle operates at more
61 | than one address, shall be construed to be a mobile surgical
62 | facility.

63 | (16) "Licensed facility" means a hospital, ambulatory
64 | surgical center, recovery care center, or mobile surgical
65 | facility licensed in accordance with this chapter.

66 | (23) "Premises" means those buildings, beds, and equipment
67 | located at the address of the licensed facility and all other
68 | buildings, beds, and equipment for the provision of hospital,
69 | ambulatory surgical, recovery, or mobile surgical care located
70 | in such reasonable proximity to the address of the licensed
71 | facility as to appear to the public to be under the dominion and
72 | control of the licensee. For any licensee that is a teaching
73 | hospital as defined in s. 408.07(45), reasonable proximity
74 | includes any buildings, beds, services, programs, and equipment
75 | under the dominion and control of the licensee that are located
76 | at a site with a main address that is within 1 mile of the main
77 | address of the licensed facility; and all such buildings, beds,
78 | and equipment may, at the request of a licensee or applicant, be

79 | included on the facility license as a single premises.

80 | (25) "Recovery care center" means a facility the primary
 81 | purpose of which is to provide recovery care services, to which
 82 | a patient is admitted and discharged within 72 hours, and which
 83 | is not part of a hospital.

84 | (26) "Recovery care services" means postsurgical and
 85 | postdiagnostic medical and general nursing care provided to
 86 | patients for whom acute care hospitalization is not required and
 87 | an uncomplicated recovery is reasonably expected. The term
 88 | includes postsurgical rehabilitation services. The term does not
 89 | include intensive care services, coronary care services, or
 90 | critical care services.

91 | Section 3. Subsection (1) of section 395.003, Florida
 92 | Statutes, is amended to read:

93 | 395.003 Licensure; denial, suspension, and revocation.—

94 | (1)(a) The requirements of part II of chapter 408 apply to
 95 | the provision of services that require licensure pursuant to ss.
 96 | 395.001-395.1065 and part II of chapter 408 and to entities
 97 | licensed by or applying for such licensure from the Agency for
 98 | Health Care Administration pursuant to ss. 395.001-395.1065. A
 99 | license issued by the agency is required in order to operate a
 100 | hospital, ambulatory surgical center, recovery care center, or
 101 | mobile surgical facility in this state.

102 | (b)1. It is unlawful for a person to use or advertise to
 103 | the public, in any way or by any medium whatsoever, any facility
 104 | as a "hospital," "ambulatory surgical center," "recovery care

105 | center," or "mobile surgical facility" unless such facility has
 106 | first secured a license under the provisions of this part.

107 | 2. This part does not apply to veterinary hospitals or to
 108 | commercial business establishments using the word "hospital,"
 109 | "ambulatory surgical center," "recovery care center," or "mobile
 110 | surgical facility" as a part of a trade name if no treatment of
 111 | human beings is performed on the premises of such
 112 | establishments.

113 | (c) Until July 1, 2006, additional emergency departments
 114 | located off the premises of licensed hospitals may not be
 115 | authorized by the agency.

116 | Section 4. Section 395.0171, Florida Statutes, is created
 117 | to read:

118 | 395.0171 Recovery care center admissions; emergency and
 119 | transfer protocols; discharge planning and protocols.-

120 | (1) Admissions to a recovery care center shall be
 121 | restricted to patients who need recovery care services.

122 | (2) Each patient must be certified by his or her attending
 123 | or referring physician or by a physician on staff at the
 124 | facility as medically stable and not in need of acute care
 125 | hospitalization before admission.

126 | (3) A patient may be admitted for recovery care services
 127 | upon discharge from a hospital or an ambulatory surgery center.
 128 | A patient may also be admitted postdiagnosis and posttreatment
 129 | for recovery care services.

130 | (4) A recovery care center must have emergency care and

131 | transfer protocols, including transportation arrangements, and
 132 | referral or admission agreements with at least one hospital.

133 | (5) A recovery care center must have procedures for
 134 | discharge planning and discharge protocols.

135 | (6) The agency may adopt rules to implement this section.

136 | Section 5. Subsections (2) and (8) of section 395.1055,
 137 | Florida Statutes, are amended, and subsection (10) is added to
 138 | that section, to read:

139 | 395.1055 Rules and enforcement.—

140 | (2) Separate standards may be provided for general and
 141 | specialty hospitals, ambulatory surgical centers, recovery care
 142 | centers, mobile surgical facilities, and statutory rural
 143 | hospitals as defined in s. 395.602.

144 | (8) The agency may not adopt any rule governing the
 145 | design, construction, erection, alteration, modification,
 146 | repair, or demolition of any public or private hospital,
 147 | intermediate residential treatment facility, recovery care
 148 | center, or ambulatory surgical center. It is the intent of the
 149 | Legislature to preempt that function to the Florida Building
 150 | Commission and the State Fire Marshal through adoption and
 151 | maintenance of the Florida Building Code and the Florida Fire
 152 | Prevention Code. However, the agency shall provide technical
 153 | assistance to the commission and the State Fire Marshal in
 154 | updating the construction standards of the Florida Building Code
 155 | and the Florida Fire Prevention Code which govern hospitals,
 156 | intermediate residential treatment facilities, recovery care

157 | centers, and ambulatory surgical centers.

158 | (10) The agency shall adopt rules for recovery care
 159 | centers which include fair and reasonable minimum standards for
 160 | ensuring that recovery care centers have:

161 | (a) A dietetic department, service, or other similarly
 162 | titled unit, either on the premises or under contract, which
 163 | shall be organized, directed, and staffed to ensure the
 164 | provision of appropriate nutritional care and quality food
 165 | service.

166 | (b) Procedures to ensure the proper administration of
 167 | medications. Such procedures shall address the prescribing,
 168 | ordering, preparing, and dispensing of medications and
 169 | appropriate monitoring of the effects of such medications on the
 170 | patient.

171 | (c) A pharmacy, pharmaceutical department, or
 172 | pharmaceutical service, or similarly titled unit, on the
 173 | premises or under contract.

174 | Section 6. Subsection (8) of section 395.10973, Florida
 175 | Statutes, is amended to read:

176 | 395.10973 Powers and duties of the agency.—It is the
 177 | function of the agency to:

178 | (8) Enforce the special-occupancy provisions of the
 179 | Florida Building Code which apply to hospitals, intermediate
 180 | residential treatment facilities, recovery care centers, and
 181 | ambulatory surgical centers in conducting any inspection
 182 | authorized by this chapter and part II of chapter 408.

183 Section 7. Subsection (3) of section 395.301, Florida
 184 Statutes, is amended to read:

185 395.301 Itemized patient bill; form and content prescribed
 186 by the agency; patient admission status notification.—

187 (3) On each itemized statement submitted pursuant to
 188 subsection (1) there shall appear the words "A FOR-PROFIT (or
 189 NOT-FOR-PROFIT or PUBLIC) HOSPITAL (or AMBULATORY SURGICAL
 190 CENTER or RECOVERY CARE CENTER) LICENSED BY THE STATE OF
 191 FLORIDA" or substantially similar words sufficient to identify
 192 clearly and plainly the ownership status of the licensed
 193 facility. Each itemized statement must prominently display the
 194 phone number of the medical facility's patient liaison who is
 195 responsible for expediting the resolution of any billing dispute
 196 between the patient, or his or her representative, and the
 197 billing department.

198 Section 8. Subsection (30) is added to section 408.802,
 199 Florida Statutes, to read:

200 408.802 Applicability.—The provisions of this part apply
 201 to the provision of services that require licensure as defined
 202 in this part and to the following entities licensed, registered,
 203 or certified by the agency, as described in chapters 112, 383,
 204 390, 394, 395, 400, 429, 440, 483, and 765:

205 (30) Recovery care centers, as provided under part I of
 206 chapter 395.

207 Section 9. Subsection (29) is added to section 408.820,
 208 Florida Statutes, to read:

209 408.820 Exemptions.—Except as prescribed in authorizing
 210 statutes, the following exemptions shall apply to specified
 211 requirements of this part:

212 (29) Recovery care centers, as provided under part I of
 213 chapter 395, are exempt from s. 408.810(7)-(10).

214 Section 10. Subsection (7) of section 394.4787, Florida
 215 Statutes, is amended to read:

216 394.4787 Definitions; ss. 394.4786, 394.4787, 394.4788,
 217 and 394.4789.—As used in this section and ss. 394.4786,
 218 394.4788, and 394.4789:

219 (7) "Specialty psychiatric hospital" means a hospital
 220 licensed by the agency pursuant to s. 395.002(30) ~~395.002(28)~~
 221 and part II of chapter 408 as a specialty psychiatric hospital.

222 Section 11. Paragraph (b) of subsection (1) of section
 223 409.975, Florida Statutes, is amended to read:

224 409.975 Managed care plan accountability.—In addition to
 225 the requirements of s. 409.967, plans and providers
 226 participating in the managed medical assistance program shall
 227 comply with the requirements of this section.

228 (1) PROVIDER NETWORKS.—Managed care plans must develop and
 229 maintain provider networks that meet the medical needs of their
 230 enrollees in accordance with standards established pursuant to
 231 s. 409.967(2)(c). Except as provided in this section, managed
 232 care plans may limit the providers in their networks based on
 233 credentials, quality indicators, and price.

234 (b) Certain providers are statewide resources and

235 essential providers for all managed care plans in all regions.
 236 All managed care plans must include these essential providers in
 237 their networks. Statewide essential providers include:
 238 1. Faculty plans of Florida medical schools.
 239 2. Regional perinatal intensive care centers as defined in
 240 s. 383.16(2).
 241 3. Hospitals licensed as specialty children's hospitals as
 242 defined in s. 395.002(30) ~~395.002(28)~~.
 243 4. Accredited and integrated systems serving medically
 244 complex children that are comprised of separately licensed, but
 245 commonly owned, health care providers delivering at least the
 246 following services: medical group home, in-home and outpatient
 247 nursing care and therapies, pharmacy services, durable medical
 248 equipment, and Prescribed Pediatric Extended Care.
 249
 250 Managed care plans that have not contracted with all statewide
 251 essential providers in all regions as of the first date of
 252 recipient enrollment must continue to negotiate in good faith.
 253 Payments to physicians on the faculty of nonparticipating
 254 Florida medical schools shall be made at the applicable Medicaid
 255 rate. Payments for services rendered by regional perinatal
 256 intensive care centers shall be made at the applicable Medicaid
 257 rate as of the first day of the contract between the agency and
 258 the plan. Payments to nonparticipating specialty children's
 259 hospitals shall equal the highest rate established by contract
 260 between that provider and any other Medicaid managed care plan.

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261

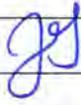
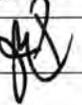
Section 12. This act shall take effect July 1, 2016.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 423 Drug Prescription by Advanced Registered Nurse Practitioners & Physician Assistants

SPONSOR(S): Pigman and others

TIED BILLS: IDEN./SIM. **BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	12 Y, 1 N	Siples	O'Callaghan
2) Health Care Appropriations Subcommittee		Garner 	Pridgeon 
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Unlike all other states in the U.S., Florida does not allow advanced registered nurse practitioners (ARNPs) to prescribe controlled substances and is one of two states that does not allow physician assistants (PAs) to prescribe controlled substances.

The bill authorizes ARNPs to prescribe, dispense, order, and administer controlled substances, but only to the extent authorized under a supervising physician's protocol. The bill also authorizes PAs to prescribe controlled substances that are not listed on the formulary established by the Council on Physician Assistants, under current supervisory standards. The bill subjects ARNPs and PAs to administrative disciplinary actions, such as fines or license suspensions, for violating standards of practice in law relating to prescribing and dispensing controlled substances. The bill adds specific prohibited acts related to the prescribing of controlled substances, which constitute grounds for denial of license or disciplinary action, into the Nurse Practice Act.

The bill requires ARNPs and PAs who prescribe controlled substances for the treatment of chronic nonmalignant pain to meet certain registration and prescribing requirements, but prevents ARNPs and PAs from prescribing controlled substances in registered pain management clinics.

The bill adds ARNPs and PAs into the definition of "practitioner" in the Florida Comprehensive Drug Abuse Prevention and Control Act (Act) requiring compliance with the prescribing and dispensing requirements and limitations under the Act.

The bill makes several technical and conforming changes and amends several statutes to recognize that an ARNP or a PA may be a prescriber of controlled substances. These include statutes relating to pilot licensure, criminal probation, and the state employees' prescription drug program.

The bill may have an insignificant, negative fiscal impact on the Department of Health, however current existing budget authority is adequate to absorb it. There is no fiscal impact on local governments.

The bill provides an effective date of July 1, 2016.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Physician Assistants

Licensure and Regulation

A physician assistant (PA) is a person who has completed an approved medical training program and is licensed to perform medical services, as delegated by a supervising physician.¹ The licensure of PAs in Florida is governed by ss. 458.347(7) and 459.022(7), F.S. The Department of Health (DOH) licenses PAs, and the Florida Council on Physician Assistants (Council) regulates the practice of PAs in conjunction with either the Florida Board of Medicine (Board of Medicine) for PAs licensed under ch. 458, F.S., or the Board of Osteopathic Medicine (Osteopathic Board) for PAs licensed under ch. 459, F.S. There are currently 7,987 PAs who hold active licenses in Florida.²

To be licensed as a PA in Florida, an applicant must demonstrate to the Council that he or she has met the following requirements:

- Satisfactory passage of the proficiency examination administered by the National Commission on Certification of Physician Assistants;
- Completion of an application and remittance of the applicable fees to the DOH;³
- Completion of an approved PA training program;
- Submission of a sworn statement of any prior felony convictions;
- Submission of a sworn statement of any revocation or denial of licensure or certification in any state;
- Submission of two letters of recommendation; and
- If the applicant is seeking prescribing authority, a submission of a copy of course transcripts and the course description from a PA training program describing the course content in pharmacotherapy.⁴

Licenses are renewed biennially.⁵ At the time of renewal, a PA must demonstrate that he or she has met the continuing medical education requirements of 100 hours and must submit a sworn statement that he or she has not been convicted of any felony in the previous two years.⁶ If a PA is licensed as a prescribing PA, an additional 10 hours of continuing medical education in the specialty areas of his or her supervising physician must be completed.⁷

Supervision of PAs

A PA may only practice under the delegated authority of a supervising physician. A supervising physician may only delegate tasks and procedures to the PA that are within the supervising physician's

¹ Sections 458.347(2)(e) and 459.022(2)(e), F.S.

² Email correspondence with the Department of Health on November 9, 2015. The number of active-licensed PAs include both in-state and out-of-state licensees, as of November 9, 2015.

³ The application fee is \$100 and the initial license fee is \$200. Applicants must also pay an unlicensed activity fee of \$5. See Rules 64B8-30.019 and 64B15-6.013, F.A.C.

⁴ Sections 458.347(7) and 459.022(7), F.S.

⁵ For timely renewed licenses, the renewal fee is \$275 and the prescribing registration fee is \$150. Additionally, at the time of renewal, the PA must pay an unlicensed activity fee of \$5. See Rules 64B8-30.019 and 64B15-6.013, F.A.C.

⁶ Sections 458.347(7)(c)-(d) and 459.022(7)(c)-(d), F.S.

⁷ Rules 64B8-30.005(6) and 64B15-6.0035(6), F.A.C.

scope of practice.⁸ Supervision is defined as responsible supervision and control that requires the easy availability or physical presence of the licensed physician for consultation and direction of the PA.⁹ A physician may not supervise more than four PAs at any time.¹⁰

The Board of Medicine and the Osteopathic Board have prescribed by rule what constitutes adequate responsible supervision. Responsible supervision is the ability of a supervising physician to reasonably exercise control and provide direction over the services or tasks performed by the PA.¹¹ Whether the supervision of the PA is adequate is dependent on the:

- Complexity of the task;
- Risk to the patient;
- Background, training, and skill of the PA;
- Adequacy of the direction in terms of its form;
- Setting in which the tasks are performed;
- Availability of the supervising physician;
- Necessity for immediate attention; and
- Number of other persons that the supervising physician must supervise.¹²

The decision to permit a PA to perform a task or procedure under direct or indirect supervision is made by the supervising physician based on reasonable medical judgment regarding the probability of morbidity and mortality to the patient.¹³ Direct supervision refers to the physical presence of the supervising physician so that the physician is immediately available to the PA when needed.¹⁴ Indirect supervision refers to the reasonable physical proximity of the supervising physician to the PA or availability by telecommunication.¹⁵

Delegable Tasks

Rules of both the Board of Medicine and the Osteopathic Board place limitations on a supervising physician's ability to delegate certain tasks. The following tasks are not permitted to be delegated to a PA, except when specifically authorized by statute:

- Prescribing, dispensing, or compounding medicinal drugs; and
- Final diagnosis.¹⁶

A supervising physician may delegate authority to a PA the authority to:

- Prescribe or dispense any medicinal drug used in the supervising physician's practice;¹⁷
- Order medicinal drugs for a hospitalized patient of the supervising physician;¹⁸ and
- Administer a medicinal drug under the direction and supervision of the physician.

⁸ Rules 64B8-30.012(1) and 64B15-6.010(1), F.A.C. The term "scope of practice" refers to those tasks and procedures that the supervising physician is qualified by training or experience to support.

⁹ Sections 458.347(2)(f) and 459.022(2)(f), F.S.

¹⁰ Sections 458.347(3) and 459.022(3), F.S.

¹¹ Rules 64B8-30.001(3) and 64B15-6.001(3), F.A.C.

¹² *Id.*

¹³ Rules 64B8-30.012(2) and 64B15-6.010(2), F.A.C.

¹⁴ Rules 64B8-30.001(4) and 64B15-6.001(4), F.A.C.

¹⁵ Rules 64B8-30.001(5) and 64B15-6.001(5), F.A.C.

¹⁶ *Supra* note 12.

¹⁷ Sections 458.347(4)(f)1., F.S., and 459.022(4)(e), F.S., directs the Council to establish a formulary listing the medical drugs that a PA may not prescribe. The formulary in Rules 64B8-30.008 and 64B15-6.0038, F.A.C., prohibits PAs from prescribing controlled substances, as defined in Chapter 893, F.S., general, spinal, or epidural anesthetics, and radiographic contrast materials.

¹⁸ Sections 458.347(4)(g), and 459.022(4)(f), F.S., provides that an order is not a prescription.

Currently, PAs are prohibited from prescribing controlled substances, anesthetics, and radiographic contrast materials.¹⁹ However, physicians may delegate the authority to order controlled substances in facilities licensed under ch. 395, F.S.²⁰

Education of PAs

According to the American Academy of Physician Assistants, all accredited PA educational programs include pharmacology courses, and the average amount of formal classroom instruction in pharmacology is 75 hours.²¹ Course topics, include pharmacokinetics, drug interactions, adverse effects, contraindications, indications, and dosage, generally by doctoral-level pharmacologists or clinical pharmacists.²² Additionally, pharmacology education occurs on all clinical clerkships or rotations.²³

Regulation of Advanced Registered Nurse Practitioners

Part I of ch. 464, F.S. (Nurse Practice Act), governs the licensure and regulation of advanced registered nurse practitioners (ARNPs) in Florida. Nurses are licensed by the DOH and are regulated by the Board of Nursing.²⁴ There are 22,003 actively licensed ARNPs in Florida.²⁵

In Florida, an ARNP is a licensed nurse who is certified in advanced or specialized nursing practice and may practice as a certified registered nurse anesthetist, a certified nurse midwife, or a nurse practitioner.²⁶ Section 464.003(2), F.S., defines “advanced or specialized nursing practice” to include the performance of advanced-level nursing acts approved by the Board of Nursing, which by virtue of postbasic specialized education, training, and experience are appropriately performed by an ARNP.²⁷

Florida recognizes three types of ARNPs: nurse anesthetist, certified nurse midwife, and nurse practitioner. The Board of Nursing, created by s. 464.004, F.S., establishes the eligibility criteria for an applicant to be certified as an ARNP and the applicable regulatory standards for ARNP nursing practices.²⁸ To be certified as an ARNP, the applicant must:

- Have a registered nurse license;
- Have earned, at least, a master’s degree; and
- Submit proof to the Board of Nursing of holding a current national advanced practice certification obtained from a board-approved nursing specialty board.²⁹

¹⁹ Rules 64B8-30.008, F.A.C., and 64B15-6.0038, F.A.C.

²⁰ Sections 458.347(4)(g), F.S., and 459.022(4)(f), F.S.; the facilities licensed in ch. 395, F.S., include hospitals, ambulatory surgical centers, and mobile surgical facilities.

²¹ American Academy of Physician Assistants, *PAs as Prescribers of Controlled Medications*, Professional Issues – Issue Brief (Dec. 2013), available at <https://www.aapa.org/workarea/downloadasset.aspx?id=2549> (last visited Nov. 19, 2015).

²² *Id.*

²³ *Id.*

²⁴ Pursuant to s. 464.004, F.S., the Board of Nursing is comprised of 13 members appointed by the Governor and confirmed by the Senate who serve 4-year terms. The Board is comprised of three licensed practical nurses who have practiced for at least four years, seven members who are registered nurses who have practiced for at least 4 years; three Florida residents who have never been licensed as nurses, are not connected to the practice of nursing, and have no financial interest in any health care facility, agency, or insurer; and seven members who are registered nurses who have practiced at least four years. Among the seven members who are registered nurses, there must be at least one must be an ARNP, one nurse educator of an approved program, and one nurse executive.

²⁵ E-mail correspondence with the Department of Health (Nov. 9, 2015) (on file with committee staff). This number includes all active licenses, including out of state practitioners.

²⁶ Section 464.003(3), F.S.

²⁷ Section 464.003(2), F.S.

²⁸ Section 464.012(2), F.S.

²⁹ Section 464.012(1), F.S., and Rule 64B9-4.002, F.A.C. A nursing specialty board must attest to the competency of nurses in a clinical specialty area, require nurses to take a written examination prior to certification, require nurses to complete a formal program prior to eligibility of examination, maintain program accreditation, and identify standards or scope of practice statements appropriate for each nursing specialty.

All ARNPs must carry malpractice insurance or demonstrate proof of financial responsibility.³⁰ An applicant for certification is required to submit proof of coverage or financial responsibility within sixty days of certification and with each biennial renewal.³¹ An ARNP must have professional liability coverage of at least \$100,000 per claim with a minimum annual aggregate of at least \$300,000, or an unexpired irrevocable letter of credit, which is payable to the ARNP as beneficiary, in the amount of at least \$100,000 per claim with a minimum aggregate availability of at least \$300,000.³²

Supervision of ARNPs

Pursuant to s. 464.012(3), F.S., ARNPs may only perform nursing practices delineated in an established protocol filed with the Board of Nursing that is filed within 30 days of entering into a supervisory relationship with a physician and upon biennial license renewal.³³ Florida law allows a primary care physician to supervise ARNPs in up to four offices, in addition to the physician's primary practice location.³⁴ If the physician provides specialty health care services, then only two medical offices, in addition to the physician's primary practice location, may be supervised.

The supervision limitations do not apply in the following facilities:

- Hospitals;
- Colleges of medicine or nursing;
- Nonprofit family-planning clinics;
- Rural and federally qualified health centers;
- Nursing homes;
- Assisted living facilities;
- Student health care centers or school health clinics; and
- Other government facilities.³⁵

To ensure appropriate medical care, the number of ARNPs a supervising physician may supervise is limited based on consideration of the following factors:

- Risk to the patient;
- Educational preparation, specialty, and experience in relation to the supervising physician's protocol;
- Complexity and risk of the procedures;
- Practice setting; and
- Availability of the supervising physician or dentist.³⁶

Delegable Tasks

Within the framework of a written physician protocol, an ARNP may:

- Monitor and alter drug therapies;
- Initiate appropriate therapies for certain conditions;
- Order diagnostic tests and physical and occupational therapy;
- Perform certain acts within his or her specialty;
- Perform medical acts authorized by a joint committee; and

³⁰ Section 456.048, F.S.

³¹ Rule 64B9-4.002(5), F.A.C.

³² *Id.*

³³ Physicians are also required to provide notice of the written protocol and the supervisory relationship to the Board of Medicine or Board of Osteopathic Medicine, respectively. See ss. 458.348 and 459.025, F.S.

³⁴ Sections 458.348(4) and 459.025(3), F.S.

³⁵ Sections 458.348(4)(e), and 459.025(3)(e), F.S.

³⁶ Rule 64B9-4.010, F.A.C.

- Perform additional functions determined by rule.³⁷

Florida law does not authorize ARNPs to prescribe, independently administer, or dispense controlled substances.³⁸

Controlled Substances

Controlled substances are drugs with the potential for abuse. Chapter 893, F.S., sets forth the Florida Comprehensive Drug Abuse Prevention and Control Act (Act) and classifies controlled substances into five categories, known as schedules.³⁹ The distinguishing factors between the different drug schedules are the “potential for abuse” of the substance and whether there is a currently accepted medical use for the substance. Schedules are used to regulate the manufacture, distribution, preparation and dispensing of the substances. The Act provides requirements for the prescribing and administering of controlled substances by health care practitioners and proper dispensing by pharmacists and health care practitioners.⁴⁰

Controlled Substance Prescribing for Nonmalignant Pain in Florida

As of January 1, 2012, every physician, podiatrist, or dentist, who prescribes controlled substances in the state for the treatment of chronic nonmalignant pain,⁴¹ must register as a controlled substance prescribing practitioner and comply with certain practice standards specified in statute and rule.⁴² Before prescribing controlled substances for the treatment of chronic nonmalignant pain, a practitioner must:

- Document certain characteristics about the nature of the patient's pain, success of past treatments, and a history of alcohol and substance abuse;
- Develop a written plan for assessing the patient's risk for aberrant drug-related behavior and monitor such behavior throughout the course of controlled substance treatment;
- Develop an written individualized treatment plan for each patient stating the objectives that will be used to determine treatment success; and
- Enter into a controlled substance agreement with each patient that must be signed by the patient or their legal representative and by the prescribing practitioner. Such agreements must include:
 - The number and frequency of prescriptions and refills;
 - A statement outlining expectations for patient compliance and reasons for which the drug therapy may be discontinued, such as violation of the agreement; and
 - An agreement that the patient's chronic nonmalignant pain only be treated by a single treating practitioner unless otherwise authorized and documented in the medical record.⁴³

Patients being treated with controlled substances for chronic nonmalignant pain must be seen by their prescribing practitioners at least once every three months to monitor progress and compliance, and detailed medical records relating to such treatment must be maintained.⁴⁴ Patients at special risk for drug abuse or diversion may require consultation with or a referral to an addiction medicine physician or

³⁷ Section 464.012(3), F.S. Pursuant to s. 464.012(4), F.S., certified registered nurse anesthetists, certified nurse midwives, and certified nurse practitioners are authorized to perform additional acts that are within their specialty and authorized under an established supervisory protocol.

³⁸ Sections 893.02(21) and 893.05(1), F.S. The definition of practitioner does not include ARNPs.

³⁹ See s. 893.03, F.S.

⁴⁰ Sections 893.04 and 893.05, F.S.

⁴¹ “Chronic nonmalignant pain” is defined as pain unrelated to cancer which persists beyond the usual course of disease or the injury that is the cause of the pain or more than 90 days after surgery. Section 456.44(1)(e), F.S.

⁴² Chapter 2011-141, s. 3, Laws of Fla. (creating ss. 456.44, F.S., effective July 1, 2011).

⁴³ Section 465.44(3), F.S.

⁴⁴ Section 465.44(3)(d), F.S.

a psychiatrist.⁴⁵ Anyone with signs or symptoms of substance abuse must be immediately referred to a pain-management physician, an addiction medicine specialist, or an addiction medicine facility.⁴⁶

Drug Enforcement Administration

The Drug Enforcement Administration (DEA), housed within the U.S. Department of Justice, enforces the controlled substances laws and regulations of the United States, including preventing and investigating the diversion of controlled pharmaceuticals.⁴⁷

Any health care professional wishing to prescribe controlled substances must apply for a registration number from the DEA. Registration numbers are linked to state licenses and may be suspended or revoked upon any disciplinary action taken against a licensee.⁴⁸ The DEA will grant registration numbers to a wide range of health care professionals, including physicians, nurse practitioners, physician assistants, optometrists, dentists, and veterinarians, but such professionals may only prescribe controlled substances as authorized under state law.⁴⁹ The DEA provides that a controlled substance prescription may only be issued by a registered practitioner who is:

- Authorized to prescribe controlled substances by the jurisdiction in which the practitioner is licensed to practice; and
- Registered with the DEA, or exempt from registration (e.g., Public Health Service, Federal Bureau of Prisons, or military practitioners); or
- An qualified agent or employee of a hospital or other institution acting in the normal course of business or employment under the DEA registration number of the hospital or other institution which is registered in lieu of the individual practitioner being registered.⁵⁰

The DEA's Practitioner Manual includes requirements for valid prescriptions. The DEA defines "prescription" as an order for medication which is dispensed to or for an ultimate user, but is not an order for a medication dispensed for immediate administration to the user, such as an order to dispense a drug to a patient in a hospital setting.⁵¹

Other States' Controlled Substance Prescriptive Authority for ARNPs and PAs

ARNPs

An ARNP's ability to prescribe, dispense, or administer controlled substances is dependent on his or her specific state's law. Forty-nine states authorize ARNPs to prescribe controlled substances.⁵² Twenty-one states and the District of Columbia allow an ARNP to practice independently, including evaluating, diagnosing, ordering, and interpreting diagnostic tests, and managing treatment, including prescribing medications, of a patient without physician supervision.⁵³ Twenty-two states specifically prohibit certified registered nurse anesthetists from prescribing controlled substances.⁵⁴

⁴⁵ Section 465.44(3)(e), F.S.

⁴⁶ Section 456.44(3)(g), F.S.

⁴⁷ Drug Enforcement Administration, *About Us*, available at <http://www.deadiversion.usdoj.gov/Inside.html> (last visited Nov. 15, 2015).

⁴⁸ Registration numbers must be renewed every three years. Drug Enforcement Administration, *Practitioners Manual*, 7(2006), available at http://www.deadiversion.usdoj.gov/pubs/manuals/pract/pract_manual012508.pdf (last visited Nov. 19, 2015).

⁴⁹ *Id.* at 7.

⁵⁰ DEA, *Practitioner Manual*, 18.

⁵¹ *Id.*

⁵² Drug Enforcement Agency, *Mid-Level Practitioners Authorization by State* (Nov. 10, 2015), available at http://www.deadiversion.usdoj.gov/drugreg/practioners/mlp_by_state.pdf (last visited Nov. 19, 2015). The Commonwealth of Puerto Rico also prohibits ARNPs from prescribing controlled substances.

⁵³ Alaska, Arizona, Colorado, Connecticut, Hawaii, Idaho, Iowa, Maine, Maryland, Minnesota, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Dakota, Oregon, Rhode Island, Vermont, Washington, and Wyoming allow for independent practice. See American Association of Nurse Practitioners, *State Practice Environment*, available at <https://www.aanp.org/legislation-regulation/state-legislation/state-practice-environment/66-legislation-regulation/state-practice-environment/1380-state-practice-by-type> (last visited Nov. 19, 2015).

⁵⁴ American Association of Nurse Anesthetists, *AANA Journal*, June 2011; 79(3):235, on file with committee staff.

Some states have specific limitations regarding ARNPs prescribing authority for schedule II controlled substances,⁵⁵ for example, 7 states authorize ARNPs to prescribe all levels of scheduled drugs, except for schedule II. Some states have specific education requirements for those ARNPs who wish to prescribe schedule II substances or require additional registration for ARNPs to be authorized to prescribe.⁵⁶

PAs

A PA's ability to prescribe, dispense, or administer controlled substances is dependent on their specific state's law. Forty-eight states authorize PAs to prescribe controlled substances within an agreement with a supervisory physician, with varying limitations on administration, dispensing, and independent prescribing.⁵⁷ Of the 48 states, some have specific restrictions on PAs' prescribing authority for schedule II controlled substances; for example, Texas and Hawaii only authorize PAs to order schedule II controlled substances in an inpatient hospital setting. Some states have medication quantity restrictions on prescriptions for schedule II drugs and some states give PAs' prescriptive authority for all levels of scheduled drugs except for schedule II.⁵⁸ Some states also have a formulary determined by the relevant PA licensing board which identifies the controlled substances that PAs are authorized to prescribe.

Effect of Proposed Changes

The bill authorizes PAs licensed under ch. 458, F.S., the Medical Practice Act or under ch. 459, F.S., the Osteopathic Medical Practice Act, and ARNPs certified under part I of ch. 464, F.S., the Nurse Practice Act, to prescribe controlled substances under current supervisory standards for PAs and protocols for ARNPs.

Physician Assistants

The bill authorizes PAs to prescribe controlled substances by removing the requirement that the formulary of medicinal drugs that a PA may not prescribe include controlled substances. However, because the formulary is determined by the Council on Physician Assistants pursuant to s. 458.347(4)(f)1., F.S.,⁵⁹ the Council may elect to add controlled substances to the formulary, prohibiting PAs from prescribing them.

The bill subjects PAs to administrative disciplinary actions in s. 456.072, F.S., such as fines or license suspensions for violating standards of practice in law relating to prescribing and dispensing controlled substances.⁶⁰

Advanced Registered Nurse Practitioners

The bill authorizes ARNPs, regulated under s. 464.012(3), F.S., to prescribe, dispense, order, or administer controlled substances, if allowed under a supervising physician's protocol. The bill adds additional acts related to the prescribing of controlled substances into s. 464.018, F.S., which an ARNP is prohibited from performing and which, if performed, constitute grounds for denial of license or disciplinary actions.

⁵⁵ *Supra* note 51.

⁵⁶ *Id.*

⁵⁷ *Id.* Every state, except Florida and Kentucky, has some form of controlled substance prescriptive authority for PAs.

⁵⁸ *Id.*

⁵⁹ Section 459.022(4)(e), F.S., of the Osteopathic Medical Practice Act refers to the formulary in the Medical Practice Act.

⁶⁰ Disciplinary sanctions against physicians apply to PAs. Sections 458.347(7)(g) and 459.022(7)(g), F.S., state that the Board of Medicine or the Board of Osteopathic Medicine may impose any penalty authorized under ss. 456.072, 458.332(2), and 459.015(2), F.S., on a PA if the PA or the supervising physician has been found guilty of any prohibited acts.

Section 456.072(7), F.S., is revised to include disciplinary actions against ARNPs including specific fines and license suspension, which mirror actions against physicians for prescribing or dispensing a controlled substance other than in the course of professional practice or for failing to meet practice standards.

Controlled Substances

The bill adds PAs and ARNPs to the definition of practitioner in ch. 893, F.S., the Florida Comprehensive Drug Abuse Prevention and Control Act (Act), thus requiring these practitioners to comply with the prescribing and dispensing requirements and limitations under the Act. This definition also requires practitioners to hold a valid federal DEA controlled substance registry number.

The bill amends s. 456.44, F.S., to require a PA or ARNP who prescribes any controlled substance that is listed in schedule II, schedule III, or schedule IV, for the treatment of chronic nonmalignant pain to register himself or herself as a controlled substance prescribing practitioner on his or her practitioner profile maintained by the DOH and to meet other statutory requirements for such registrants.⁶¹ The bill also replaces the terms physician and clinician with registrant throughout this section of law. The bill specifies that this registration is not required to prescribe medication in a facility licensed under ch. 395, F.S.⁶²

The bill amends sections regulating pain-management clinics under the Medical Practice Act and the Osteopathic Medical Practice Act to only authorize physicians licensed under ch. 458, F.S., or ch. 459, F.S., to prescribe controlled substances in a pain-management clinic. Accordingly, PAs and ARNPs are prohibited from prescribing controlled substances in pain-management clinics.

The bill makes several conforming changes to various statutes to recognize the new prescribing authority for PAs and ARNPs.

The bill provides an effective date of July 1, 2016.

B. SECTION DIRECTORY:

Section 1. Amends s. 110.12315, F.S., relating to prescription drug program.

Section 2. Amends s. 310.071, F.S., relating to deputy pilot certification.

Section 3. Amends s. 310.073, F.S., relating to state pilot licensing.

Section 4. Amends s. 310.081, F.S., relating to department examination and licensure of state pilots and certification of deputy pilots; vacancies.

Section 5. Amends s. 456.072, F.S., relating to grounds for discipline; penalties; enforcement.

Section 6. Amends s. 456.44, F.S., relating to controlled substance prescribing.

Section 7. Amends s. 458.3265, F.S., relating to pain-management clinics.

Section 8. Amends s. 458.347, F.S., relating to physician assistants.

Section 9. Amends s. 459.0137, F.S., relating to pain-management clinics.

Section 10. Amends s. 464.012, relating to certification of advanced registered nurse practitioners; fees; controlled substance prescribing.

Section 11. Amends s. 464.018, F.S., relating to disciplinary actions.

Section 12. Amends s. 893.02, F.S., relating to definitions.

Section 13. Amends s. 948.03, F.S., relating to terms and conditions of probation.

Section 14. Reenacts s. 310.071, F.S., relating to deputy pilot certification.

Section 15. Reenacts s. 458.331, F.S., relating to ground for discipline; action by the board and department; s. 458.347, F.S., relating to physician assistants; s. 459.022, F.S., relating to physician assistants; and s. 465.0158, relating to nonresident sterile compounding permit.

⁶¹ Currently, PAs do not have practitioner profiles. Practitioner profiles contain information about a practitioner's education, training, and practice and are accessible to the public. If the bill is enacted, the Department will need to develop a profile for PAs.

⁶² The facilities licensed under ch. 395, F.S., include hospitals, ambulatory surgical centers, and mobile surgical facilities.

Section 16. Reenacts s. 456.072, F.S., relating to grounds for discipline; penalties; enforcement and s. 466.02751, F.S., relating to establishment of practitioner profile for designation as a controlled substance prescribing practitioner.

Section 17. Reenacts s. 458.303, F.S., relating to provisions not applicable to other practitioners; exceptions, etc.; s. 458.347, F.S., relating to physician assistants; s. 458.3475, F.S., relating to anesthesiologist assistants; s. 459.022, F.S., relating to physician assistants; and s. 459.023, F.S., relating to relating to anesthesiologist assistants.

Section 18. Reenacts s. 456.041, F.S., relating to practitioner profile; creation; s. 458.348, F.S., relating to formal supervisory relationships, standing orders, and established protocols; notice; standards; and s. 459.025, F.S., relating to relating to formal supervisory relationships, standing orders, and established protocols; notice; standards.

Section 19. Reenacts s. 464.008, F.S., relating to licensure by examination; s. 464.009, F.S., relating to licensure by endorsement; s. 464.018, F.S., relating to disciplinary actions; and s. 464.0205, F.S., relating to retired volunteer nurse certificate.

Section 20. Reenacts s. 775.051, F.S., relating to voluntary intoxication; not a defense; evidence not admissible for certain purposes; exceptions.

Section 21. Reenacts s. 944.17, F.S., relating to commitments and classification; transfers; s. 948.001, F.S., relating to definitions; and s. 948.101, F.S., relating to terms and conditions of community control.

Section 22. Provides an effective date of July 1, 2016.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

The bill may have an insignificant negative fiscal impact on the Department of Health associated with rulemaking, the creation of practitioner profiles for PAs, and workload impacts related to potential additional practitioner complaints and investigations. Current budget authority and revenues are adequate to absorb any additional workload.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Patients may see reduced health care costs and efficiencies in health care delivery as a result of having their health care needs more fully addressed by the PA or ARNP without specific additional involvement of a physician prescribing a needed controlled substance for treatment. Any such impacts are indeterminate.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. This bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The Board of Nursing, Board of Medicine, Board of Osteopathic Medicine, the Department of Health, and the Department of Management Services have sufficient rule-making authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
 2 An act relating to drug prescription by advanced
 3 registered nurse practitioners and physician
 4 assistants; amending s. 110.12315, F.S.; expanding the
 5 categories of persons who may prescribe brand drugs
 6 under the prescription drug program when medically
 7 necessary; amending ss. 310.071, 310.073, and 310.081,
 8 F.S.; exempting controlled substances prescribed by an
 9 advanced registered nurse practitioner or a physician
 10 assistant from the disqualifications for certification
 11 or licensure, and for continued certification or
 12 licensure, as a deputy or state pilot; amending s.
 13 456.072, F.S.; applying existing penalties for
 14 violations relating to the prescribing or dispensing
 15 of controlled substances to an advanced registered
 16 nurse practitioner; amending s. 456.44, F.S.; deleting
 17 an obsolete date; requiring advanced registered nurse
 18 practitioners and physician assistants who prescribe
 19 controlled substances for certain pain to make a
 20 certain designation, comply with registration
 21 requirements, and follow specified standards of
 22 practice; providing applicability; amending ss.
 23 458.3265 and 459.0137, F.S.; limiting the authority to
 24 prescribe a controlled substance in a pain-management
 25 clinic to a physician licensed under chapter 458 or
 26 chapter 459, F.S.; amending s. 458.347, F.S.;

27 | expanding the prescribing authority of a licensed
 28 | physician assistant; amending s. 464.012, F.S.;
 29 | authorizing an advanced registered nurse practitioner
 30 | to prescribe, dispense, administer, or order drugs,
 31 | rather than to monitor and alter drug therapies;
 32 | amending s. 464.018, F.S.; specifying acts that
 33 | constitute grounds for denial of a license for or
 34 | disciplinary action against an advanced registered
 35 | nurse practitioner; amending s. 893.02, F.S.;
 36 | redefining the term "practitioner" to include advanced
 37 | registered nurse practitioners and physician
 38 | assistants under the Florida Comprehensive Drug Abuse
 39 | Prevention and Control Act; amending s. 948.03, F.S.;
 40 | providing that possession of drugs or narcotics
 41 | prescribed by an advanced registered nurse
 42 | practitioner or physician assistant is an exception
 43 | from a prohibition relating to the possession of drugs
 44 | or narcotics during probation; reenacting s.
 45 | 310.071(3), F.S., relating to deputy pilot
 46 | certification, to incorporate the amendment made by
 47 | the act to s. 310.071, F.S., in a reference thereto;
 48 | reenacting ss. 458.331(10), 458.347(7)(g),
 49 | 459.015(10), 459.022(7)(f), and 465.0158(5)(b), F.S.,
 50 | relating to grounds for disciplinary action against
 51 | certain licensed health care practitioners or
 52 | applicants, physician assistant licensure, the

53 | imposition of penalties upon physician assistants by
54 | the Board of Osteopathic Medicine, and nonresident
55 | sterile compounding permits, respectively, to
56 | incorporate the amendment made by the act to s.
57 | 456.072, F.S., in references thereto; reenacting ss.
58 | 456.072(1)(mm) and 466.02751, F.S., relating to
59 | grounds for discipline of certain licensed health care
60 | practitioners or applicants and dentist practitioner
61 | profiles, respectively, to incorporate the amendment
62 | made by the act to s. 456.44, F.S., in references
63 | thereto; reenacting ss. 458.303, 458.347(4)(e) and
64 | (9)(c), 458.3475(7)(b), 459.022(4)(e) and (9)(c), and
65 | 459.023(7)(b), F.S., relating to the nonapplicability
66 | of certain provisions to specified health care
67 | practitioners, the prescribing or dispensing of
68 | medications by physician assistants, the duties of the
69 | Council on Physician Assistants, and the duties of the
70 | Board of Medicine and the Board of Osteopathic
71 | Medicine with respect to anesthesiologist assistants,
72 | respectively, to incorporate the amendment made by the
73 | act to s. 458.347, F.S., in references thereto;
74 | reenacting ss. 456.041(1)(a), 458.348(1) and (2), and
75 | 459.025(1), F.S., relating to practitioner profiles
76 | and notice and standards for formal supervisory
77 | relationships, standing orders, and established
78 | protocols, respectively, to incorporate the amendment

79 | made by the act to s. 464.012, F.S., in references
80 | thereto; reenacting ss. 464.008(2), 464.009(5),
81 | 464.018(2), and 464.0205(1)(b), (3), and (4)(b), F.S.,
82 | relating to licensure by examination of registered
83 | nurses and licensed practical nurses, licensure by
84 | endorsement to practice professional or practical
85 | nursing, disciplinary actions against nursing
86 | applicants or licensees, and retired volunteer nurse
87 | certifications, respectively, to incorporate the
88 | amendment made by the act to s. 464.018, F.S., in
89 | references thereto; reenacting s. 775.051, F.S.,
90 | relating to the exclusion as a defense and
91 | nonadmissibility as evidence of voluntary
92 | intoxication, to incorporate the amendment made by the
93 | act to s. 893.02, F.S., in a reference thereto;
94 | reenacting ss. 944.17(3)(a), 948.001(8), and
95 | 948.101(1)(e), F.S., relating to the receipt by the
96 | state correctional system of certain persons sentenced
97 | to incarceration, the definition of the term
98 | "probation," and the terms and conditions of community
99 | control, respectively, to incorporate the amendment
100 | made by the act to s. 948.03, F.S., in references
101 | thereto; providing an effective date.

102 |
103 | Be It Enacted by the Legislature of the State of Florida:
104 |

105 Section 1. Subsection (7) of section 110.12315, Florida
 106 Statutes, is amended to read:

107 110.12315 Prescription drug program.—The state employees'
 108 prescription drug program is established. This program shall be
 109 administered by the Department of Management Services, according
 110 to the terms and conditions of the plan as established by the
 111 relevant provisions of the annual General Appropriations Act and
 112 implementing legislation, subject to the following conditions:

113 (7) The department shall establish the reimbursement
 114 schedule for prescription pharmaceuticals dispensed under the
 115 program. Reimbursement rates for a prescription pharmaceutical
 116 must be based on the cost of the generic equivalent drug if a
 117 generic equivalent exists, unless the physician, advanced
 118 registered nurse practitioner, or physician assistant
 119 prescribing the pharmaceutical clearly states on the
 120 prescription that the brand name drug is medically necessary or
 121 that the drug product is included on the formulary of drug
 122 products that may not be interchanged as provided in chapter
 123 465, in which case reimbursement must be based on the cost of
 124 the brand name drug as specified in the reimbursement schedule
 125 adopted by the department.

126 Section 2. Paragraph (c) of subsection (1) of section
 127 310.071, Florida Statutes, is amended to read:

128 310.071 Deputy pilot certification.—

129 (1) In addition to meeting other requirements specified in
 130 this chapter, each applicant for certification as a deputy pilot

131 must:

132 (c) Be in good physical and mental health, as evidenced by
 133 documentary proof of having satisfactorily passed a complete
 134 physical examination administered by a licensed physician within
 135 the preceding 6 months. The board shall adopt rules to establish
 136 requirements for passing the physical examination, which rules
 137 shall establish minimum standards for the physical or mental
 138 capabilities necessary to carry out the professional duties of a
 139 certificated deputy pilot. Such standards shall include zero
 140 tolerance for any controlled substance regulated under chapter
 141 893 unless that individual is under the care of a physician,
 142 advanced registered nurse practitioner, or physician assistant
 143 and that controlled substance was prescribed by that physician,
 144 advanced registered nurse practitioner, or physician assistant.

145 To maintain eligibility as a certificated deputy pilot, each
 146 certificated deputy pilot must annually provide documentary
 147 proof of having satisfactorily passed a complete physical
 148 examination administered by a licensed physician. The physician
 149 must know the minimum standards and certify that the
 150 certificateholder satisfactorily meets the standards. The
 151 standards for certificateholders shall include a drug test.

152 Section 3. Subsection (3) of section 310.073, Florida
 153 Statutes, is amended to read:

154 310.073 State pilot licensing.—In addition to meeting
 155 other requirements specified in this chapter, each applicant for
 156 license as a state pilot must:

157 (3) Be in good physical and mental health, as evidenced by
 158 documentary proof of having satisfactorily passed a complete
 159 physical examination administered by a licensed physician within
 160 the preceding 6 months. The board shall adopt rules to establish
 161 requirements for passing the physical examination, which rules
 162 shall establish minimum standards for the physical or mental
 163 capabilities necessary to carry out the professional duties of a
 164 licensed state pilot. Such standards shall include zero
 165 tolerance for any controlled substance regulated under chapter
 166 893 unless that individual is under the care of a physician,
 167 advanced registered nurse practitioner, or physician assistant
 168 and that controlled substance was prescribed by that physician,
 169 advanced registered nurse practitioner, or physician assistant.
 170 To maintain eligibility as a licensed state pilot, each licensed
 171 state pilot must annually provide documentary proof of having
 172 satisfactorily passed a complete physical examination
 173 administered by a licensed physician. The physician must know
 174 the minimum standards and certify that the licensee
 175 satisfactorily meets the standards. The standards for licensees
 176 shall include a drug test.

177 Section 4. Paragraph (b) of subsection (3) of section
 178 310.081, Florida Statutes, is amended to read:

179 310.081 Department to examine and license state pilots and
 180 certificate deputy pilots; vacancies.-

181 (3) Pilots shall hold their licenses or certificates
 182 pursuant to the requirements of this chapter so long as they:

183 (b) Are in good physical and mental health as evidenced by
 184 documentary proof of having satisfactorily passed a physical
 185 examination administered by a licensed physician or physician
 186 assistant within each calendar year. The board shall adopt rules
 187 to establish requirements for passing the physical examination,
 188 which rules shall establish minimum standards for the physical
 189 or mental capabilities necessary to carry out the professional
 190 duties of a licensed state pilot or a certificated deputy pilot.
 191 Such standards shall include zero tolerance for any controlled
 192 substance regulated under chapter 893 unless that individual is
 193 under the care of a physician, advanced registered nurse
 194 practitioner, or physician assistant and that controlled
 195 substance was prescribed by that physician, advanced registered
 196 nurse practitioner, or physician assistant. To maintain
 197 eligibility as a certificated deputy pilot or licensed state
 198 pilot, each certificated deputy pilot or licensed state pilot
 199 must annually provide documentary proof of having satisfactorily
 200 passed a complete physical examination administered by a
 201 licensed physician. The physician must know the minimum
 202 standards and certify that the certificateholder or licensee
 203 satisfactorily meets the standards. The standards for
 204 certificateholders and for licensees shall include a drug test.
 205
 206 Upon resignation or in the case of disability permanently
 207 affecting a pilot's ability to serve, the state license or
 208 certificate issued under this chapter shall be revoked by the

209 department.

210 Section 5. Subsection (7) of section 456.072, Florida
 211 Statutes, is amended to read:

212 456.072 Grounds for discipline; penalties; enforcement.—

213 (7) Notwithstanding subsection (2), upon a finding that a
 214 physician has prescribed or dispensed a controlled substance, or
 215 caused a controlled substance to be prescribed or dispensed, in
 216 a manner that violates the standard of practice set forth in s.
 217 458.331(1)(q) or (t), s. 459.015(1)(t) or (x), s. 461.013(1)(o)
 218 or (s), or s. 466.028(1)(p) or (x), or that an advanced
 219 registered nurse practitioner has prescribed or dispensed a
 220 controlled substance, or caused a controlled substance to be
 221 prescribed or dispensed, in a manner that violates the standard
 222 of practice set forth in s. 464.018(1)(n) or (p)6., the
 223 physician or advanced registered nurse practitioner shall be
 224 suspended for a period of not less than 6 months and pay a fine
 225 of not less than \$10,000 per count. Repeated violations shall
 226 result in increased penalties.

227 Section 6. Subsections (2) and (3) of section 456.44,
 228 Florida Statutes, are amended to read:

229 456.44 Controlled substance prescribing.—

230 (2) REGISTRATION. ~~Effective January 1, 2012,~~ A physician
 231 licensed under chapter 458, chapter 459, chapter 461, or chapter
 232 466, a physician assistant licensed under chapter 458 or chapter
 233 459, or an advanced registered nurse practitioner certified
 234 under part I of chapter 464 who prescribes any controlled

235 substance, listed in Schedule II, Schedule III, or Schedule IV
 236 as defined in s. 893.03, for the treatment of chronic
 237 nonmalignant pain, must:

238 (a) Designate himself or herself as a controlled substance
 239 prescribing practitioner on his or her ~~the physician's~~
 240 practitioner profile.

241 (b) Comply with the requirements of this section and
 242 applicable board rules.

243 (3) STANDARDS OF PRACTICE.—The standards of practice in
 244 this section do not supersede the level of care, skill, and
 245 treatment recognized in general law related to health care
 246 licensure.

247 (a) A complete medical history and a physical examination
 248 must be conducted before beginning any treatment and must be
 249 documented in the medical record. The exact components of the
 250 physical examination shall be left to the judgment of the
 251 registrant ~~clinician~~ who is expected to perform a physical
 252 examination proportionate to the diagnosis that justifies a
 253 treatment. The medical record must, at a minimum, document the
 254 nature and intensity of the pain, current and past treatments
 255 for pain, underlying or coexisting diseases or conditions, the
 256 effect of the pain on physical and psychological function, a
 257 review of previous medical records, previous diagnostic studies,
 258 and history of alcohol and substance abuse. The medical record
 259 shall also document the presence of one or more recognized
 260 medical indications for the use of a controlled substance. Each

261 registrant must develop a written plan for assessing each
262 patient's risk of aberrant drug-related behavior, which may
263 include patient drug testing. Registrants must assess each
264 patient's risk for aberrant drug-related behavior and monitor
265 that risk on an ongoing basis in accordance with the plan.

266 (b) Each registrant must develop a written individualized
267 treatment plan for each patient. The treatment plan shall state
268 objectives that will be used to determine treatment success,
269 such as pain relief and improved physical and psychosocial
270 function, and shall indicate if any further diagnostic
271 evaluations or other treatments are planned. After treatment
272 begins, the registrant ~~physician~~ shall adjust drug therapy to
273 the individual medical needs of each patient. Other treatment
274 modalities, including a rehabilitation program, shall be
275 considered depending on the etiology of the pain and the extent
276 to which the pain is associated with physical and psychosocial
277 impairment. The interdisciplinary nature of the treatment plan
278 shall be documented.

279 (c) The registrant ~~physician~~ shall discuss the risks and
280 benefits of the use of controlled substances, including the
281 risks of abuse and addiction, as well as physical dependence and
282 its consequences, with the patient, persons designated by the
283 patient, or the patient's surrogate or guardian if the patient
284 is incompetent. The registrant ~~physician~~ shall use a written
285 controlled substance agreement between the registrant ~~physician~~
286 and the patient outlining the patient's responsibilities,

287 including, but not limited to:

288 1. Number and frequency of controlled substance
289 prescriptions and refills.

290 2. Patient compliance and reasons for which drug therapy
291 may be discontinued, such as a violation of the agreement.

292 3. An agreement that controlled substances for the
293 treatment of chronic nonmalignant pain shall be prescribed by a
294 single treating registrant ~~physician~~ unless otherwise authorized
295 by the treating registrant ~~physician~~ and documented in the
296 medical record.

297 (d) The patient shall be seen by the registrant ~~physician~~
298 at regular intervals, not to exceed 3 months, to assess the
299 efficacy of treatment, ensure that controlled substance therapy
300 remains indicated, evaluate the patient's progress toward
301 treatment objectives, consider adverse drug effects, and review
302 the etiology of the pain. Continuation or modification of
303 therapy shall depend on the registrant's ~~physician's~~ evaluation
304 of the patient's progress. If treatment goals are not being
305 achieved, despite medication adjustments, the registrant
306 ~~physician~~ shall reevaluate the appropriateness of continued
307 treatment. The registrant ~~physician~~ shall monitor patient
308 compliance in medication usage, related treatment plans,
309 controlled substance agreements, and indications of substance
310 abuse or diversion at a minimum of 3-month intervals.

311 (e) The registrant ~~physician~~ shall refer the patient as
312 necessary for additional evaluation and treatment in order to

313 | achieve treatment objectives. Special attention shall be given
314 | to those patients who are at risk for misusing their medications
315 | and those whose living arrangements pose a risk for medication
316 | misuse or diversion. The management of pain in patients with a
317 | history of substance abuse or with a comorbid psychiatric
318 | disorder requires extra care, monitoring, and documentation and
319 | requires consultation with or referral to an addiction medicine
320 | specialist or psychiatrist.

321 | (f) A registrant ~~physician~~ registered under this section
322 | must maintain accurate, current, and complete records that are
323 | accessible and readily available for review and comply with the
324 | requirements of this section, the applicable practice act, and
325 | applicable board rules. The medical records must include, but
326 | are not limited to:

- 327 | 1. The complete medical history and a physical
328 | examination, including history of drug abuse or dependence.
329 | 2. Diagnostic, therapeutic, and laboratory results.
330 | 3. Evaluations and consultations.
331 | 4. Treatment objectives.
332 | 5. Discussion of risks and benefits.
333 | 6. Treatments.
334 | 7. Medications, including date, type, dosage, and quantity
335 | prescribed.
336 | 8. Instructions and agreements.
337 | 9. Periodic reviews.
338 | 10. Results of any drug testing.

339 11. A photocopy of the patient's government-issued photo
340 identification.

341 12. If a written prescription for a controlled substance
342 is given to the patient, a duplicate of the prescription.

343 13. The registrant's ~~physician's~~ full name presented in a
344 legible manner.

345 (g) Patients with signs or symptoms of substance abuse
346 shall be immediately referred to a board-certified pain
347 management physician, an addiction medicine specialist, or a
348 mental health addiction facility as it pertains to drug abuse or
349 addiction unless the registrant is a physician who is board
350 certified ~~board-certified~~ or board eligible ~~board-eligible~~ in
351 pain management. Throughout the period of time before receiving
352 the consultant's report, a prescribing registrant ~~physician~~
353 shall clearly and completely document medical justification for
354 continued treatment with controlled substances and those steps
355 taken to ensure medically appropriate use of controlled
356 substances by the patient. Upon receipt of the consultant's
357 written report, the prescribing registrant ~~physician~~ shall
358 incorporate the consultant's recommendations for continuing,
359 modifying, or discontinuing controlled substance therapy. The
360 resulting changes in treatment shall be specifically documented
361 in the patient's medical record. Evidence or behavioral
362 indications of diversion shall be followed by discontinuation of
363 controlled substance therapy, and the patient shall be
364 discharged, and all results of testing and actions taken by the

365 registrant ~~physician~~ shall be documented in the patient's
366 medical record.

367

368 This subsection does not apply to a board-eligible or board-
369 certified anesthesiologist, physiatrist, rheumatologist, or
370 neurologist, or to a board-certified physician who has surgical
371 privileges at a hospital or ambulatory surgery center and
372 primarily provides surgical services. This subsection does not
373 apply to a board-eligible or board-certified medical specialist
374 who has also completed a fellowship in pain medicine approved by
375 the Accreditation Council for Graduate Medical Education or the
376 American Osteopathic Association, or who is board eligible or
377 board certified in pain medicine by the American Board of Pain
378 Medicine or a board approved by the American Board of Medical
379 Specialties or the American Osteopathic Association and performs
380 interventional pain procedures of the type routinely billed
381 using surgical codes. This subsection does not apply to a
382 registrant, physician, advanced registered nurse practitioner,
383 or physician assistant who prescribes medically necessary
384 controlled substances for a patient during an inpatient stay in
385 a hospital licensed under chapter 395.

386 Section 7. Paragraph (b) of subsection (2) of section
387 458.3265, Florida Statutes, is amended to read:

388 458.3265 Pain-management clinics.—

389 (2) PHYSICIAN RESPONSIBILITIES.—These responsibilities
390 apply to any physician who provides professional services in a

391 pain-management clinic that is required to be registered in
 392 subsection (1).

393 (b) A person may not dispense any medication on the
 394 premises of a registered pain-management clinic unless he or she
 395 is a physician licensed under this chapter or chapter 459. A
 396 person may not prescribe any controlled substance regulated
 397 under chapter 893 on the premises of a registered pain-
 398 management clinic unless he or she is a physician licensed under
 399 this chapter or chapter 459.

400 Section 8. Paragraph (f) of subsection (4) of section
 401 458.347, Florida Statutes, is amended to read:

402 458.347 Physician assistants.—

403 (4) PERFORMANCE OF PHYSICIAN ASSISTANTS.—

404 (f)1. The council shall establish a formulary of medicinal
 405 drugs that a fully licensed physician assistant having
 406 prescribing authority under this section or s. 459.022 may not
 407 prescribe. The formulary must include ~~controlled substances as~~
 408 ~~defined in chapter 893,~~ general anesthetics, and radiographic
 409 contrast materials.

410 2. In establishing the formulary, the council shall
 411 consult with a pharmacist licensed under chapter 465, but not
 412 licensed under this chapter or chapter 459, who shall be
 413 selected by the State Surgeon General.

414 3. Only the council shall add to, delete from, or modify
 415 the formulary. Any person who requests an addition, deletion, or
 416 modification of a medicinal drug listed on such formulary has

417 the burden of proof to show cause why such addition, deletion,
 418 or modification should be made.

419 4. The boards shall adopt the formulary required by this
 420 paragraph, and each addition, deletion, or modification to the
 421 formulary, by rule. Notwithstanding any provision of chapter 120
 422 to the contrary, the formulary rule shall be effective 60 days
 423 after the date it is filed with the Secretary of State. Upon
 424 adoption of the formulary, the department shall mail a copy of
 425 such formulary to each fully licensed physician assistant having
 426 prescribing authority under this section or s. 459.022, and to
 427 each pharmacy licensed by the state. The boards shall establish,
 428 by rule, a fee not to exceed \$200 to fund the provisions of this
 429 paragraph and paragraph (e).

430 Section 9. Paragraph (b) of subsection (2) of section
 431 459.0137, Florida Statutes, is amended to read:

432 459.0137 Pain-management clinics.—

433 (2) PHYSICIAN RESPONSIBILITIES.—These responsibilities
 434 apply to any osteopathic physician who provides professional
 435 services in a pain-management clinic that is required to be
 436 registered in subsection (1).

437 (b) A person may not dispense any medication on the
 438 premises of a registered pain-management clinic unless he or she
 439 is a physician licensed under this chapter or chapter 458. A
 440 person may not prescribe any controlled substance regulated
 441 under chapter 893 on the premises of a registered pain-
 442 management clinic unless he or she is a physician licensed under

443 | this chapter or chapter 458.

444 | Section 10. Section 464.012, Florida Statutes, is amended
445 | to read:

446 | 464.012 Certification of advanced registered nurse
447 | practitioners; fees; controlled substance prescribing.-

448 | (1) Any nurse desiring to be certified as an advanced
449 | registered nurse practitioner shall apply to the department and
450 | submit proof that he or she holds a current license to practice
451 | professional nursing and that he or she meets one or more of the
452 | following requirements as determined by the board:

453 | (a) Satisfactory completion of a formal postbasic
454 | educational program of at least one academic year, the primary
455 | purpose of which is to prepare nurses for advanced or
456 | specialized practice.

457 | (b) Certification by an appropriate specialty board. Such
458 | certification shall be required for initial state certification
459 | and any recertification as a registered nurse anesthetist or
460 | nurse midwife. The board may by rule provide for provisional
461 | state certification of graduate nurse anesthetists and nurse
462 | midwives for a period of time determined to be appropriate for
463 | preparing for and passing the national certification
464 | examination.

465 | (c) Graduation from a program leading to a master's degree
466 | in a nursing clinical specialty area with preparation in
467 | specialized practitioner skills. For applicants graduating on or
468 | after October 1, 1998, graduation from a master's degree program

469 shall be required for initial certification as a nurse
470 practitioner under paragraph (4)(c). For applicants graduating
471 on or after October 1, 2001, graduation from a master's degree
472 program shall be required for initial certification as a
473 registered nurse anesthetist under paragraph (4)(a).

474 (2) The board shall provide by rule the appropriate
475 requirements for advanced registered nurse practitioners in the
476 categories of certified registered nurse anesthetist, certified
477 nurse midwife, and nurse practitioner.

478 (3) An advanced registered nurse practitioner shall
479 perform those functions authorized in this section within the
480 framework of an established protocol that is filed with the
481 board upon biennial license renewal and within 30 days after
482 entering into a supervisory relationship with a physician or
483 changes to the protocol. The board shall review the protocol to
484 ensure compliance with applicable regulatory standards for
485 protocols. The board shall refer to the department licensees
486 submitting protocols that are not compliant with the regulatory
487 standards for protocols. A practitioner currently licensed under
488 chapter 458, chapter 459, or chapter 466 shall maintain
489 supervision for directing the specific course of medical
490 treatment. Within the established framework, an advanced
491 registered nurse practitioner may:

492 (a) Prescribe, dispense, administer, or order any ~~Monitor~~
493 ~~and alter~~ drug therapies.

494 (b) Initiate appropriate therapies for certain conditions.

495 (c) Perform additional functions as may be determined by
496 rule in accordance with s. 464.003(2).

497 (d) Order diagnostic tests and physical and occupational
498 therapy.

499 (4) In addition to the general functions specified in
500 subsection (3), an advanced registered nurse practitioner may
501 perform the following acts within his or her specialty:

502 (a) The certified registered nurse anesthetist may, to the
503 extent authorized by established protocol approved by the
504 medical staff of the facility in which the anesthetic service is
505 performed, perform any or all of the following:

506 1. Determine the health status of the patient as it
507 relates to the risk factors and to the anesthetic management of
508 the patient through the performance of the general functions.

509 2. Based on history, physical assessment, and supplemental
510 laboratory results, determine, with the consent of the
511 responsible physician, the appropriate type of anesthesia within
512 the framework of the protocol.

513 3. Order under the protocol preanesthetic medication.

514 4. Perform under the protocol procedures commonly used to
515 render the patient insensible to pain during the performance of
516 surgical, obstetrical, therapeutic, or diagnostic clinical
517 procedures. These procedures include ordering and administering
518 regional, spinal, and general anesthesia; inhalation agents and
519 techniques; intravenous agents and techniques; and techniques of
520 hypnosis.

521 5. Order or perform monitoring procedures indicated as
522 pertinent to the anesthetic health care management of the
523 patient.

524 6. Support life functions during anesthesia health care,
525 including induction and intubation procedures, the use of
526 appropriate mechanical supportive devices, and the management of
527 fluid, electrolyte, and blood component balances.

528 7. Recognize and take appropriate corrective action for
529 abnormal patient responses to anesthesia, adjunctive medication,
530 or other forms of therapy.

531 8. Recognize and treat a cardiac arrhythmia while the
532 patient is under anesthetic care.

533 9. Participate in management of the patient while in the
534 postanesthesia recovery area, including ordering the
535 administration of fluids and drugs.

536 10. Place special peripheral and central venous and
537 arterial lines for blood sampling and monitoring as appropriate.

538 (b) The certified nurse midwife may, to the extent
539 authorized by an established protocol which has been approved by
540 the medical staff of the health care facility in which the
541 midwifery services are performed, or approved by the nurse
542 midwife's physician backup when the delivery is performed in a
543 patient's home, perform any or all of the following:

544 1. Perform superficial minor surgical procedures.

545 2. Manage the patient during labor and delivery to include
546 amniotomy, episiotomy, and repair.

547 3. Order, initiate, and perform appropriate anesthetic
548 procedures.

549 4. Perform postpartum examination.

550 5. Order appropriate medications.

551 6. Provide family-planning services and well-woman care.

552 7. Manage the medical care of the normal obstetrical
553 patient and the initial care of a newborn patient.

554 (c) The nurse practitioner may perform any or all of the
555 following acts within the framework of established protocol:

556 1. Manage selected medical problems.

557 2. Order physical and occupational therapy.

558 3. Initiate, monitor, or alter therapies for certain
559 uncomplicated acute illnesses.

560 4. Monitor and manage patients with stable chronic
561 diseases.

562 5. Establish behavioral problems and diagnosis and make
563 treatment recommendations.

564 (5) The board shall certify, and the department shall
565 issue a certificate to, any nurse meeting the qualifications in
566 this section. The board shall establish an application fee not
567 to exceed \$100 and a biennial renewal fee not to exceed \$50. The
568 board is authorized to adopt such other rules as are necessary
569 to implement the provisions of this section.

570 Section 11. Paragraph (p) is added to subsection (1) of
571 section 464.018, Florida Statutes, to read:

572 464.018 Disciplinary actions.—

573 (1) The following acts constitute grounds for denial of a
574 license or disciplinary action, as specified in s. 456.072(2):

575 (p) For an advanced registered nurse practitioner:

576 1. Presigning blank prescription forms.

577 2. Prescribing for office use any medicinal drug appearing
578 on Schedule II in chapter 893.

579 3. Prescribing, ordering, dispensing, administering,
580 supplying, selling, or giving a drug that is an amphetamine or a
581 sympathomimetic amine drug, or a compound designated pursuant to
582 chapter 893 as a Schedule II controlled substance, to or for any
583 person except for:

584 a. The treatment of narcolepsy; hyperkinesis; behavioral
585 syndrome in children characterized by the developmentally
586 inappropriate symptoms of moderate to severe distractibility,
587 short attention span, hyperactivity, emotional lability, and
588 impulsivity; or drug-induced brain dysfunction.

589 b. The differential diagnostic psychiatric evaluation of
590 depression or the treatment of depression shown to be refractory
591 to other therapeutic modalities.

592 c. The clinical investigation of the effects of such drugs
593 or compounds when an investigative protocol is submitted to,
594 reviewed by, and approved by the department before such
595 investigation is begun.

596 4. Prescribing, ordering, dispensing, administering,
597 supplying, selling, or giving growth hormones, testosterone or
598 its analogs, human chorionic gonadotropin (HCG), or other

599 hormones for the purpose of muscle building or to enhance
600 athletic performance. As used in this subparagraph, the term
601 "muscle building" does not include the treatment of injured
602 muscle. A prescription written for the drug products listed in
603 this paragraph may be dispensed by a pharmacist with the
604 presumption that the prescription is for legitimate medical use.

605 5. Promoting or advertising on any prescription form a
606 community pharmacy unless the form also states: "This
607 prescription may be filled at any pharmacy of your choice."

608 6. Prescribing, dispensing, administering, mixing, or
609 otherwise preparing a legend drug, including a controlled
610 substance, other than in the course of his or her professional
611 practice. For the purposes of this subparagraph, it is legally
612 presumed that prescribing, dispensing, administering, mixing, or
613 otherwise preparing legend drugs, including all controlled
614 substances, inappropriately or in excessive or inappropriate
615 quantities is not in the best interest of the patient and is not
616 in the course of the advanced registered nurse practitioner's
617 professional practice, without regard to his or her intent.

618 7. Prescribing, dispensing, or administering a medicinal
619 drug appearing on any schedule set forth in chapter 893 to
620 himself or herself, except a drug prescribed, dispensed, or
621 administered to the advanced registered nurse practitioner by
622 another practitioner authorized to prescribe, dispense, or
623 administer medicinal drugs.

624 8. Prescribing, ordering, dispensing, administering,

625 supplying, selling, or giving amygdalin (laetrile) to any
626 person.

627 9. Dispensing a controlled substance listed on Schedule II
628 or Schedule III in chapter 893 in violation of s. 465.0276.

629 10. Promoting or advertising through any communication
630 medium the use, sale, or dispensing of a controlled substance
631 appearing on any schedule in chapter 893.

632 Section 12. Subsection (21) of section 893.02, Florida
633 Statutes, is amended to read:

634 893.02 Definitions.—The following words and phrases as
635 used in this chapter shall have the following meanings, unless
636 the context otherwise requires:

637 (21) "Practitioner" means a physician licensed under
638 ~~pursuant to~~ chapter 458, a dentist licensed under ~~pursuant to~~
639 chapter 466, a veterinarian licensed under ~~pursuant to~~ chapter
640 474, an osteopathic physician licensed under ~~pursuant to~~ chapter
641 459, an advanced registered nurse practitioner certified under
642 chapter 464, a naturopath licensed under ~~pursuant to~~ chapter
643 462, a certified optometrist licensed under ~~pursuant to~~ chapter
644 463, ~~or~~ a podiatric physician licensed under ~~pursuant to~~ chapter
645 461, or a physician assistant licensed under chapter 458 or
646 chapter 459, provided such practitioner holds a valid federal
647 controlled substance registry number.

648 Section 13. Paragraph (n) of subsection (1) of section
649 948.03, Florida Statutes, is amended to read:

650 948.03 Terms and conditions of probation.—

651 (1) The court shall determine the terms and conditions of
 652 probation. Conditions specified in this section do not require
 653 oral pronouncement at the time of sentencing and may be
 654 considered standard conditions of probation. These conditions
 655 may include among them the following, that the probationer or
 656 offender in community control shall:

657 (n) Be prohibited from using intoxicants to excess or
 658 possessing any drugs or narcotics unless prescribed by a
 659 physician, advanced registered nurse practitioner, or physician
 660 assistant. The probationer or community controllee may ~~shall~~ not
 661 knowingly visit places where intoxicants, drugs, or other
 662 dangerous substances are unlawfully sold, dispensed, or used.

663 Section 14. Subsection (3) of s. 310.071, Florida
 664 Statutes, is reenacted for the purpose of incorporating the
 665 amendment made by this act to s. 310.071, Florida Statutes, in a
 666 reference thereto.

667 Section 15. Subsection (10) of s. 458.331, paragraph (g)
 668 of subsection (7) of s. 458.347, subsection (10) of s. 459.015,
 669 paragraph (f) of subsection (7) of s. 459.022, and paragraph (b)
 670 of subsection (5) of s. 465.0158, Florida Statutes, are
 671 reenacted for the purpose of incorporating the amendment made by
 672 this act to s. 456.072, Florida Statutes, in references thereto.

673 Section 16. Paragraph (mm) of subsection (1) of s. 456.072
 674 and s. 466.02751, Florida Statutes, are reenacted for the
 675 purpose of incorporating the amendment made by this act to s.
 676 456.44, Florida Statutes, in references thereto.

677 Section 17. Section 458.303, paragraph (e) of subsection
 678 (4) and paragraph (c) of subsection (9) of s. 458.347, paragraph
 679 (b) of subsection (7) of s. 458.3475, paragraph (e) of
 680 subsection (4) and paragraph (c) of subsection (9) of s.
 681 459.022, and paragraph (b) of subsection (7) of s. 459.023,
 682 Florida Statutes, are reenacted for the purpose of incorporating
 683 the amendment made by this act to s. 458.347, Florida Statutes,
 684 in references thereto.

685 Section 18. Paragraph (a) of subsection (1) of s. 456.041,
 686 subsections (1) and (2) of s. 458.348, and subsection (1) of s.
 687 459.025, Florida Statutes, are reenacted for the purpose of
 688 incorporating the amendment made by this act to s. 464.012,
 689 Florida Statutes, in references thereto.

690 Section 19. Subsection (2) of s. 464.008, subsection (5)
 691 of s. 464.009, subsection (2) of s. 464.018, and paragraph (b)
 692 of subsection (1), subsection (3), and paragraph (b) of
 693 subsection (4) of s. 464.0205, Florida Statutes, are reenacted
 694 for the purpose of incorporating the amendment made by this act
 695 to s. 464.018, Florida Statutes, in references thereto.

696 Section 20. Section 775.051, Florida Statutes, is
 697 reenacted for the purpose of incorporating the amendment made by
 698 this act to s. 893.02, Florida Statutes, in a reference thereto.

699 Section 21. Paragraph (a) of subsection (3) of s. 944.17,
 700 subsection (8) of s. 948.001, and paragraph (e) of subsection
 701 (1) of s. 948.101, Florida Statutes, are reenacted for the
 702 purpose of incorporating the amendment made by this act to s.

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703 | 948.03, Florida Statutes, in references thereto.

704 | Section 22. This act shall take effect July 1, 2016.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 437 Certificates of Need for Hospitals
SPONSOR(S): Sprowls
TIED BILLS: IDEN./SIM. BILLS:

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Select Committee on Affordable Healthcare Access	10 Y, 4 N	Guzzo	Calamas
2) Health Care Appropriations Subcommittee		Clark <i>abc</i>	Pridgeon <i>[Signature]</i>
3) Health & Human Services Committee			

SUMMARY ANALYSIS

The certificate of need (CON) program, administered by the Agency for Health Care Administration (AHCA), requires certain health care facilities to obtain authorization from the state before offering certain new or expanded services. Health care facilities subject to CON review include hospitals, nursing homes, hospices, and intermediate care facilities for the developmentally disabled.

Florida's CON program was established in 1973, and has undergone several changes over the years. From 1974 through 1986, the specifics of the program were largely dictated by the federal National Health Planning and Resources Development Act, which established minimum requirements regarding the type of services subject to CON review, review procedures, and review criteria. Each state was required to have a CON program in compliance with those standards as a condition for obtaining federal funds for health programs. The federal health planning legislation was repealed in 1986, but Florida retained its CON program. Nationally, 22 states do not require CON review to add hospital beds. Of those states, 14 have no CON requirements for any health care facility or service.

The Florida CON program has three levels of review: full, expedited and exempt. Expedited review is primarily targeted towards nursing home projects. Projects required to undergo full comparative review include:

- Construction of a new hospital;
- Replacement of a hospital if the proposed project site is more than one mile from the hospital being replaced;
- Conversion from one type of hospital to another, including the conversion between a general hospital, specialty hospital, or a long-term care hospital; and
- Establishment of tertiary health services and comprehensive rehabilitation services.

The CON program exempts from full CON review the addition of beds to certain existing services, including comprehensive rehabilitation, neonatal intensive care, and psychiatric and substance abuse services.

An applicant for CON review must submit a fee with the application. The minimum CON application filing fee is \$10,000. In addition to the base fee, an applicant must pay a fee of 1.5 percent of each dollar of the proposed expenditure; however the total fee may not exceed \$50,000. The fee for a CON exemption is \$250.

HB 437 eliminates CON review requirements for hospitals and hospital services and makes necessary conforming changes throughout part I of chapter 408, F.S. The bill also removes the CON review requirement for increasing the number of comprehensive rehabilitation beds in a facility that offers comprehensive rehabilitation services.

The bill makes a conforming change to s. 395.1055, F.S., to ensure that AHCA has rulemaking authority, after the repeal of the CON review process for hospitals, to maintain licensure requirements and quality standards for tertiary health services offered by a hospital.

The bill is expected to have a negative fiscal impact on AHCA resulting from the loss of CON application and exemption fees; however, the loss will be offset by an increase in project and licensure fees for new hospitals and services.

The bill provides an effective date of July 1, 2016.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Hospital Licensure

Hospitals are regulated by the Agency for Health Care Administration (AHCA) under chapter 395, F.S., and the general licensure provisions of part II, of chapter 408, F.S. Hospitals offer a range of health care services with beds for use beyond 24 hours by individuals requiring diagnosis, treatment, or care.¹ Hospitals must make regularly available at least clinical laboratory services, diagnostic X-ray services, and treatment facilities for surgery or obstetrical care, or other definitive medical treatment.²

A specialty hospital, in addition to providing the same services as general hospitals, provides other services, including:

- A range of medical services restricted to a defined age or gender group;
- A restricted range of services appropriate to the diagnosis, care, and treatment of patients with specific categories of medical or psychiatric illnesses or disorders; or
- Intensive residential treatment programs for children and adolescents.³

AHCA must maintain an inventory of hospitals with an emergency department.⁴ The inventory must list all services within the capability of each hospital, and such services must appear on the face of the hospital's license. As of November 13, 2015, 219 of the 306 licensed hospitals in the state have an emergency department.⁵

Hospitals must meet initial licensing requirements by submitting a completed application and required documentation, and the satisfactory completion of a facility survey. The license fee is \$1,565.13 or \$31.46 per bed, whichever is greater.⁶ The survey fee is \$400.00 or \$12.00 per bed, whichever is greater.⁷

Section 395.1055, F.S., authorizes AHCA to adopt rules for hospitals. Separate standards may be provided for general and specialty hospitals.⁸ The rules for general and specialty hospitals must include minimum standards to ensure:

- A sufficient number of qualified types of personnel and occupational disciplines are on duty and available at all times to provide necessary and adequate patient care;
- Infection control, housekeeping, sanitary conditions, and medical record procedures are established and implemented to adequately protect patients;
- A comprehensive emergency management plan is prepared and updated annually;
- Licensed facilities are established, organized, and operated consistent with established standards and rules; and
- Licensed facility beds conform to minimum space, equipment, and furnishing standards.⁹

¹ S.395.002(12), F.S.

² Id.

³ S. 395.002(28), F.S.

⁴ S. 395.1041(2), F.S.

⁵ Agency for Health Care Administration, Facility/Provider Search Results, *Hospitals*, available at <http://www.floridahealthfinder.gov/facilitylocator/ListFacilities.aspx> (report generated on November 13, 2015).

⁶ Rule 59A-3.006(3), F.A.C.

⁷ S. 395.0161(3)(a), F.S.

⁸ S. 395.1055(2), F.S.

⁹ S. 395.1055(1), F.S.

The minimum standards for hospital licensure are contained in Chapter 59A-3, F.A.C.

Certificate of Need (CON)

CON laws require approval by a state health planning agency before a health care facility may construct or expand, offer a new service, or purchase equipment exceeding a certain cost.

CON programs are designed to restrain health care costs and provide for directed, measured planning for new services and facilities.¹⁰ Such programs were originally established to regulate the addition of new facilities, or new beds in hospitals and nursing homes, for example, and to prevent overbuying of expensive equipment, under the economic theory that excess capacity directly results in health care price inflation.¹¹ When a hospital or health care service provider cannot meet its obligations, fixed costs must be met through higher charges for the beds that are used or for the number of patients using the service.¹² Larger institutions have higher costs, so CON supporters say it makes sense to limit facilities to building only enough capacity to meet actual needs.¹³

In addition to cost containment, CON regulation is intended to create a "quid pro quo" in which profitability of covered medical services is increased by restricting competition and, in return, medical providers cross-subsidize specified amounts of indigent care, or medical services to the poor that are unprofitable to the provider.¹⁴ Some states require facilities and providers that obtain a CON to provide a certain amount of indigent care to underinsured or uninsured patients.¹⁵

Studies have found that CON programs do not meet the goal of limiting costs in health care. A literature review conducted in 2004 by the Federal Trade Commission and the Department of Justice concluded that:

[O]n balance, CON programs are not successful in containing health care costs, and that they pose serious anticompetitive risks that usually outweigh their purported economic benefits. Market incumbents can too easily use CON procedures to forestall competitors from entering an incumbent's market. [. . .] Indeed, there is considerable evidence that CON programs can actually increase prices by fostering anticompetitive barriers to entry. Other means of cost control appear to be more effective and pose less significant competitive concerns.¹⁶

Studies are split, however, on whether CON regulation has improved access to care for the underinsured and uninsured.¹⁷ While there is limited research on the subject, some studies have found

¹⁰ National Conference of State Legislators, Certificate of Need: State Laws and Programs, available at <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx> (last viewed November 13, 2015).

¹¹ Id.

¹² Id.

¹³ Id.

¹⁴ Thomas Stratmann and Jacob Russ, "Do Certificate-of-Need Laws Increase Indigent Care?" Mercatus Center at George Mason University, July 2014, pg. 2, available at: <http://mercatus.org/publication/do-certificate-need-laws-increase-indigent-care> (last viewed November 13, 2015).

¹⁵ For example, Delaware (Del. Code Ann. tit. 16 § 9303), Georgia (Ga. Code Ann. §111-2-2.40), Rhode Island (R.I. Code R. §6.2.4(B)), and Virginia (12 Va. Admin. Code §5-230-40 and §5-220-270) require CON applicants to comply with such provisions.

¹⁶ "Improving Health Care: A Does of Competition: A Report by the Federal Trade Commission and the Department of Justice," July 2004, available at: <https://www.ftc.gov/reports/improving-health-care-dose-competition-report-federal-trade-commission-department-justice> (last viewed November 13, 2015): "[t]here is near universal agreement among the authors [of studies on the economic effects of CON programs] and other health economists that CON has been unsuccessful in containing health care costs"; Daniel Sherman, Federal Trade Comm'n, The Effect of State Certificate-of-Need Laws on Hospital Costs: An Economic Policy Analysis (1988) (concluding, after empirical study of CON programs' effects on hospital costs using 1983-84 data, that strong CON programs do not lead to lower costs but may actually increase costs); Monica Noether, Federal Trade Comm'n, Competition Among Hospitals 82(1987) (empirical study concluding that CON regulation led to higher prices and expenditures).

¹⁷ Supra, FN 10 at pg. 18.

that access to care for the underserved populations has increased in states with CON programs,¹⁸ while another has found little, if any, evidence to support such a conclusion.¹⁹ In Florida, the Statewide Medicaid Managed Care (SMMC) program requires all managed care plans to comply with provider network standards to ensure access to care for beneficiaries and imposes significant penalties if access to care is impeded within the program. While Florida maintains a CON program for several types of health care facilities and services, accountability standards within the SMMC program would ensure access to care for Medicaid patients should the CON program be repealed.

According to one study, states with hospital CON regulations have 13 percent fewer hospital beds per 100,000 persons than states without hospital CON regulations.²⁰ The impact of CON regulations in Florida has been examined as well. A study found that, in Miami-Dade County, CON regulations result in approximately 3,428 fewer hospital beds, between 5 and 10 fewer hospitals offering MRI services, and 18 fewer hospitals offering CT scans.²¹

Florida's CON Program

Overview

Florida's CON program has existed since July 1973. From 1974 through 1986, the specifics of the program were largely dictated by the federal National Health Planning and Resources Development Act of 1974 (the "Act"), which established minimum requirements regarding the type of services subject to CON review, review procedures, and review criteria.²² Each state was required to have a CON program in compliance with the Act as a condition for obtaining federal funds for health programs. The Act was repealed in 1986.

In Florida, a CON is a written statement issued by AHCA evidencing community need for a new, converted, expanded, or otherwise significantly modified health care facility or health service, including hospices. The Florida CON program has three levels of review: full, expedited and exempt.²³ Unless a hospital project is exempt from the CON program, it must undergo a full comparative review. Expedited review is primarily targeted towards nursing home projects.

Projects Subject to Full CON Review

Some hospital projects are required to undergo a full comparative CON review, including:

- New construction of general hospitals, long-term care hospitals, and freestanding specialty hospitals; and
- Replacement of a hospital if the proposed project site is not located on the same site or within one mile of the existing health care facility.²⁴

The addition of certain new or expansion of certain existing hospital services are also required to undergo a full comparative CON review, including:

- Establishing comprehensive medical rehabilitation inpatient services or increasing the number of beds for comprehensive rehabilitation;²⁵ and

¹⁸ Tracy Yee, Lucy B. Stark, et al, "Health Care Certificate-of-Need Laws: Policy or Politics?," Research Brief, National Institute for Health Care Reform, No. 4, May 2011, pg. 6, available at: <http://www.nihcr.org/index.php?download=119ncfl17> (citing Elana C. Fric-Shamji and Mohammed F. Shamji, "Impact of U.S. Government Regulation on Access to Elective Surgical Care," *Clinical & Investigative Medicine*, vol. 31, no. 5 (October 2008) and Ellen S. Campbell and Gary M. Fournier, "Certificate-of-Need Deregulation and Indigent Hospital Care," *Journal of Health Politics, Policy and Law*, vol. 18, no. 4 (Winter 1993)).

¹⁹ Christopher J. Conover and Frank A. Sloan, "Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?," *Journal of Health Politics, Policy and Law*, vol. 23, no. 3, pg. 478 (June 1998).

²⁰ *Id.*

²¹ Christopher Koopman and Thomas Stratman, "Certificate-of-Need Laws: Implications for Florida," March 2015, pg. 2, available at: <http://mercatus.org/sites/default/files/Koopman-Certificate-of-NeedFL-MOP.pdf>. (last viewed November 13, 2015).

²² Pub. L. No. 93-641, 42 U.S.C. §§ 300k et seq.

²³ S. 408.036, F.S.

²⁴ S. 408.036(1)(b), F.S.

- Establishing tertiary health services.²⁶

Comprehensive medical rehabilitation inpatient services shape an organized program of intensive care services provided by a coordinated multidisciplinary team to patients with severe physical disabilities, including:

- Stroke;
- Spinal cord injury;
- Congenital deformity;
- Amputation;
- Major multiple trauma;
- Hip fracture;
- Brain injury;
- Rheumatoid arthritis;
- Neurological disorders;
- Burns; and
- Neurological disorders.²⁷

Section 408.032(17), F.S., requires AHCA to establish by rule a list of all tertiary health services subject to CON review. The list of tertiary health services must be reviewed annually by AHCA to determine if services should be added or deleted.²⁸

Hospitals must undergo full comparative CON review for the establishment of the following tertiary health services:

- Pediatric cardiac catheterization;
- Pediatric open-heart surgery;
- Neonatal intensive care units;
- Adult open heart surgery; and
- Organ transplantation; including
 - Heart;
 - Kidney;
 - Liver;
 - Bone marrow;
 - Lung; and
 - Pancreas.²⁹

²⁵ S. 408.0361(1)(e), F.S.

²⁶ S. 408.036(1)(f), F.S., and s. 408.032(17), F.S., which defines "tertiary health service" as a health service which, due to its high level of intensity, complexity, specialized or limited applicability, and cost, should be limited to, and concentrated in, a limited number of hospitals to ensure the quality, availability, and cost-effectiveness of such service. Examples of tertiary health services include pediatric cardiac catheterization, pediatric open-heart surgery, organ transplantation, neonatal intensive care units, comprehensive rehabilitation, and medical or surgical services which are experimental or developmental in nature to the extent that the provision of such services is not yet contemplated within the commonly accepted course of diagnosis or treatment for the condition addressed by a given service.

²⁷ Rule 59C-1.039(2)(c), F.A.C.

²⁸ Rule 59C-1.002(41), F.A.C.

²⁹ Rule 59C-1.002(41), F.A.C.

Projects Subject to Expedited CON Review

Certain projects are eligible for expedited CON review. Applicants for expedited review are not subject to the application deadlines associated with full comparative review and may submit an application at any time. Projects subject to an expedited review include:

- Transfer of a CON;
- Replacement of a nursing home within the same district;
- Replacement of a nursing home if the proposed site is within a 30-mile radius of the existing nursing home;
- Relocation of a portion of a nursing home's beds to another facility or to establish a new facility in the same district, or a contiguous district, if the relocation is within a 30-mile radius of the existing facility and the total number of nursing home beds in the state does not increase; and
- Construction of a new community nursing home in a retirement community under certain conditions.³⁰

Exemptions from CON Review

Section 408.036(3), F.S., provides many exemptions to CON review for certain hospital projects, including:

- Adding swing beds³¹ in a rural hospital, the total of which does not exceed one-half of its licensed beds.
- Converting licensed acute care hospital beds to Medicare and Medicaid certified skilled nursing beds in a rural hospital, as defined in s. 395.602, F.S., so long as the conversion of the beds does not involve the construction of new facilities.
- Adding hospital beds licensed under chapter 395, F.S., for comprehensive rehabilitation, the total of which may not exceed 10 total beds or 10 percent of the licensed capacity, whichever is greater.
- Establishing a level II neonatal intensive care unit (NICU) if the unit has at least 10 beds, and if the hospital had a minimum of 1,500 births during the previous 12 months.
- Establishing a level III NICU if the unit has at least 15 beds, and if the hospital had a minimum of at least 3,500 births during the previous 12 months.
- Establishing a level III NICU if the unit has at least 5 beds, and is a verified trauma center,³² and if the applicant has a level II NICU.
- Establishing an adult open heart surgery program in a hospital located within the boundaries of a health service planning district, which:
 - Has experienced an annual net out-migration of at least 600 open heart surgery cases for 3 consecutive years; and
 - Has a population that exceeds the state average of population per licensed and operational open-heart programs by at least 25 percent.
- For the provision of percutaneous coronary intervention for patients presenting with emergency myocardial infarctions in a hospital that does not have an approved adult open-heart-surgery program.

³⁰ S. 408.036(2), F.S.

³¹ S. 395.602(2)(g), F.S., defines "swing bed" as a bed which can be used interchangeably as either a hospital, skilled nursing facility (SNF), or intermediate care facility (ICF) bed pursuant to 42 C.F.R. parts 405, 435, 440, 442, and 447.

³² S. 395.4001(14), F.S., defines "trauma center" as a hospital that has been verified by the Department of Health to be in substantial compliance with the requirements in s. 395.4025, F.S., and has been approved to operate as a Level I trauma center, Level II trauma center, or pediatric trauma center, or is designated as a Level II trauma center pursuant to s. 395.4025(14), F.S.

CON Determination of Need and Application and Review Process

A CON is predicated on a determination of need. The future need for services and projects is known as the "fixed need pool"³³, which AHCA publishes for each batching cycle. A batching cycle is a means of grouping of, for comparative review, CON applications submitted for beds, services or programs having a like CON need methodology or licensing category in the same planning horizon and the same applicable district or subdistrict.³⁴ Chapter 59C-1, F.A.C., provides need formulas³⁵ to calculate the fixed need pool for certain services, including NICU services³⁶, adult and child psychiatric services³⁷, adult substance abuse services³⁸, and comprehensive rehabilitation services.³⁹

Upon determining that a need exists, AHCA accepts applications for CON based on batching cycles. Section 408.032(5), F.S., establishes the 11 district service areas in Florida, illustrated in the chart below.

Certificate of Need Service Areas



³³ Rule 59C-1.002(19), F.A.C., defines "fixed need pool" as the identified numerical need, as published in the Florida Administrative Register, for new beds or services for the applicable planning horizon established by AHCA in accordance with need methodologies which are in effect by rule at the time of publication of the fixed need pools for the applicable batching cycle.

³⁴ Rule 59C-1.002(5), F.A.C.

³⁵ Rule 59C-1.039(5), F.A.C., provides the need formula for comprehensive medical rehabilitation inpatient beds as follows: $((PD/P) \times PP / (365 \times .85)) - LB - AB = NN$ where: 1. NN equals the net need for Comprehensive Medical Rehabilitation Inpatient Beds in a District. 2. PD equals the number of inpatient days in Comprehensive Medical Rehabilitation Inpatient Beds in a district for the 12-month period ending 6 months prior to the beginning date of the quarter of the publication of the Fixed Bed Need Pool.

3. P equals the estimated population in the district. For applications submitted between January 1 and June 30, P is the population estimate for January of the preceding year; for applications submitted between July 1 and December 31, P is the population estimate for July of the preceding year. The population estimate shall be the most recent estimate published by the Office of the Governor and available to the Department at least 4 weeks prior to publication of the Fixed Bed Need Pool.

4. PP equals the estimated population in the district for the applicable planning horizon. The population estimate shall be the most recent estimate published by the Office of the Governor and available to the Department at least 4 weeks prior to publication of the Fixed Bed Need Pool. 5. .85 equals the desired average annual occupancy rate for Comprehensive Medical Rehabilitation Inpatient Beds in the district. 6. LB equals the district's number of licensed Comprehensive Medical Rehabilitation Inpatient Beds as of the most recent published deadline for Agency initial decisions prior to publication of the Fixed Bed Need Pool.

7. AB equals the district's number of approved Comprehensive Medical Rehabilitation Inpatient Beds.

³⁶ Rule 59C-1.042(3), F.A.C.

³⁷ Rule 59C-1.040(4), F.A.C.

³⁸ Rule 59C-1.041(4), F.A.C.

³⁹ Rule 59C-1.039(5), F.A.C.

The CON review process consists of four batching cycles each year, including two batching cycles each year for each of two project categories: hospital beds and facilities, and other beds and programs.⁴⁰ The “hospital beds and facilities” batching cycle includes applicants for new or expanded:

- Comprehensive medical rehabilitation beds;
- Adult psychiatric beds;
- Child and adolescent psychiatric beds;
- Adult substance abuse beds;
- NICU level II beds; and
- NICU level III beds.⁴¹

The “other beds and programs” batching cycle includes:

- Nursing home beds;
- Hospice beds;
- Pediatric open heart surgery;
- Pediatric cardiac catheterization services; and
- Organ transplantation services.⁴²

Hospital Beds & Facilities Applications for Last 4 Batching Cycles 2013-2015⁴³

<i>Proposed Project</i>	<i>Applications Received</i>	<i>Applications Approved</i>
Establish a Comprehensive Medical Rehabilitation Unit	9	1
Establish an Acute Care Hospital	4	3
Establish an Adult Inpatient Psychiatric Hospital	4	3
Establish a Long-Term Care Hospital	2	2
Establish a Replacement Acute Care Hospital	2	2
Establish a Child/Adolescent Psychiatric Hospital	1	1
Total	22	12

At least 30 days prior to the application deadline for a batch cycle, an applicant must file a letter of intent with AHCA.⁴⁴ A letter of intent must describe the proposal, specify the number of beds sought, and identify the services to be provided and the location of the project.⁴⁵

Applications for CON review must be submitted by the specified deadline for the particular batch cycle.⁴⁶ AHCA must review the application within 15 days of the filing deadline and, if necessary,

⁴⁰ Rule 59C-1.008(1)(g), F.A.C.

⁴¹ Rule 59C-1.008(1), F.A.C.

⁴² Id.

⁴³ AHCA, CON Decisions & State Agency Action Reports, Hospital Beds and Facilities, February 2015 batching cycle, August 2014 batching cycle, February 2014 batching cycle, and August 2013 batching cycle, available at http://ahca.myflorida.com/MCHQ/CON_FA/Batching/decisions.shtml (last viewed November 13, 2015). Pursuant to s. 408.036, F.S., and rule 59C-1.004(1), F.A.C., requests for an expedited review or exemption may be made at any time and are not subject to batching requirements.

⁴⁴ S. 408.039(2)(a), F.S.

⁴⁵ S. 408.039(2)(c), F.S.

request additional information for an incomplete application.⁴⁷ The applicant then has 21 days to complete the application or it is deemed withdrawn from consideration.⁴⁸

Within 60 days of receipt of the completed applications for that batch, AHCA must issue a State Agency Action Report and Notice of Intent to Award a CON for a project in its entirety, to award a CON for identifiable portions of a project, or to deny a CON for a project.⁴⁹ AHCA must then publish the decision, within 14 days, in the Florida Administrative Weekly.⁵⁰ If no administrative hearing is requested within 21 days of the publication, the State Agency Action Report and the Notice of Intent to Award the CON become a final order of AHCA.⁵¹

CON Fees

An applicant for CON review must pay a fee to AHCA when the application is submitted. The minimum CON application filing fee is \$10,000.⁵² In addition to the base fee, an applicant must pay a fee of 1.5 percent of each dollar of the proposed expenditure; however, the total fee may not exceed \$50,000.⁵³ A request for a CON exemption must be accompanied by a \$250 fee payable to AHCA.⁵⁴

CON Litigation

Florida law allows competitors to challenge CON decisions. A Notice of Intent to Award a CON may be challenged by a competing applicant in the same review cycle or an existing provider in the same district by submitting evidence that the challenge will be substantially affected if the CON is awarded.⁵⁵ A challenge to a CON decision is heard by an Administrative Law Judge under the Division of Administrative Hearings.⁵⁶ AHCA must render a Final Order within 45 days of receiving the Recommended Order of the Administrative Law Judge.⁵⁷ A party to an administrative hearing may challenge a Final Order to the District Court of Appeals for judicial review⁵⁸ within 30 days of receipt of a Final Order.⁵⁹

CON Deregulation

Florida's CON program has been reformed several times over the course of the past 15 years. In 2000, CON review was eliminated for establishing a new home health agency.⁶⁰ The number of home health agencies doubled over the ten-year period immediately succeeding the elimination of CON review for establishing a new home health agency. Since 2010, the number of home health agencies has slowly declined.⁶¹

⁴⁶ Rule 59C-1.008(1)(g), F.A.C.

⁴⁷ S. 408.039(3)(a), F.S.

⁴⁸ *Id.*

⁴⁹ S. 408.039(4)(b), F.S.

⁵⁰ S. 408.039(4)(c), F.S.

⁵¹ S. 408.039(4)(d), F.S.

⁵² S. 408.038, F.S.

⁵³ *Id.*

⁵⁴ S. 408.036(4), F.S., and Rule 59C-1.005(2)(g), F.A.C.

⁵⁵ S. 408.039(5)(c), F.S.

⁵⁶ *Id.*

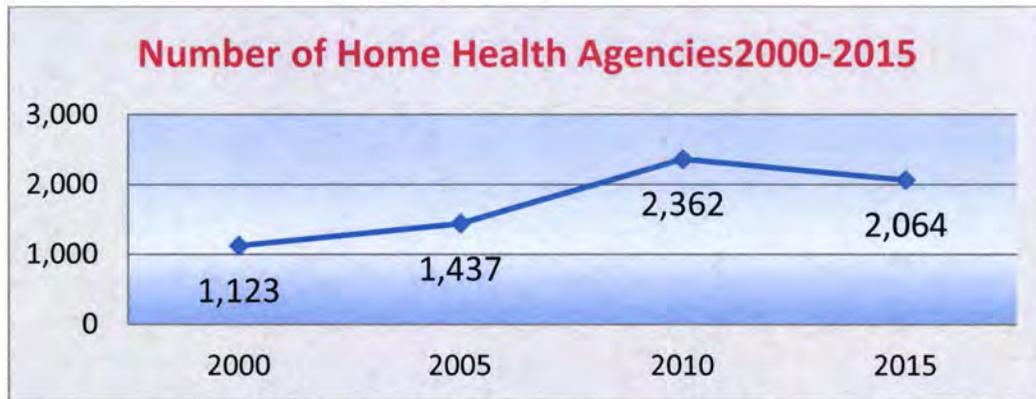
⁵⁷ S. 408.039(5)(e), F.S.

⁵⁸ S. 120.68(1), F.S., a party who is adversely affected by final agency action is entitled to judicial review. A preliminary, procedural, or intermediate order of the agency or of an administrative law judge of the Division of Administrative Hearings is immediately reviewable if review of the final agency decision would not provide an adequate remedy.

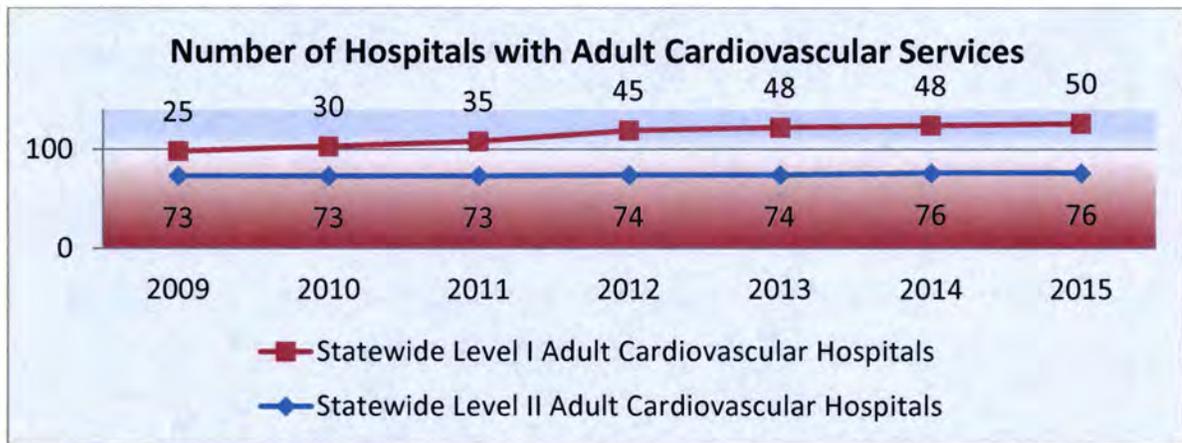
⁵⁹ S. 408.039(6), F.S.

⁶⁰ Ch. 2000-256, Laws of Fla.

⁶¹ AHCA, Current Status of Certificate of Need, Effects of Deregulation, October 20, 2015, available at <http://healthandhospitalcommission.com/Meetings.shtml> (last viewed November 13, 2015).



In 2007, CON review was eliminated for adult cardiac catheterization and adult open heart surgery services.⁶² Since the elimination of CON review for adult cardiovascular services, the number of hospitals with a Level I⁶³ adult cardiovascular services license has doubled while the number of hospitals with a Level II adult cardiovascular services license has only marginally increased.⁶⁴



In 2014, the moratorium on the granting of CONs for additional community nursing home beds was repealed.⁶⁵ In addition to the repeal, the legislature imposed limitations on the issuance of CONs for community nursing home beds to limit the growth through July 1, 2017. AHCA may not approve a CON application for new community nursing home beds following the batching cycle in which the cumulative number of new community nursing home beds approved from July 1, 2014, to June 30, 2017, equals or exceeds 3,750.⁶⁶ As of October, 2015, 3,373 nursing home beds have been approved since the moratorium has been lifted.⁶⁷

⁶² Ch. 2007-214, Laws of Fla.

⁶³ S. 408.0361, F.S., requires AHCA to adopt rules for the establishment of two hospital program licensure levels: a Level I program authorizing the performance of adult percutaneous cardiac intervention without onsite cardiac surgery and a Level II program authorizing the performance of percutaneous cardiac intervention with onsite cardiac surgery. Rule 59A-3.2085(16) and (17), F.A.C., provides the licensure requirements for Level I and Level II adult cardiovascular services licensure.

⁶⁴ Supra, FN 62 at pg. 7.

⁶⁵ Ch. 2014-110, Laws of Fla.

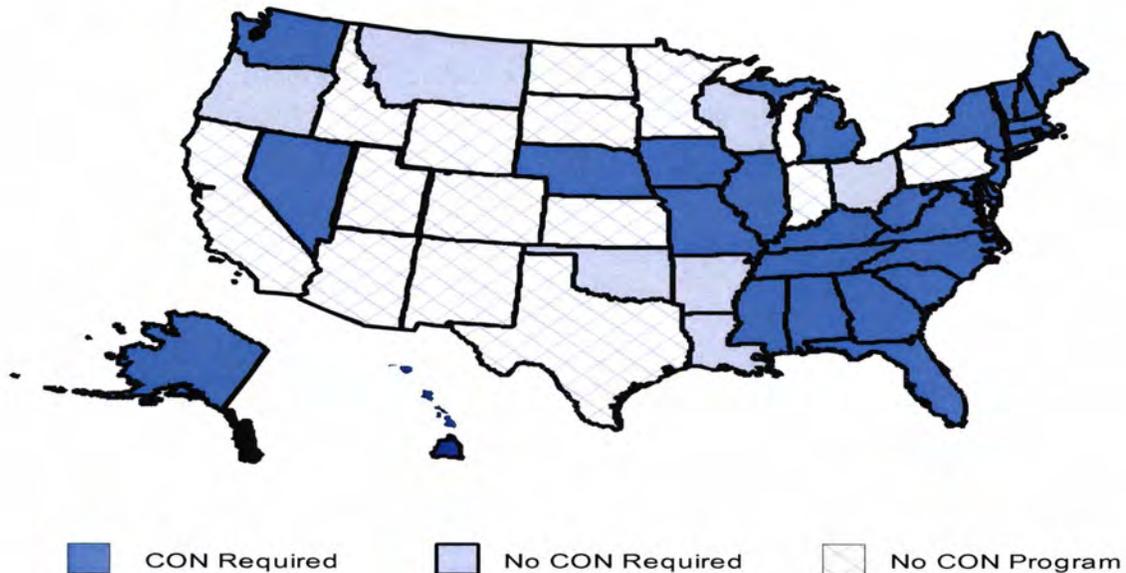
⁶⁶ S. 408.0436, F.S.

⁶⁷ AHCA, Nursing Home Licensure and Regulation, Presentation to the Health Innovation Subcommittee, October 6, 2015, (on file with Select Committee on Affordable Healthcare Access staff).

Nursing Home CON Applications Since July 2014 ⁶⁸					
	Oct. 2014 ⁶⁹	April 2015 ⁷⁰	Expedited Reviews	Exemptions	Total
Bed Need Published	3,115	657			3,772
Notices of Intent Filed	179	28			207
Applications Submitted	87	19			106
Approved Beds	2,447	381	240	305	3,373
Denied Beds	5,827	519			6,346
New Facilities	22	2	2		26
Additions to Existing Facilities	12	8			20

CON Nationwide

Fourteen states do not have CON requirements for any type of health care facility or service.⁷¹ Eight additional states have CON laws for other facilities and services, but do not have CON requirements relating specifically to the addition of hospital beds.⁷²



⁶⁸ Id.

⁶⁹ The decision date for this batching cycle was February 20, 2015.

⁷⁰ The decision date for this batching cycle was August 21, 2015.

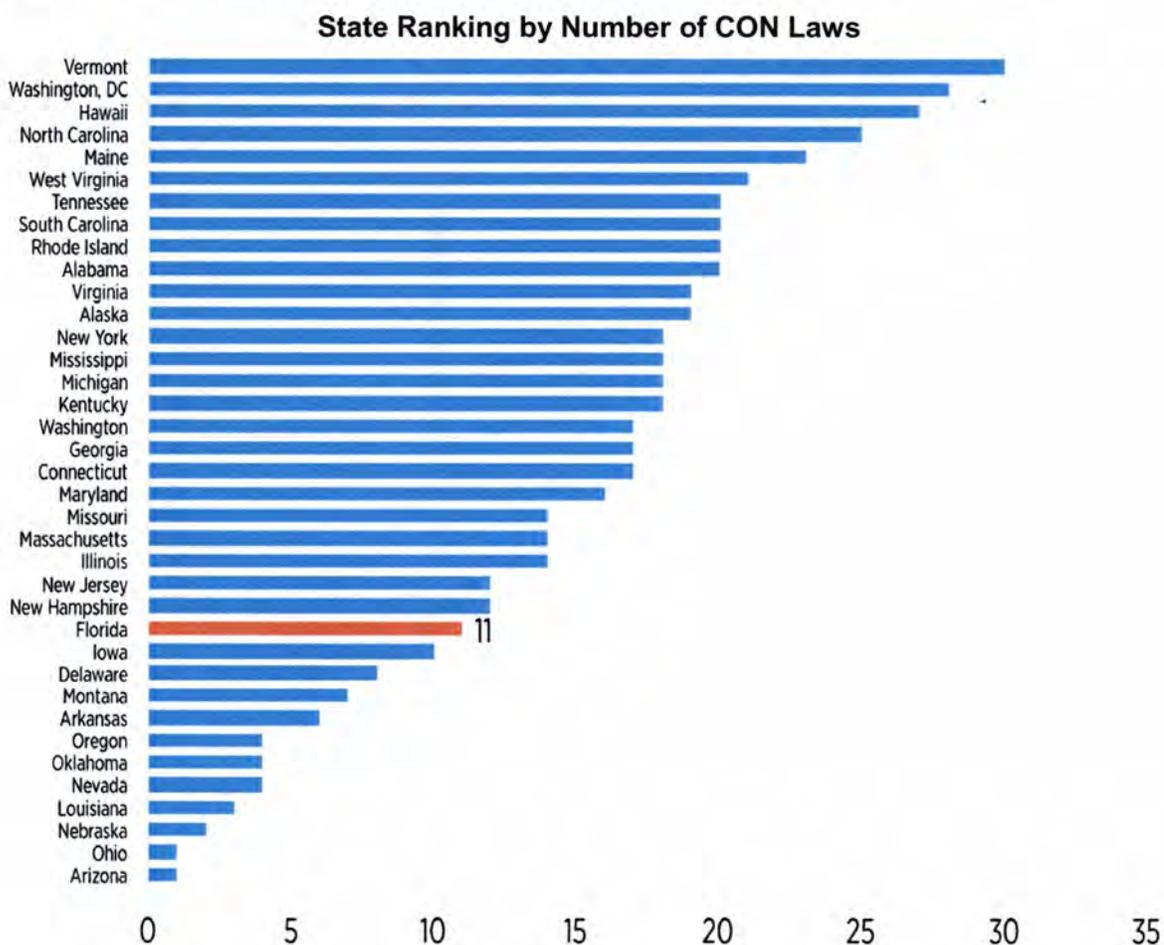
⁷¹ National Conference of State Legislators, Certificate of Need: State Laws and Programs, available at <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx> (last viewed November 13, 2015).

⁷² Id.

The states that have repealed their CON program, and the dates of repeal, are:

- Arizona (1985 – still retains CON requirements for ambulance service providers);
- California (1987);
- Idaho (1983);
- Indiana (1996);
- Kansas (1985);
- Minnesota (1985);
- New Mexico (1983);
- North Dakota (1995);
- Pennsylvania (1996);
- South Dakota (1988);
- Texas (1985);
- Utah (1984);
- Wisconsin (2011); and
- Wyoming (1989).⁷³

On average, states with CON programs regulate 14 different services, devices, and procedures.⁷⁴ Florida's CON program currently regulates 11, which is slightly below the national average.⁷⁵ Vermont has the most CON laws in place. Arizona has the least number of CON laws.⁷⁶



⁷³ Id.

⁷⁴ Supra, FN 18 at pg. 3.

⁷⁵ Id.

⁷⁶ Id.

CON Reform in Other States

Georgia

The State Commission on the Efficacy of the Certificate of Need Program recommended that CON be maintained and improved after spending 18 months examining the role of CON. The final Commission report, issued in 2006, recommended that Georgia maintain existing CON regulations for hospital beds, adult open heart surgery, and pediatric cardiac catheterization and open heart surgery.⁷⁷ The report did not recommend deregulation of any hospital CON project. The CON program for hospital facilities and services remains intact.

Illinois

In 2006, the Legislature passed a law requiring the Commission (Commission) on Government Forecasting and Accountability to “conduct a comprehensive evaluation of the Illinois Health Facilities Planning Act, including a review of the performance of the Illinois Health Facilities Planning Board, to determine if it is meeting the goals and objectives that were originally intended in the law...”⁷⁸ The Commission contracted with The Lewin Group to conduct a study on CON, which found that CONs rarely reduce health care costs and, on occasion, increase cost in some states. The study recommended that, while the traditional arguments for CON are empirically weak, based on the preponderance of hard evidence, the CON program should be allowed to sunset. However, the study cautioned that, given the potential for harm to specific critical elements of the health care system, the Legislature should move forward with an abundance of caution.⁷⁹

In 2008, the Legislature decided to study the issue further and passed legislation to create the Task Force on Health Planning Reform (task force).⁸⁰ The task force evaluated the current CON program and recommended changes to the structure and function of both the Health Facilities Planning Board and the Department of Public Health in the review of applications to establish, expand, or modify health facilities and related capital expenditures.⁸¹ The task force recommended that the state maintain the CON process and extend the sunset date.⁸² Currently, the CON program is scheduled to sunset on December 31, 2019.

Washington State

In 1999, the Joint Legislative Audit Review Committee contracted with the Health Policy Analysis Program of the University of Washington to conduct a legislatively mandated study of the CON program.⁸³ The study examined the effects of CON, and its possible repeal, on the cost, quality, and availability health care. The results of the study were based on a literature review, information gathered from service providers and other experts in Washington, and analyses of states where CON has been completely or partially repealed.⁸⁴

The study concluded that CON has not controlled overall health care spending or hospital costs and found conflicting or limited evidence of the effects of CON on the quality and availability of other health care services or of the effects of repealing CON. The study included three policy options for

⁷⁷ Supra, FN 71 at pgs. 62 and 82.

⁷⁸ Ill. House Resolution 1497 (2006).

⁷⁹ The Lewin Group, An Evaluation of Illinois' Certificate of Need Program, Prepared for the State of Illinois Commission on Government Forecasting and Accountability, February 15, 2007, available at <http://cgfa.ilga.gov/Upload/LewinGroupEvalCertOfNeed.pdf> (last viewed November 13, 2015).

⁸⁰ Ill. Senate Bill 244 (PA 95-0005) of the 95th General Assembly, 2008

⁸¹ The Illinois Task Force on Health Planning Reform, Final Report, December 31, 2008.

⁸² Id.

⁸³ State of Washington, Senate Bill 6108, 55th Legislature, 1998 Regular Session.

⁸⁴ State of Washington Joint Legislative Audit and Review Committee, Effects of Certificate of Need and its Possible Repeal, Report 99-1, January 8, 1999, available at <http://www.leg.wa.gov/JLARC/AuditAndStudyReports/1999/Documents/99-1.pdf> (last viewed October 27, 2015).

consideration: reform CON to address its current weaknesses; repeal the program while taking steps to increase monitoring and ensure that relevant goals are being met; or conduct another study to identify more clearly the possible effects of repeal. Washington State decided to keep the CON program.

Virginia

The Virginia General Assembly adopted legislation during the 2015 legislative session requiring the Secretary of Health and Human Resources to convene a workgroup to review the state's Certificate of Public Need (COPN) process.⁸⁵

The workgroup is required to develop specific recommendations for changes to the COPN process to be introduced during the 2016 Session of the General Assembly and any additional changes that may require further study or review.⁸⁶ In conducting its review and developing its recommendations, the work group must consider data and information about the current COPN process, the impact of such process, and any data or information about similar processes in other states.⁸⁷ A final report with recommendations must be provided to the General Assembly by December 1, 2015.⁸⁸

In response to a request by the Virginia House of Delegates, the Federal Trade Commission and the Antitrust Division of the U.S. Department of Justice (the agencies) submitted a joint statement to the COPN workgroup.⁸⁹ The statement explains that the agencies historically have urged states to consider repeal or reform of their CON laws because they can prevent the efficient functioning of health care markets, and thus can harm consumers.⁹⁰ As the statement describes, CON laws create barriers to expansion, limit consumer choice, and stifle innovation.⁹¹ Additionally, incumbent providers seeking to thwart or delay entry by new competitors may use CON laws to that end.⁹² Finally, the statement asserts that CON laws can deny consumers the benefit of an effective remedy for antitrust violations and can facilitate anticompetitive agreements.⁹³ For these reasons, the agencies suggested that the workgroup and the General Assembly consider whether Virginia's citizens are well served by its COPN laws and, if not, whether they would benefit from the repeal or retrenchment of those laws.⁹⁴

Currently, both North Carolina and South Carolina are considering legislation to repeal or limit their CON programs.⁹⁵

⁸⁵ SB 1283, Virginia General Assembly, 2015.

⁸⁶ 2015 Va. Acts Chapter 541.

⁸⁷ *Id.*

⁸⁸ *Id.*

⁸⁹ Joint Statement of the Federal Trade Commission and the Antitrust Division of the U.S. Department of Justice to the Virginia Certificate of Public Need Work Group, October 26, 2015, available at <http://www.vdh.state.va.us/Administration/documents/COPN/Federal%20Trade%20Commission%20and%20Department%20of%20Justice.pdf> (last viewed November 12, 2015).

⁹⁰ *Supra*, FN 87 at pg. 2.

⁹¹ *Id.*

⁹² *Id.*

⁹³ *Id.*

⁹⁴ *Supra*, FN 87 at pg. 13.

⁹⁵ The North Carolina General Assembly is considering two bills to reform their CON program during the 2016 legislative session. Senate Bill 702 proposes to repeal the CON program in its entirety. House Bill 200 proposes to provide exemptions from CON review for diagnostic centers, ambulatory surgical centers, gastrointestinal endoscopy rooms, and psychiatric hospitals. The legislative session begins in April. The South Carolina General Assembly is also considering legislation during the 2016 legislative session to reform the CON program. Currently, South Carolina's CON program requires review for 20 different health care projects and services including hospitals. House Bill 3250 proposes to repeal the CON program effective January 1, 2018, and proposes to reduce CON regulations in the interim by providing several exemptions from CON review. The legislative session begins in January.

Effect of Proposed Changes

The bill eliminates CON review requirements for hospitals and hospital services and makes necessary conforming changes throughout part I of chapter 408, F.S. The bill also removes the CON review requirement for increasing the number of comprehensive rehabilitation beds in a facility that offers comprehensive rehabilitation services. Hospitals will be able to expand the number of beds and the types of services without seeking prior authorization from the state. Similarly, facilities that offer comprehensive rehabilitation services will be able to increase the number of beds to meet demand without first seeking prior authorization from the state.

The bill also makes a conforming change to s. 395.1055, F.S., to ensure that AHCA has rulemaking authority, after the repeal of the CON review requirements for hospitals, to maintain quality requirements for tertiary services that may be offered by a hospital. Current CON rules for tertiary services, such as comprehensive medical rehabilitation, neonatal intensive care services, organ transplantation, and pediatric cardiac catheterization, include quality standards for those programs.⁹⁶ The bill deletes the definition of "tertiary health service" in s. 408.032, F.S., to repeal the CON review requirement for a hospital to establish such services. This eliminates authority for CON rules, including quality standards. The conforming change transfers rulemaking authority for the quality standards from the CON law to the hospital licensure law. The change eliminates any implication or interpretation that AHCA loses rulemaking authority to impose and maintain licensure requirements for tertiary health services as a result of the repeal of the CON review requirements for hospitals.

B. SECTION DIRECTORY:

- Section 1:** Amends s. 408.032, F.S., relating to definitions relating to Health Facility and Services Development Act.
- Section 2:** Amends s. 408.034, F.S., relating to duties and responsibilities of the agency; rules.
- Section 3:** Amends s. 408.035, F.S., relating to review criteria.
- Section 4:** Amends s. 408.036, F.S., relating to projects subject to review; exemptions.
- Section 5:** Amends s. 408.037, F.S., relating to application content.
- Section 6:** Amends s. 408.039, F.S., relating to review process.
- Section 7:** Amends s. 408.043, F.S., relating to special provisions.
- Section 8:** Amends s. 395.1055, F.S., relating to rules and enforcement.
- Section 9:** Repeals s. 395.6025, F.S., relating to rural hospital replacement facilities.
- Section 10:** Amends s. 395.603, F.S., relating to deactivation of general hospital beds; rural hospital impact statement.
- Section 11:** Amends s. 395.604, F.S., relating to other rural hospital programs.
- Section 12:** Amends s. 395.605, F.S., relating to emergency care hospitals.
- Section 13:** Amends s. 408.0361, F.S., relating to cardiovascular services and burn unit licensure.
- Section 14:** Provides an effective date of July 1, 2016.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

AHCA will experience a reduction in revenue resulting from the loss of CON application and exemption fees for hospital services which may be mitigated by a reduction in workload. Fees

⁹⁶ The current CON rules which include quality standards, in addition to the CON market-entry requirements, are 59C-1.039, F.A.C. (comprehensive medical rehabilitation); 59C-1.042, F.A.C. (neonatal intensive care services); 59C-1.044, F.A.C. (organ transplantation); 59C-1.032, F.A.C. (pediatric cardiac catheterization); 59C-1.033, F.A.C. (adult and pediatric open heart surgery programs); and 59A-3.2085(16)-(17), F.A.C. (adult cardiovascular services).

collected in Fiscal Year 2014-2015 resulted in revenue of approximately \$450,000.⁹⁷ Any decrease in CON application fees will be offset by an approximate 10 percent increase in hospital projects resulting in almost \$450,000 in new plans and construction fees.⁹⁸

2. Expenditures:

AHCA will experience increased workload resulting from an increase in hospital licensure applications. The expenditure associated with any increase in workload is indeterminate yet likely insignificant; however, the increased workload will be offset by the reduced workload resulting from the repeal of the CON review process for hospitals.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Hospitals will experience a significant positive fiscal impact resulting from the elimination of CON fees, which range from \$10,000 to \$50,000.

By removing the CON review program for hospitals, the hospital industry is likely to realize increased competition in services offered by hospitals.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. The bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

No additional rulemaking authority is necessary to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

⁹⁷ AHCA, Agency Bill Analysis of HB 437, October 26, 2015 (on file with the Select Committee on Affordable Healthcare Access staff).

⁹⁸ Id.

1 A bill to be entitled
 2 An act relating to certificates of need for hospitals;
 3 amending s. 408.032, F.S.; revising definitions;
 4 amending s. 408.034, F.S.; revising duties and
 5 responsibilities of the Agency for Health Care
 6 Administration in the exercise of its authority to
 7 issue licenses to health care facilities and health
 8 service providers; amending s. 408.035, F.S.; revising
 9 review criteria for applications for certificate-of-
 10 need determinations for health care facilities and
 11 health services; excluding general hospitals from such
 12 review; amending s. 408.036, F.S.; revising health-
 13 care-related projects subject to review for a
 14 certificate of need and exemptions therefrom; amending
 15 s. 408.037, F.S.; revising content requirements with
 16 respect to an application for a certificate of need;
 17 amending s. 408.039, F.S.; revising the review process
 18 for certificates of need; amending s. 408.043, F.S.;
 19 revising special provisions to eliminate provisions
 20 relating to osteopathic acute care hospitals; amending
 21 s. 395.1055, F.S.; revising the agency's rulemaking
 22 authority with respect to minimum standards for
 23 hospitals; requiring hospitals that provide certain
 24 services to meet specified licensure requirements;
 25 deleting requirements for submitting data by hospitals
 26 for certificate-of-need reviews, to conform to changes

27 | made by the act; repealing s. 395.6025, F.S., relating
 28 | to rural hospital replacement facilities; amending ss.
 29 | 395.603, 395.604, and 395.605, F.S.; conforming
 30 | references; amending s. 408.0361, F.S.; deleting
 31 | outdated licensure provisions for cardiovascular
 32 | services and burn units; providing an effective date.
 33 |

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

36 | Section 1. Subsections (8) through (17) of section
 37 | 408.032, Florida Statutes, are amended to read:

38 | 408.032 Definitions relating to Health Facility and
 39 | Services Development Act.—As used in ss. 408.031-408.045, the
 40 | term:

41 | (8) "Health care facility" means a ~~hospital, long-term~~
 42 | ~~care hospital,~~ skilled nursing facility, hospice, or
 43 | intermediate care facility for the developmentally disabled. A
 44 | facility relying solely on spiritual means through prayer for
 45 | healing is not included as a health care facility.

46 | ~~(9) "Health services" means inpatient diagnostic,~~
 47 | ~~curative, or comprehensive medical rehabilitative services and~~
 48 | ~~includes mental health services. Obstetric services are not~~
 49 | ~~health services for purposes of ss. 408.031-408.045.~~

50 | (9) ~~(10)~~ "Hospice" or "hospice program" means a hospice as
 51 | defined in part IV of chapter 400.

52 | ~~(11) "Hospital" means a health care facility licensed~~

53 | ~~under chapter 395.~~

54 | (10)~~(12)~~ "Intermediate care facility for the
55 | developmentally disabled" means a residential facility licensed
56 | under part VIII of chapter 400.

57 | ~~(13) "Long term care hospital" means a hospital licensed
58 | under chapter 395 which meets the requirements of 42 C.F.R. s.
59 | 412.23(e) and seeks exclusion from the acute care Medicare
60 | prospective payment system for inpatient hospital services.~~

61 | ~~(14) "Mental health services" means inpatient services
62 | provided in a hospital licensed under chapter 395 and listed on
63 | the hospital license as psychiatric beds for adults; psychiatric
64 | beds for children and adolescents; intensive residential
65 | treatment beds for children and adolescents; substance abuse
66 | beds for adults; or substance abuse beds for children and
67 | adolescents.~~

68 | (11)~~(15)~~ "Nursing home geographically underserved area"
69 | means:

70 | (a) A county in which there is no existing or approved
71 | nursing home;

72 | (b) An area with a radius of at least 20 miles in which
73 | there is no existing or approved nursing home; or

74 | (c) An area with a radius of at least 20 miles in which
75 | all existing nursing homes have maintained at least a 95 percent
76 | occupancy rate for the most recent 6 months or a 90 percent
77 | occupancy rate for the most recent 12 months.

78 | (12)~~(16)~~ "Skilled nursing facility" means an institution,

79 | or a distinct part of an institution, which is primarily engaged
 80 | in providing, to inpatients, skilled nursing care and related
 81 | services for patients who require medical or nursing care, or
 82 | rehabilitation services for the rehabilitation of injured,
 83 | disabled, or sick persons.

84 | ~~(17) "Tertiary health service" means a health service~~
 85 | ~~which, due to its high level of intensity, complexity,~~
 86 | ~~specialized or limited applicability, and cost, should be~~
 87 | ~~limited to, and concentrated in, a limited number of hospitals~~
 88 | ~~to ensure the quality, availability, and cost effectiveness of~~
 89 | ~~such service. Examples of such service include, but are not~~
 90 | ~~limited to, pediatric cardiac catheterization, pediatric open-~~
 91 | ~~heart surgery, organ transplantation, neonatal intensive care~~
 92 | ~~units, comprehensive rehabilitation, and medical or surgical~~
 93 | ~~services which are experimental or developmental in nature to~~
 94 | ~~the extent that the provision of such services is not yet~~
 95 | ~~contemplated within the commonly accepted course of diagnosis or~~
 96 | ~~treatment for the condition addressed by a given service. The~~
 97 | ~~agency shall establish by rule a list of all tertiary health~~
 98 | ~~services.~~

99 | Section 2. Subsection (2) of section 408.034, Florida
 100 | Statutes, is amended to read:

101 | 408.034 Duties and responsibilities of agency; rules.—

102 | (2) In the exercise of its authority to issue licenses to
 103 | health care facilities and health service providers, as provided
 104 | under chapter ~~chapters~~ 393 and ~~395~~ and parts II, IV, and VIII of

105 | chapter 400, the agency may not issue a license to any health
 106 | care facility or health service provider that fails to receive a
 107 | certificate of need or an exemption for the licensed facility or
 108 | service.

109 | Section 3. Section 408.035, Florida Statutes, is amended
 110 | to read:

111 | 408.035 Review criteria.—

112 | ~~(1)~~ The agency shall determine the reviewability of
 113 | applications and shall review applications for certificate-of-
 114 | need determinations for health care facilities and health
 115 | services in context with the following criteria, ~~except for~~
 116 | ~~general hospitals as defined in s. 395.002:~~

117 | (1) ~~(a)~~ The need for the health care facilities and health
 118 | services being proposed.

119 | (2) ~~(b)~~ The availability, quality of care, accessibility,
 120 | and extent of utilization of existing health care facilities and
 121 | health services in the service district of the applicant.

122 | (3) ~~(c)~~ The ability of the applicant to provide quality of
 123 | care and the applicant's record of providing quality of care.

124 | (4) ~~(d)~~ The availability of resources, including health
 125 | personnel, management personnel, and funds for capital and
 126 | operating expenditures, for project accomplishment and
 127 | operation.

128 | (5) ~~(e)~~ The extent to which the proposed services will
 129 | enhance access to health care for residents of the service
 130 | district.

131 (6)~~(f)~~ The immediate and long-term financial feasibility
 132 of the proposal.

133 (7)~~(g)~~ The extent to which the proposal will foster
 134 competition that promotes quality and cost-effectiveness.

135 (8)~~(h)~~ The costs and methods of the proposed construction,
 136 including the costs and methods of energy provision and the
 137 availability of alternative, less costly, or more effective
 138 methods of construction.

139 (9)~~(i)~~ The applicant's past and proposed provision of
 140 health care services to Medicaid patients and the medically
 141 indigent.

142 (10)~~(j)~~ The applicant's designation as a Gold Seal Program
 143 nursing facility pursuant to s. 400.235, when the applicant is
 144 requesting additional nursing home beds at that facility.

145 ~~(2) For a general hospital, the agency shall consider only~~
 146 ~~the criteria specified in paragraph (1)(a), paragraph (1)(b),~~
 147 ~~except for quality of care in paragraph (1)(b), and paragraphs~~
 148 ~~(1)(c), (g), and (i).~~

149 Section 4. Section 408.036, Florida Statutes, is amended
 150 to read:

151 408.036 Projects subject to review; exemptions.—

152 (1) APPLICABILITY.—Unless exempt under subsection (3), all
 153 health-care-related projects, as described in this subsection
 154 ~~paragraphs (a)–(f)~~, are subject to review and must file an
 155 application for a certificate of need with the agency. The
 156 agency is exclusively responsible for determining whether a

157 health-care-related project is subject to review under ss.
 158 408.031-408.045.

159 (a) The addition of beds in community nursing homes or
 160 intermediate care facilities for the developmentally disabled by
 161 new construction or alteration.

162 (b) The new construction or establishment of additional
 163 health care facilities, including a replacement health care
 164 facility when the proposed project site is not located on the
 165 same site as or within 1 mile of the existing health care
 166 facility, if the number of beds in each licensed bed category
 167 will not increase.

168 (c) The conversion from one type of health care facility
 169 to another, ~~including the conversion from a general hospital, a~~
 170 ~~specialty hospital, or a long-term care hospital.~~

171 (d) The establishment of a hospice or hospice inpatient
 172 facility, except as provided in s. 408.043.

173 ~~(e) An increase in the number of beds for comprehensive~~
 174 ~~rehabilitation.~~

175 ~~(f) The establishment of tertiary health services,~~
 176 ~~including inpatient comprehensive rehabilitation services.~~

177 (2) PROJECTS SUBJECT TO EXPEDITED REVIEW.—Unless exempt
 178 pursuant to subsection (3), the following projects are subject
 179 to expedited review:

180 (a) Transfer of a certificate of need, ~~except that when an~~
 181 ~~existing hospital is acquired by a purchaser, all certificates~~
 182 ~~of need issued to the hospital which are not yet operational~~

183 | ~~shall be acquired by the purchaser without need for a transfer.~~

184 | (b) Replacement of a nursing home, if the proposed project
185 | site is within a 30-mile radius of the replaced nursing home. If
186 | the proposed project site is outside the subdistrict where the
187 | replaced nursing home is located, the prior 6-month occupancy
188 | rate for licensed community nursing homes in the proposed
189 | subdistrict must be at least 85 percent in accordance with the
190 | agency's most recently published inventory.

191 | (c) Replacement of a nursing home within the same
192 | district, if the proposed project site is outside a 30-mile
193 | radius of the replaced nursing home but within the same
194 | subdistrict or a geographically contiguous subdistrict. If the
195 | proposed project site is in the geographically contiguous
196 | subdistrict, the prior 6-month occupancy rate for licensed
197 | community nursing homes for that subdistrict must be at least 85
198 | percent in accordance with the agency's most recently published
199 | inventory.

200 | (d) Relocation of a portion of a nursing home's licensed
201 | beds to another facility or to establish a new facility within
202 | the same district or within a geographically contiguous
203 | district, if the relocation is within a 30-mile radius of the
204 | existing facility and the total number of nursing home beds in
205 | the state does not increase.

206 | (e) New construction of a community nursing home in a
207 | retirement community as further provided in this paragraph.

208 | 1. Expedited review under this paragraph is available if

209 | all of the following criteria are met:

210 | a. The residential use area of the retirement community is
 211 | deed-restricted as housing for older persons as defined in s.
 212 | 760.29(4)(b).

213 | b. The retirement community is located in a county in
 214 | which 25 percent or more of its population is age 65 and older.

215 | c. The retirement community is located in a county that
 216 | has a rate of no more than 16.1 beds per 1,000 persons age 65
 217 | years or older. The rate shall be determined by using the
 218 | current number of licensed and approved community nursing home
 219 | beds in the county per the agency's most recent published
 220 | inventory.

221 | d. The retirement community has a population of at least
 222 | 8,000 residents within the county, based on a population data
 223 | source accepted by the agency.

224 | e. The number of proposed community nursing home beds in
 225 | an application does not exceed the projected bed need after
 226 | applying the rate of 16.1 beds per 1,000 persons aged 65 years
 227 | and older projected for the county 3 years into the future using
 228 | the estimates adopted by the agency reduced by the agency's most
 229 | recently published inventory of licensed and approved community
 230 | nursing home beds in the county.

231 | 2. No more than 120 community nursing home beds shall be
 232 | approved for a qualified retirement community under each request
 233 | for expedited review. Subsequent requests for expedited review
 234 | under this process may not be made until 2 years after

235 construction of the facility has commenced or 1 year after the
 236 beds approved through the initial request are licensed,
 237 whichever occurs first.

238 3. The total number of community nursing home beds which
 239 may be approved for any single deed-restricted community
 240 pursuant to this paragraph may not exceed 240, regardless of
 241 whether the retirement community is located in more than one
 242 qualifying county.

243 4. Each nursing home facility approved under this
 244 paragraph must be dually certified for participation in the
 245 Medicare and Medicaid programs.

246 5. Each nursing home facility approved under this
 247 paragraph must be at least 1 mile, as measured over publicly
 248 owned roadways, from an existing approved and licensed community
 249 nursing home.

250 6. A retirement community requesting expedited review
 251 under this paragraph shall submit a written request to the
 252 agency for expedited review. The request must include the number
 253 of beds to be added and provide evidence of compliance with the
 254 criteria specified in subparagraph 1.

255 7. After verifying that the retirement community meets the
 256 criteria for expedited review specified in subparagraph 1., the
 257 agency shall publicly notice in the Florida Administrative
 258 Register that a request for an expedited review has been
 259 submitted by a qualifying retirement community and that the
 260 qualifying retirement community intends to make land available

261 | for the construction and operation of a community nursing home.
 262 | The agency's notice must identify where potential applicants can
 263 | obtain information describing the sales price of, or terms of
 264 | the land lease for, the property on which the project will be
 265 | located and the requirements established by the retirement
 266 | community. The agency notice must also specify the deadline for
 267 | submission of the certificate-of-need application, which may not
 268 | be earlier than the 91st day or later than the 125th day after
 269 | the date the notice appears in the Florida Administrative
 270 | Register.

271 | 8. The qualified retirement community shall make land
 272 | available to applicants it deems to have met its requirements
 273 | for the construction and operation of a community nursing home
 274 | but may sell or lease the land only to the applicant that is
 275 | issued a certificate of need by the agency under this paragraph.

276 | a. A certificate-of-need application submitted under this
 277 | paragraph must identify the intended site for the project within
 278 | the retirement community and the anticipated costs for the
 279 | project based on that site. The application must also include
 280 | written evidence that the retirement community has determined
 281 | that both the provider submitting the application and the
 282 | project satisfy its requirements for the project.

283 | b. If the retirement community determines that more than
 284 | one provider satisfies its requirements for the project, it may
 285 | notify the agency of the provider it prefers.

286 | 9. The agency shall review each submitted application. If

287 multiple applications are submitted for a project published
 288 pursuant to subparagraph 7., the agency shall review the
 289 competing applications.

290

291 The agency shall develop rules to implement the expedited review
 292 process, including time schedule, application content that may
 293 be reduced from the full requirements of s. 408.037(1), and
 294 application processing.

295 (3) EXEMPTIONS.—Upon request, the following projects are
 296 subject to exemption from the provisions of subsection (1):

297 (a) For hospice services ~~or for swing beds in a rural~~
 298 ~~hospital, as defined in s. 395.602, in a number that does not~~
 299 ~~exceed one-half of its licensed beds.~~

300 ~~(b) For the conversion of licensed acute care hospital~~
 301 ~~beds to Medicare and Medicaid certified skilled nursing beds in~~
 302 ~~a rural hospital, as defined in s. 395.602, so long as the~~
 303 ~~conversion of the beds does not involve the construction of new~~
 304 ~~facilities. The total number of skilled nursing beds, including~~
 305 ~~swing beds, may not exceed one-half of the total number of~~
 306 ~~licensed beds in the rural hospital as of July 1, 1993.~~
 307 ~~Certified skilled nursing beds designated under this paragraph,~~
 308 ~~excluding swing beds, shall be included in the community nursing~~
 309 ~~home bed inventory. A rural hospital that subsequently~~
 310 ~~decertifies any acute care beds exempted under this paragraph~~
 311 ~~shall notify the agency of the decertification, and the agency~~
 312 ~~shall adjust the community nursing home bed inventory~~

313 | ~~accordingly.~~

314 | (b)~~(e)~~ For the addition of nursing home beds at a skilled
 315 | nursing facility that is part of a retirement community that
 316 | provides a variety of residential settings and supportive
 317 | services and that has been incorporated and operated in this
 318 | state for at least 65 years on or before July 1, 1994. All
 319 | nursing home beds must not be available to the public but must
 320 | be for the exclusive use of the community residents.

321 | (c)~~(d)~~ For an inmate health care facility built by or for
 322 | the exclusive use of the Department of Corrections as provided
 323 | in chapter 945. This exemption expires when such facility is
 324 | converted to other uses.

325 | (d)~~(e)~~ For mobile surgical facilities and related health
 326 | care services provided under contract with the Department of
 327 | Corrections or a private correctional facility operating
 328 | pursuant to chapter 957.

329 | (e)~~(f)~~ For the addition of nursing home beds licensed
 330 | under chapter 400 in a number not exceeding 30 total beds or 25
 331 | percent of the number of beds licensed in the facility being
 332 | replaced under paragraph (2)(b), paragraph (2)(c), or paragraph
 333 | (j)~~(p)~~, whichever is less.

334 | (f)~~(g)~~ For state veterans' nursing homes operated by or on
 335 | behalf of the Florida Department of Veterans' Affairs in
 336 | accordance with part II of chapter 296 for which at least 50
 337 | percent of the construction cost is federally funded and for
 338 | which the Federal Government pays a per diem rate not to exceed

339 one-half of the cost of the veterans' care in such state nursing
 340 homes. These beds shall not be included in the nursing home bed
 341 inventory.

342 (g)~~(h)~~ For combination within one nursing home facility of
 343 the beds or services authorized by two or more certificates of
 344 need issued in the same planning subdistrict. An exemption
 345 granted under this paragraph shall extend the validity period of
 346 the certificates of need to be consolidated by the length of the
 347 period beginning upon submission of the exemption request and
 348 ending with issuance of the exemption. The longest validity
 349 period among the certificates shall be applicable to each of the
 350 combined certificates.

351 (h)~~(i)~~ For division into two or more nursing home
 352 facilities of beds or services authorized by one certificate of
 353 need issued in the same planning subdistrict. An exemption
 354 granted under this paragraph shall extend the validity period of
 355 the certificate of need to be divided by the length of the
 356 period beginning upon submission of the exemption request and
 357 ending with issuance of the exemption.

358 ~~(j) For the addition of hospital beds licensed under~~
 359 ~~chapter 395 for comprehensive rehabilitation in a number that~~
 360 ~~may not exceed 10 total beds or 10 percent of the licensed~~
 361 ~~capacity, whichever is greater.~~

362 ~~1. In addition to any other documentation otherwise~~
 363 ~~required by the agency, a request for exemption submitted under~~
 364 ~~this paragraph must:~~

365 ~~a. Certify that the prior 12-month average occupancy rate~~
 366 ~~for the licensed beds being expanded meets or exceeds 80~~
 367 ~~percent.~~

368 ~~b. Certify that the beds have been licensed and~~
 369 ~~operational for at least 12 months.~~

370 ~~2. The timeframes and monitoring process specified in s.~~
 371 ~~408.040(2)(a)-(c) apply to any exemption issued under this~~
 372 ~~paragraph.~~

373 ~~3. The agency shall count beds authorized under this~~
 374 ~~paragraph as approved beds in the published inventory of~~
 375 ~~hospital beds until the beds are licensed.~~

376 (i) ~~(k)~~ For the addition of nursing home beds licensed
 377 under chapter 400 in a number not exceeding 10 total beds or 10
 378 percent of the number of beds licensed in the facility being
 379 expanded, whichever is greater; or, for the addition of nursing
 380 home beds licensed under chapter 400 at a facility that has been
 381 designated as a Gold Seal nursing home under s. 400.235 in a
 382 number not exceeding 20 total beds or 10 percent of the number
 383 of licensed beds in the facility being expanded, whichever is
 384 greater.

385 1. In addition to any other documentation required by the
 386 agency, a request for exemption submitted under this paragraph
 387 must certify that:

388 a. The facility has not had any class I or class II
 389 deficiencies within the 30 months preceding the request.

390 b. The prior 12-month average occupancy rate for the

391 nursing home beds at the facility meets or exceeds 94 percent.

392 c. Any beds authorized for the facility under this
 393 paragraph before the date of the current request for an
 394 exemption have been licensed and operational for at least 12
 395 months.

396 2. The timeframes and monitoring process specified in s.
 397 408.040(2)(a)-(c) apply to any exemption issued under this
 398 paragraph.

399 3. The agency shall count beds authorized under this
 400 paragraph as approved beds in the published inventory of nursing
 401 home beds until the beds are licensed.

402 ~~(1) For the establishment of:~~

403 ~~1. A Level II neonatal intensive care unit with at least
 404 10 beds, upon documentation to the agency that the applicant
 405 hospital had a minimum of 1,500 births during the previous 12
 406 months;~~

407 ~~2. A Level III neonatal intensive care unit with at least
 408 15 beds, upon documentation to the agency that the applicant
 409 hospital has a Level II neonatal intensive care unit of at least
 410 10 beds and had a minimum of 3,500 births during the previous 12
 411 months; or~~

412 ~~3. A Level III neonatal intensive care unit with at least
 413 5 beds, upon documentation to the agency that the applicant
 414 hospital is a verified trauma center pursuant to s.
 415 395.4001(14), and has a Level II neonatal intensive care unit,~~

416

417 ~~if the applicant demonstrates that it meets the requirements for~~
 418 ~~quality of care, nurse staffing, physician staffing, physical~~
 419 ~~plant, equipment, emergency transportation, and data reporting~~
 420 ~~found in agency certificate of need rules for Level II and Level~~
 421 ~~III neonatal intensive care units and if the applicant commits~~
 422 ~~to the provision of services to Medicaid and charity patients at~~
 423 ~~a level equal to or greater than the district average. Such a~~
 424 ~~commitment is subject to s. 408.040.~~

425 ~~(m)1. For the provision of adult open-heart services in a~~
 426 ~~hospital located within the boundaries of a health service~~
 427 ~~planning district, as defined in s. 408.032(5), which has~~
 428 ~~experienced an annual net out-migration of at least 600 open-~~
 429 ~~heart surgery cases for 3 consecutive years according to the~~
 430 ~~most recent data reported to the agency, and the district's~~
 431 ~~population per licensed and operational open-heart programs~~
 432 ~~exceeds the state average of population per licensed and~~
 433 ~~operational open-heart programs by at least 25 percent. All~~
 434 ~~hospitals within a health service planning district which meet~~
 435 ~~the criteria reference in sub-subparagraphs 2.a. h. shall be~~
 436 ~~eligible for this exemption on July 1, 2004, and shall receive~~
 437 ~~the exemption upon filing for it and subject to the following:~~

438 ~~a. A hospital that has received a notice of intent to~~
 439 ~~grant a certificate of need or a final order of the agency~~
 440 ~~granting a certificate of need for the establishment of an open-~~
 441 ~~heart surgery program is entitled to receive a letter of~~
 442 ~~exemption for the establishment of an adult open-heart surgery~~

443 ~~program upon filing a request for exemption and complying with~~
444 ~~the criteria enumerated in sub-subparagraphs 2.a. h., and is~~
445 ~~entitled to immediately commence operation of the program.~~

446 ~~b. An otherwise eligible hospital that has not received a~~
447 ~~notice of intent to grant a certificate of need or a final order~~
448 ~~of the agency granting a certificate of need for the~~
449 ~~establishment of an open-heart-surgery program is entitled to~~
450 ~~immediately receive a letter of exemption for the establishment~~
451 ~~of an adult open-heart-surgery program upon filing a request for~~
452 ~~exemption and complying with the criteria enumerated in sub-~~
453 ~~subparagraphs 2.a. h., but is not entitled to commence operation~~
454 ~~of its program until December 31, 2006.~~

455 ~~2. A hospital shall be exempt from the certificate-of-need~~
456 ~~review for the establishment of an open-heart-surgery program~~
457 ~~when the application for exemption submitted under this~~
458 ~~paragraph complies with the following criteria:~~

459 ~~a. The applicant must certify that it will meet and~~
460 ~~continuously maintain the minimum licensure requirements adopted~~
461 ~~by the agency governing adult open-heart programs, including the~~
462 ~~most current guidelines of the American College of Cardiology~~
463 ~~and American Heart Association Guidelines for Adult Open Heart~~
464 ~~Programs.~~

465 ~~b. The applicant must certify that it will maintain~~
466 ~~sufficient appropriate equipment and health personnel to ensure~~
467 ~~quality and safety.~~

468 ~~c. The applicant must certify that it will maintain~~

469 ~~appropriate times of operation and protocols to ensure~~
 470 ~~availability and appropriate referrals in the event of~~
 471 ~~emergencies.~~

472 ~~d. The applicant can demonstrate that it has discharged at~~
 473 ~~least 300 inpatients with a principal diagnosis of ischemic~~
 474 ~~heart disease for the most recent 12-month period as reported to~~
 475 ~~the agency.~~

476 ~~e. The applicant is a general acute care hospital that is~~
 477 ~~in operation for 3 years or more.~~

478 ~~f. The applicant is performing more than 300 diagnostic~~
 479 ~~cardiac catheterization procedures per year, combined inpatient~~
 480 ~~and outpatient.~~

481 ~~g. The applicant's payor mix at a minimum reflects the~~
 482 ~~community average for Medicaid, charity care, and self-pay~~
 483 ~~patients or the applicant must certify that it will provide a~~
 484 ~~minimum of 5 percent of Medicaid, charity care, and self-pay to~~
 485 ~~open-heart-surgery patients.~~

486 ~~h. If the applicant fails to meet the established criteria~~
 487 ~~for open heart programs or fails to reach 300 surgeries per year~~
 488 ~~by the end of its third year of operation, it must show cause~~
 489 ~~why its exemption should not be revoked.~~

490 ~~3. By December 31, 2004, and annually thereafter, the~~
 491 ~~agency shall submit a report to the Legislature providing~~
 492 ~~information concerning the number of requests for exemption it~~
 493 ~~has received under this paragraph during the calendar year and~~
 494 ~~the number of exemptions it has granted or denied during the~~

495 ~~calendar year.~~

496 ~~(n) For the provision of percutaneous coronary~~
 497 ~~intervention for patients presenting with emergency myocardial~~
 498 ~~infarctions in a hospital without an approved adult open-heart-~~
 499 ~~surgery program. In addition to any other documentation required~~
 500 ~~by the agency, a request for an exemption submitted under this~~
 501 ~~paragraph must comply with the following:~~

502 ~~1. The applicant must certify that it will meet and~~
 503 ~~continuously maintain the requirements adopted by the agency for~~
 504 ~~the provision of these services. These licensure requirements~~
 505 ~~shall be adopted by rule and must be consistent with the~~
 506 ~~guidelines published by the American College of Cardiology and~~
 507 ~~the American Heart Association for the provision of percutaneous~~
 508 ~~coronary interventions in hospitals without adult open-heart~~
 509 ~~services. At a minimum, the rules must require the following:~~

510 ~~a. Cardiologists must be experienced interventionalists~~
 511 ~~who have performed a minimum of 75 interventions within the~~
 512 ~~previous 12 months.~~

513 ~~b. The hospital must provide a minimum of 36 emergency~~
 514 ~~interventions annually in order to continue to provide the~~
 515 ~~service.~~

516 ~~e. The hospital must offer sufficient physician, nursing,~~
 517 ~~and laboratory staff to provide the services 24 hours a day, 7~~
 518 ~~days a week.~~

519 ~~d. Nursing and technical staff must have demonstrated~~
 520 ~~experience in handling acutely ill patients requiring~~

521 | ~~intervention based on previous experience in dedicated~~
 522 | ~~interventional laboratories or surgical centers.~~

523 | ~~e. Cardiac care nursing staff must be adept in hemodynamic~~
 524 | ~~monitoring and Intra-aortic Balloon Pump (IABP) management.~~

525 | ~~f. Formalized written transfer agreements must be~~
 526 | ~~developed with a hospital with an adult open-heart surgery~~
 527 | ~~program, and written transport protocols must be in place to~~
 528 | ~~ensure safe and efficient transfer of a patient within 60~~
 529 | ~~minutes. Transfer and transport agreements must be reviewed and~~
 530 | ~~tested, with appropriate documentation maintained at least every~~
 531 | ~~3 months. However, a hospital located more than 100 road miles~~
 532 | ~~from the closest Level II adult cardiovascular services program~~
 533 | ~~does not need to meet the 60-minute transfer time protocol if~~
 534 | ~~the hospital demonstrates that it has a formalized, written~~
 535 | ~~transfer agreement with a hospital that has a Level II program.~~
 536 | ~~The agreement must include written transport protocols that~~
 537 | ~~ensure the safe and efficient transfer of a patient, taking into~~
 538 | ~~consideration the patient's clinical and physical~~
 539 | ~~characteristics, road and weather conditions, and viability of~~
 540 | ~~ground and air ambulance service to transfer the patient.~~

541 | ~~g. Hospitals implementing the service must first undertake~~
 542 | ~~a training program of 3 to 6 months' duration, which includes~~
 543 | ~~establishing standards and testing logistics, creating quality~~
 544 | ~~assessment and error management practices, and formalizing~~
 545 | ~~patient selection criteria.~~

546 | ~~2. The applicant must certify that it will use at all~~

547 ~~times the patient selection criteria for the performance of~~
548 ~~primary angioplasty at hospitals without adult open-heart-~~
549 ~~surgery programs issued by the American College of Cardiology~~
550 ~~and the American Heart Association. At a minimum, these criteria~~
551 ~~would provide for the following:~~

552 ~~a. Avoidance of interventions in hemodynamically stable~~
553 ~~patients who have identified symptoms or medical histories.~~

554 ~~b. Transfer of patients who have a history of coronary~~
555 ~~disease and clinical presentation of hemodynamic instability.~~

556 ~~3. The applicant must agree to submit a quarterly report~~
557 ~~to the agency detailing patient characteristics, treatment, and~~
558 ~~outcomes for all patients receiving emergency percutaneous~~
559 ~~coronary interventions pursuant to this paragraph. This report~~
560 ~~must be submitted within 15 days after the close of each~~
561 ~~calendar quarter.~~

562 ~~4. The exemption provided by this paragraph does not apply~~
563 ~~unless the agency determines that the hospital has taken all~~
564 ~~necessary steps to be in compliance with all requirements of~~
565 ~~this paragraph, including the training program required under~~
566 ~~sub-subparagraph 1.g.~~

567 ~~5. Failure of the hospital to continuously comply with the~~
568 ~~requirements of sub-subparagraphs 1.e. f. and subparagraphs 2.~~
569 ~~and 3. will result in the immediate expiration of this~~
570 ~~exemption.~~

571 ~~6. Failure of the hospital to meet the volume requirements~~
572 ~~of sub-subparagraphs 1.a. and b. within 18 months after the~~

573 | ~~program begins offering the service will result in the immediate~~
 574 | ~~expiration of the exemption.~~

575 |

576 | ~~If the exemption for this service expires under subparagraph 5.~~
 577 | ~~or subparagraph 6., the agency may not grant another exemption~~
 578 | ~~for this service to the same hospital for 2 years and then only~~
 579 | ~~upon a showing that the hospital will remain in compliance with~~
 580 | ~~the requirements of this paragraph through a demonstration of~~
 581 | ~~corrections to the deficiencies that caused expiration of the~~
 582 | ~~exemption. Compliance with the requirements of this paragraph~~
 583 | ~~includes compliance with the rules adopted pursuant to this~~
 584 | ~~paragraph.~~

585 | ~~(o) For the addition of mental health services or beds if~~
 586 | ~~the applicant commits to providing services to Medicaid or~~
 587 | ~~charity care patients at a level equal to or greater than the~~
 588 | ~~district average. Such a commitment is subject to s. 408.040.~~

589 | (j) ~~(p)~~ For replacement of a licensed nursing home on the
 590 | same site, or within 5 miles of the same site if within the same
 591 | subdistrict, if the number of licensed beds does not increase
 592 | except as permitted under paragraph (e) ~~(f)~~.

593 | (k) ~~(q)~~ For consolidation or combination of licensed
 594 | nursing homes or transfer of beds between licensed nursing homes
 595 | within the same planning district, by nursing homes with any
 596 | shared controlled interest within that planning district, if
 597 | there is no increase in the planning district total number of
 598 | nursing home beds and the site of the relocation is not more

599 | than 30 miles from the original location.

600 | (1)~~(r)~~ For beds in state mental health treatment
 601 | facilities defined in s. 394.455 and state mental health
 602 | forensic facilities operated under chapter 916.

603 | (m)~~(s)~~ For beds in state developmental disabilities
 604 | centers as defined in s. 393.063.

605 | (n)~~(t)~~ For the establishment of a health care facility or
 606 | project that meets all of the following criteria:

607 | 1. The applicant was previously licensed within the past
 608 | 21 days as a health care facility or provider that is subject to
 609 | subsection (1).

610 | 2. The applicant failed to submit a renewal application
 611 | and the license expired on or after January 1, 2015.

612 | 3. The applicant does not have a license denial or
 613 | revocation action pending with the agency at the time of the
 614 | request.

615 | 4. The applicant's request is for the same service type,
 616 | district, service area, and site for which the applicant was
 617 | previously licensed.

618 | 5. The applicant's request, if applicable, includes the
 619 | same number and type of beds as were previously licensed.

620 | 6. The applicant agrees to the same conditions that were
 621 | previously imposed on the certificate of need or on an exemption
 622 | related to the applicant's previously licensed health care
 623 | facility or project.

624 | 7. The applicant applies for initial licensure as required

625 | under s. 408.806 within 21 days after the agency approves the
 626 | exemption request. If the applicant fails to apply in a timely
 627 | manner, the exemption expires on the 22nd day following the
 628 | agency's approval of the exemption.

629 |
 630 | Notwithstanding subparagraph 1., an applicant whose license
 631 | expired between January 1, 2015, and the effective date of this
 632 | act may apply for an exemption within 30 days of this act
 633 | becoming law.

634 | (4) REQUESTS FOR EXEMPTION.—A request for exemption under
 635 | subsection (3) may be made at any time and is not subject to the
 636 | batching requirements of this section. The request shall be
 637 | supported by such documentation as the agency requires by rule.
 638 | The agency shall assess a fee of \$250 for each request for
 639 | exemption submitted under subsection (3).

640 | (5) NOTIFICATION.—Health care facilities and providers
 641 | must provide to the agency notification of+

642 | ~~(a)~~ replacement of a health care facility when the
 643 | proposed project site is located in the same district and on the
 644 | existing site or within a 1-mile radius of the replaced health
 645 | care facility, if the number and type of beds do not increase.

646 | ~~(b) The termination of a health care service, upon 30~~
 647 | ~~days' written notice to the agency.~~

648 | ~~(c) The addition or delicensure of beds.~~

649 |
 650 | Notification under this subsection may be made by electronic,

651 | facsimile, or written means at any time before the described
 652 | action has been taken.

653 | Section 5. Section 408.037, Florida Statutes, is amended
 654 | to read:

655 | 408.037 Application content.—

656 | (1) ~~Except as provided in subsection (2) for a general~~
 657 | ~~hospital,~~ An application for a certificate of need must contain:

658 | (a) A detailed description of the proposed project and
 659 | statement of its purpose and need in relation to the district
 660 | health plan.

661 | (b) A statement of the financial resources needed by and
 662 | available to the applicant to accomplish the proposed project.
 663 | This statement must include:

664 | 1. A complete listing of all capital projects, including
 665 | new health facility development projects and health facility
 666 | acquisitions applied for, pending, approved, or underway in any
 667 | state at the time of application, regardless of whether or not
 668 | that state has a certificate-of-need program or a capital
 669 | expenditure review program pursuant to s. 1122 of the Social
 670 | Security Act. The agency may, by rule, require less-detailed
 671 | information from major health care providers. This listing must
 672 | include the applicant's actual or proposed financial commitment
 673 | to those projects and an assessment of their impact on the
 674 | applicant's ability to provide the proposed project.

675 | 2. A detailed listing of the needed capital expenditures,
 676 | including sources of funds.

677 3. A detailed financial projection, including a statement
 678 of the projected revenue and expenses for the first 2 years of
 679 operation after completion of the proposed project. This
 680 statement must include a detailed evaluation of the impact of
 681 the proposed project on the cost of other services provided by
 682 the applicant.

683 (c) An audited financial statement of the applicant or the
 684 applicant's parent corporation if audited financial statements
 685 of the applicant do not exist. In an application submitted by an
 686 existing health care facility, health maintenance organization,
 687 or hospice, financial condition documentation must include, but
 688 need not be limited to, a balance sheet and a profit-and-loss
 689 statement of the 2 previous fiscal years' operation.

690 ~~(2) An application for a certificate of need for a general~~
 691 ~~hospital must contain a detailed description of the proposed~~
 692 ~~general hospital project and a statement of its purpose and the~~
 693 ~~needs it will meet. The proposed project's location, as well as~~
 694 ~~its primary and secondary service areas, must be identified by~~
 695 ~~zip code. Primary service area is defined as the zip codes from~~
 696 ~~which the applicant projects that it will draw 75 percent of its~~
 697 ~~discharges. Secondary service area is defined as the zip codes~~
 698 ~~from which the applicant projects that it will draw its~~
 699 ~~remaining discharges. If, subsequent to issuance of a final~~
 700 ~~order approving the certificate of need, the proposed location~~
 701 ~~of the general hospital changes or the primary service area~~
 702 ~~materially changes, the agency shall revoke the certificate of~~

703 ~~need. However, if the agency determines that such changes are~~
 704 ~~deemed to enhance access to hospital services in the service~~
 705 ~~district, the agency may permit such changes to occur. A party~~
 706 ~~participating in the administrative hearing regarding the~~
 707 ~~issuance of the certificate of need for a general hospital has~~
 708 ~~standing to participate in any subsequent proceeding regarding~~
 709 ~~the revocation of the certificate of need for a hospital for~~
 710 ~~which the location has changed or for which the primary service~~
 711 ~~area has materially changed. In addition, the application for~~
 712 ~~the certificate of need for a general hospital must include a~~
 713 ~~statement of intent that, if approved by final order of the~~
 714 ~~agency, the applicant shall within 120 days after issuance of~~
 715 ~~the final order or, if there is an appeal of the final order,~~
 716 ~~within 120 days after the issuance of the court's mandate on~~
 717 ~~appeal, furnish satisfactory proof of the applicant's financial~~
 718 ~~ability to operate. The agency shall establish documentation~~
 719 ~~requirements, to be completed by each applicant, which show~~
 720 ~~anticipated provider revenues and expenditures, the basis for~~
 721 ~~financing the anticipated cash-flow requirements of the~~
 722 ~~provider, and an applicant's access to contingency financing. A~~
 723 ~~party participating in the administrative hearing regarding the~~
 724 ~~issuance of the certificate of need for a general hospital may~~
 725 ~~provide written comments concerning the adequacy of the~~
 726 ~~financial information provided, but such party does not have~~
 727 ~~standing to participate in an administrative proceeding~~
 728 ~~regarding proof of the applicant's financial ability to operate.~~

729 ~~The agency may require a licensee to provide proof of financial~~
 730 ~~ability to operate at any time if there is evidence of financial~~
 731 ~~instability, including, but not limited to, unpaid expenses~~
 732 ~~necessary for the basic operations of the provider.~~

733 (2)~~(3)~~ The applicant must certify that it will license and
 734 operate the health care facility. For an existing health care
 735 facility, the applicant must be the licenseholder of the
 736 facility.

737 Section 6. Paragraphs (c) and (d) of subsection (3),
 738 paragraphs (b) and (c) of subsection (5), and paragraph (d) of
 739 subsection (6) of section 408.039, Florida Statutes, are amended
 740 to read:

741 408.039 Review process.—The review process for
 742 certificates of need shall be as follows:

743 (3) APPLICATION PROCESSING.—

744 ~~(c) Except for competing applicants, in order to be~~
 745 ~~eligible to challenge the agency decision on a general hospital~~
 746 ~~application under review pursuant to paragraph (5)(c), existing~~
 747 ~~hospitals must submit a detailed written statement of opposition~~
 748 ~~to the agency and to the applicant. The detailed written~~
 749 ~~statement must be received by the agency and the applicant~~
 750 ~~within 21 days after the general hospital application is deemed~~
 751 ~~complete and made available to the public.~~

752 ~~(d) In those cases where a written statement of opposition~~
 753 ~~has been timely filed regarding a certificate of need~~
 754 ~~application for a general hospital, the applicant for the~~

755 ~~general hospital may submit a written response to the agency.~~
 756 ~~Such response must be received by the agency within 10 days of~~
 757 ~~the written statement due date.~~

758 (5) ADMINISTRATIVE HEARINGS.—

759 (b) Hearings shall be held in Tallahassee unless the
 760 administrative law judge determines that changing the location
 761 will facilitate the proceedings. The agency shall assign
 762 proceedings requiring hearings to the Division of Administrative
 763 Hearings of the Department of Management Services within 10 days
 764 after the time has expired for requesting a hearing. Except upon
 765 unanimous consent of the parties or upon the granting by the
 766 administrative law judge of a motion of continuance, hearings
 767 shall commence within 60 days after the administrative law judge
 768 has been assigned. ~~For an application for a general hospital,~~
 769 ~~administrative hearings shall commence within 6 months after the~~
 770 ~~administrative law judge has been assigned, and a continuance~~
 771 ~~may not be granted absent a finding of extraordinary~~
 772 ~~circumstances by the administrative law judge.~~ All parties,
 773 except the agency, shall bear their own expense of preparing a
 774 transcript. In any application for a certificate of need which
 775 is referred to the Division of Administrative Hearings for
 776 hearing, the administrative law judge shall complete and submit
 777 to the parties a recommended order as provided in ss. 120.569
 778 and 120.57. The recommended order shall be issued within 30 days
 779 after the receipt of the proposed recommended orders or the
 780 deadline for submission of such proposed recommended orders,

781 | whichever is earlier. The division shall adopt procedures for
 782 | administrative hearings which shall maximize the use of
 783 | stipulated facts and shall provide for the admission of prepared
 784 | testimony.

785 | (c) In administrative proceedings challenging the issuance
 786 | or denial of a certificate of need, only applicants considered
 787 | by the agency in the same batching cycle are entitled to a
 788 | comparative hearing on their applications. Existing health care
 789 | facilities may initiate or intervene in an administrative
 790 | hearing upon a showing that an established program will be
 791 | substantially affected by the issuance of any certificate of
 792 | need, whether reviewed under s. 408.036(1) or (2), to a
 793 | competing proposed facility or program within the same district.
 794 | ~~With respect to an application for a general hospital, competing~~
 795 | ~~applicants and only those existing hospitals that submitted a~~
 796 | ~~detailed written statement of opposition to an application as~~
 797 | ~~provided in this paragraph may initiate or intervene in an~~
 798 | ~~administrative hearing. Such challenges to a general hospital~~
 799 | ~~application shall be limited in scope to the issues raised in~~
 800 | ~~the detailed written statement of opposition that was provided~~
 801 | ~~to the agency. The administrative law judge may, upon a motion~~
 802 | ~~showing good cause, expand the scope of the issues to be heard~~
 803 | ~~at the hearing. Such motion shall include substantial and~~
 804 | ~~detailed facts and reasons for failure to include such issues in~~
 805 | ~~the original written statement of opposition.~~

806 | (6) JUDICIAL REVIEW.—

807 ~~(d) The party appealing a final order that grants a~~
 808 ~~general hospital certificate of need shall pay the appellee's~~
 809 ~~attorney's fees and costs, in an amount up to \$1 million, from~~
 810 ~~the beginning of the original administrative action if the~~
 811 ~~appealing party loses the appeal, subject to the following~~
 812 ~~limitations and requirements:~~

813 ~~1. The party appealing a final order must post a bond in~~
 814 ~~the amount of \$1 million in order to maintain the appeal.~~

815 ~~2. Except as provided under s. 120.595(5), in no event~~
 816 ~~shall the agency be held liable for any other party's attorney's~~
 817 ~~fees or costs.~~

818 Section 7. Subsection (1) of section 408.043, Florida
 819 Statutes, is amended to read:

820 408.043 Special provisions.—

821 ~~(1) OSTEOPATHIC ACUTE CARE HOSPITALS. When an application~~
 822 ~~is made for a certificate of need to construct or to expand an~~
 823 ~~osteopathic acute care hospital, the need for such hospital~~
 824 ~~shall be determined on the basis of the need for and~~
 825 ~~availability of osteopathic services and osteopathic acute care~~
 826 ~~hospitals in the district. When a prior certificate of need to~~
 827 ~~establish an osteopathic acute care hospital has been issued in~~
 828 ~~a district, and the facility is no longer used for that purpose,~~
 829 ~~the agency may continue to count such facility and beds as an~~
 830 ~~existing osteopathic facility in any subsequent application for~~
 831 ~~construction of an osteopathic acute care hospital.~~

832 Section 8. Paragraph (f) of subsection (1) of section

833 | 395.1055, Florida Statutes, is amended to read:

834 | 395.1055 Rules and enforcement.—

835 | (1) The agency shall adopt rules pursuant to ss.
836 | 120.536(1) and 120.54 to implement the provisions of this part,
837 | which shall include reasonable and fair minimum standards for
838 | ensuring that:

839 | (f) All hospitals providing pediatric cardiac
840 | catheterization, pediatric open-heart surgery, organ
841 | transplantation, neonatal intensive care services, psychiatric
842 | services, or comprehensive medical rehabilitation meet the
843 | minimum licensure requirements adopted by the agency. Such
844 | licensure requirements shall include quality of care, nurse
845 | staffing, physician staffing, physical plant, equipment,
846 | emergency transportation, and data reporting standards ~~submit~~
847 | ~~such data as necessary to conduct certificate-of-need reviews~~
848 | ~~required under part I of chapter 408. Such data shall include,~~
849 | ~~but shall not be limited to, patient origin data, hospital~~
850 | ~~utilization data, type of service reporting, and facility~~
851 | ~~staffing data. The agency may not collect data that identifies~~
852 | ~~or could disclose the identity of individual patients. The~~
853 | ~~agency shall utilize existing uniform statewide data sources~~
854 | ~~when available and shall minimize reporting costs to hospitals.~~

855 | Section 9. Section 395.6025, Florida Statutes, is
856 | repealed.

857 | Section 10. Subsection (1) of section 395.603, Florida
858 | Statutes, is amended to read:

859 | 395.603 Deactivation of general hospital beds; rural
 860 | hospital impact statement.—
 861 | (1) The agency shall establish, by rule, a process by
 862 | which a rural hospital, as defined in s. 395.602, that seeks
 863 | licensure as a rural primary care hospital or as an emergency
 864 | care hospital, or becomes a certified rural health clinic as
 865 | defined in Pub. L. No. 95-210, or becomes a primary care program
 866 | such as a county health department, community health center, or
 867 | other similar outpatient program that provides preventive and
 868 | curative services, may deactivate general hospital beds. Rural
 869 | primary care hospitals and emergency care hospitals shall
 870 | maintain the number of actively licensed general hospital beds
 871 | necessary for the facility to be certified for Medicare
 872 | reimbursement. Hospitals that discontinue inpatient care to
 873 | become rural health care clinics or primary care programs shall
 874 | deactivate all licensed general hospital beds. All hospitals,
 875 | clinics, and programs with inactive beds shall provide 24-hour
 876 | emergency medical care by staffing an emergency room. Providers
 877 | with inactive beds shall be subject to the criteria in s.
 878 | 395.1041. The agency shall specify in rule requirements for
 879 | making 24-hour emergency care available. ~~Inactive general~~
 880 | ~~hospital beds shall be included in the acute care bed inventory,~~
 881 | ~~maintained by the agency for certificate-of-need purposes, for~~
 882 | ~~10 years from the date of deactivation of the beds. After 10~~
 883 | ~~years have elapsed, inactive beds shall be excluded from the~~
 884 | ~~inventory.~~ The agency shall, at the request of the licensee,

885 | reactivate the inactive general beds upon a showing by the
 886 | licensee that licensure requirements for the inactive general
 887 | beds are met.

888 | Section 11. Subsection (1) of section 395.604, Florida
 889 | Statutes, is amended to read:

890 | 395.604 Other rural hospital programs.-

891 | (1) The agency may license rural primary care hospitals
 892 | subject to federal approval for participation in the Medicare
 893 | and Medicaid programs. Rural primary care hospitals shall be
 894 | treated in the same manner as emergency care hospitals and rural
 895 | hospitals with respect to ss. 395.605(2)-(7)(a) ~~395.605(2)-~~
 896 | ~~(8)(a)~~, 408.033(2)(b)3., and 408.038.

897 | Section 12. Subsection (5) of section 395.605, Florida
 898 | Statutes, is amended to read:

899 | 395.605 Emergency care hospitals.-

900 | ~~(5) Rural hospitals that make application under the~~
 901 | ~~certificate of need program to be licensed as emergency care~~
 902 | ~~hospitals shall receive expedited review as defined in s.~~
 903 | ~~408.032. Emergency care hospitals seeking relicensure as acute~~
 904 | ~~care general hospitals shall also receive expedited review.~~

905 | Section 13. Subsections (2) and (4) of section 408.0361,
 906 | Florida Statutes, are amended to read:

907 | 408.0361 Cardiovascular services and burn unit licensure.-

908 | (2) Each provider of adult cardiovascular services or
 909 | operator of a burn unit shall comply with rules adopted by the
 910 | agency that establish licensure standards that govern the

911 provision of adult cardiovascular services or the operation of a
 912 burn unit. Such rules shall consider, at a minimum, staffing,
 913 equipment, physical plant, operating protocols, the provision of
 914 services to Medicaid and charity care patients, accreditation,
 915 licensure period and fees, and enforcement of minimum standards.
 916 ~~The certificate of need rules for adult cardiovascular services~~
 917 ~~and burn units in effect on June 30, 2004, are authorized~~
 918 ~~pursuant to this subsection and shall remain in effect and shall~~
 919 ~~be enforceable by the agency until the licensure rules are~~
 920 ~~adopted.~~ Existing providers and any provider with a notice of
 921 intent to grant a certificate of need or a final order of the
 922 agency granting a certificate of need for adult cardiovascular
 923 services or burn units shall be considered grandfathered and
 924 receive a license for their programs effective on the effective
 925 date of this act. The grandfathered licensure shall be for at
 926 least 3 years or until July 1, 2008, whichever is longer, but
 927 shall be required to meet licensure standards applicable to
 928 existing programs for every subsequent licensure period.

929 ~~(4) In order to ensure continuity of available services,~~
 930 ~~the holder of a certificate of need for a newly licensed~~
 931 ~~hospital that meets the requirements of this subsection may~~
 932 ~~apply for and shall be granted Level I program status regardless~~
 933 ~~of whether rules relating to Level I programs have been adopted.~~
 934 ~~To qualify for a Level I program under this subsection, a~~
 935 ~~hospital seeking a Level I program must be a newly licensed~~
 936 ~~hospital established pursuant to a certificate of need in a~~

937 | ~~physical location previously licensed and operated as a~~
938 | ~~hospital, the former hospital must have provided a minimum of~~
939 | ~~300 adult inpatient and outpatient diagnostic cardiac~~
940 | ~~catheterizations for the most recent 12-month period as reported~~
941 | ~~to the agency, and the newly licensed hospital must have a~~
942 | ~~formalized, written transfer agreement with a hospital that has~~
943 | ~~a Level II program, including written transport protocols to~~
944 | ~~ensure safe and efficient transfer of a patient within 60~~
945 | ~~minutes. A hospital meeting the requirements of this subsection~~
946 | ~~may apply for certification of Level I program status before~~
947 | ~~taking possession of the physical location of the former~~
948 | ~~hospital, and the effective date of Level I program status shall~~
949 | ~~be concurrent with the effective date of the newly issued~~
950 | ~~hospital license.~~

951 | Section 14. This act shall take effect July 1, 2016.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 581 State Veterans' Nursing Homes
SPONSOR(S): Magar
TIED BILLS: IDEN./SIM. BILLS:

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee	10 Y, 0 N	Guzzo	Poche
2) Health Care Appropriations Subcommittee		Garner 	Pridgeon 
3) Health & Human Services Committee			

SUMMARY ANALYSIS

HB 581 creates a site selection process for new state veterans' nursing homes to be administered by the Florida Department of Veterans' Affairs (FDVA).

The State Veterans' Homes Program, administered by FDVA, provides care to eligible veterans in need of either long-term skilled nursing care or assisted living services. Currently, there are six state veterans' nursing homes in Florida. Because of the size and age of the veteran population, Florida is near the top of the list of states with a "Great Need" for veterans' nursing home beds as determined by the U.S. Department of Veterans' Affairs (VA). As a result, Florida will receive priority over other states applying to the VA for grants for the construction of new state veterans' nursing homes.

Currently, no Florida law governs FDVA's site selection process. FDVA's current process is two-tiered. First, FDVA contracts for a Site Selection Study (Study) to rank each county based on greatest need using certain measureable criteria. Second, FDVA sends applications to the top ten counties identified in the Study. Each county that wishes to be considered in the selection process must submit an application, which includes other measureable criteria, to FDVA by a specified date. The application is scored by a Site Selection Committee appointed by the Executive Director of FDVA. The county with the highest score is awarded the site, subject to approval by the Governor and the Cabinet.

The bill creates a single-step site selection process, in new s. 296.42, F.S. The bill requires FDVA to contract for a study to determine the most appropriate county for construction of a nursing home based on the greatest level of need. The study must be delivered to the Governor, the President of the Senate, and the Speaker of the House of Representatives by November 1, 2016, and a new study must be conducted and submitted every 4 years thereafter.

The bill requires that the study rank each county using the following criteria:

- The distance from the geographic center of the county to the nearest existing state veterans' nursing home;
- The number of veterans aged 65 years and older living in the county;
- The availability of emergency health care in the county;
- The presence of an existing Veterans' Health Administration Medical Center or Outpatient Clinic in the county;
- The number of existing nursing home beds per 1,000 elderly male residents of the county;
- The presence of accredited education institutions with health care programs in the county; and
- The county poverty rate.

FDVA must select the county with the highest ranking as the site for the new home, subject to approval by the Governor and the Cabinet. The bill requires the next highest ranked county to be selected if a higher ranked county cannot participate. The study must be used to determine the site of any new veterans' nursing home authorized before July 1, 2020. The bill requires the Site Selection Study dated February 7, 2014, to be used to select a county for a new veterans' nursing home before November 1, 2016, if authorized.

The bill requires the FDVA to contract for a Site Selection Study which was competitively procured in previous years at the cost of \$38,692. This additional cost can be absorbed with existing appropriations.

The bill provides an effective date of July 1, 2016.

This document does not reflect the intent or official position of the bill sponsor or House of Representatives.

STORAGE NAME: h0581b.HCAS.DOCX

DATE: 12/3/2015

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

State Veterans' Homes Program

The Florida Department of Veterans' Affairs (FDVA) operates the State Veterans' Homes Program (Program) as authorized by Chapters 292 and 296, F.S.¹ The Program provides care to eligible veterans in need of either long-term skilled nursing care or assisted living services. Care is provided to veterans with qualifying war or peacetime service, who are residents of Florida and who require skilled care as certified by a U.S. Department of Veterans' Affairs (USDVA) physician.² There are over 700,000 veterans aged 65 years and older in the state.³

Currently, there are six state veterans' nursing homes in Florida. Five of the six homes have dementia-specific care.⁴ The six nursing homes are located in Daytona Beach, Land O' Lakes, Pembroke Pines, Panama City, Port Charlotte, and St. Augustine. Currently, the Program has a total of 720 skilled-nursing beds and an average occupancy rate of 99%.⁵ In 2014, St. Lucie County was selected as the site for the seventh nursing home. The home is currently in the initial planning stages.⁶

Funding

The construction of a new nursing home is subject to approval by the Governor and Cabinet. Funding is based on a 65% / 35% federal/state split of the cost.⁷ Florida is near the top of the list of states with a "Great Need" for veterans' nursing home beds as determined by the USDVA.⁸ As a result, Florida will receive priority over other states applying to USDVA for grants for the construction of new state veterans' nursing homes. The estimated cost to build a new nursing home can range from \$37 million to \$50 million, depending on style, land condition, materials used, weather resistance and energy efficiency.⁹

According to FDVA, the total cost of the seventh nursing home in St. Lucie County is \$39.8 million.¹⁰ The state pro-rata share of cost is \$13.9 million and will be paid from the FDVA Operations and Maintenance Trust Fund.¹¹ Funding for future nursing homes will need to be supported by General Revenue funding.¹²

¹ S. 292.05(7), F.S. "The Department shall administer this chapter and shall have the authority and responsibility to apply for and administer any federal programs and develop and coordinate such state programs as may be beneficial to the particular interests of the veterans of this state."; part II of ch. 296, F.S., titled "The Veterans' Nursing Home of Florida Act" provides for the establishment of basic standards by FDVA for the operation of veteran's nursing homes for eligible veterans in need of such services.

² S. 296.36, F.S.

³ Florida Department of Veterans' Affairs, *Long Range Program Plan Fiscal Years 2016-17 through 2020-21*, page 10, available at <http://floridavets.org/about-us/long-range-program-plan/> (last viewed on November 24, 2015).

⁴ AHCA, Florida Health Finder.gov, *Facility Provider Locator; General Search by Nursing Home; Advanced Search (Special Programs and Services) by Alzheimer's*, available at <http://www.floridahealthfinder.gov/facilitylocator/FacilitySearch.aspx> (last viewed November 24, 2015).

⁵ FDVA, Presentation to the House Health Care Appropriations Committee on November 3, 2015, *State Veterans' Homes Program and Fixed Capital Outlay Projects*, at pg. 3 (on file with Health Innovation Subcommittee staff).

⁶ FDVA, *Fourth Quarter Report, Administrative Highlights, Current Issues Concerns, New State Veterans' Nursing Home*, (April 1 – June 30, 2015).

⁷ 38 CFR §59.80

⁸ 38 CFR §59.50(1)(iii); see also 38 CFR §§59.40 and .50.

⁹ E-mail correspondence, FDVA, February 12, 2015, (on file with Health Innovation Subcommittee staff).

¹⁰ Supra, FN 5 at pg. 10, "Changes in the construction schedule of state veteran' home number 7 may result in differences in actual expenditures by fiscal year. However, total cost of the project is not expected to vary from the total amount of \$39.75 million.

¹¹ Id.

¹² Supra, at FN 8.

Site Selection Process for Recently Authorized State Veterans' Nursing Homes

State Veterans' Nursing Home Seven (St. Lucie County)

In 2013, the Legislature appropriated funds for FDVA to contract with a private entity to conduct a Site Selection Study (Study).¹³ The purpose of the Study was to identify five communities, defined as single-county or multi-county areas, to be given priority for development of a new state veterans' nursing home.

Counties that did not meet certain minimum threshold criteria, including access to emergency care and the availability of health care professionals, were eliminated from consideration before the Study began. Counties with an existing state veterans' nursing home and those located within 25 miles of an existing home were also eliminated from consideration.

The Study used the following criteria to score the counties, rank ordered from greatest to least value assigned:

- Number of elderly veterans in the county;
- Ratio of existing nursing home beds per/1,000 elderly male residents in the county;
- County poverty rate;
- Distance to an existing state veterans' nursing home;
- Presence of an existing veterans' health care facility in the county; and
- Presence of nursing education programs in the county.

The Study identified the following top ten counties with the greatest need for a new state veterans' nursing home, ranked in order of greatest need based on the scoring criteria:

Study Ranking	County
1	Collier
2	Lee
3	Polk
4	Manatee
5	Marion
6	Putnam
7	St. Lucie
8	Hillsborough
9	Palm Beach
10	Sumter

FDVA sent applications to all ten counties listed in the Study. Six of the counties submitted applications: Collier County, Polk County, Manatee County, Marion County, Putnam County, and St. Lucie County. A Site Selection Committee (Committee) was created by the Executive Director of FDVA to evaluate each application.

The Committee established factors for consideration, and assigned a score of 0 to 50 points for each of the following criteria:

- Number of veterans aged 65 or older living within a 75 mile radius of the proposed site;
- Number of nursing home beds and assisted living facility beds located within 10 miles of the proposed site;

¹³ Hoy & Stark Architects, *Site Selection Study; Phase I State Veterans' Nursing Homes Statewide*, February 7, 2014, (on file with the Health Innovation Subcommittee staff).

- Suitability of the donated site in terms of its general surroundings and support capabilities;
- Availability of emergency health care, as determined by:
 - Number of hospitals and/or emergency care centers within 25 miles of the proposed site;
 - Number of emergency room holding beds per facility;
 - Presence of in-house physicians on staff in the emergency room 24 hours/day, 7 days/week; and
 - The nursing workforce.
- Availability of health care professionals, as determined by the number of accredited educational institutions located within 50 miles of the proposed site; and
- Availability of infrastructure at the site, including roads, water, sewer, telephone lines, and electricity/natural gas services, all of which must link to the property line of the proposed site at no cost to the state.

The Committee's final rankings were:

Committee Ranking	County	Study Ranking
1	St. Lucie	7
2	Marion	5
3	Collier Site B	1
4	Collier Site A	1
5	Polk Site A	3
6	Polk Site B	3

St. Lucie County was selected as the site for the seventh nursing home, and approved by the Governor and Cabinet on September 23, 2014.

State Veterans' Nursing Home Six (St. Johns County)

The same site selection process was used to determine the site of the sixth nursing home. A Study¹⁴ was conducted in 2004 and the home was built in 2010. The extended length of time between site selection and construction of the nursing home was due to a lack of funds caused by the economic recession in the mid-2000s.

The Study identified the following top twelve areas, which included counties and multi-county groups, with the greatest need for a veterans' nursing home:

Study Ranking	County or Area
1	Lake/Marion/Sumter
2	Duval
3	Brevard
4	Escambia/Santa Rosa/Okaloosa
5	Indian River/Martin/St. Lucie
6	Orange/Seminole
7	Collier/Lee
8	Palm Beach
9	Sarasota/Manatee
10	Polk
11	Citrus/Hernando
12	Pinellas

The Committee selected St. Johns County as the site for sixth veterans' nursing home. St. Johns County was not identified in the Study as an area of need.

Site Selection Process Workshop

In February 2015, FDVA conducted a state veterans' nursing home site selection process workshop (workshop). The goal of the workshop was to review the existing site selection process and determine if the process is valid and useful for future site selections.¹⁵

The final report from the workshop included the following recommendations:

- Follow the 2014 site selection study recommendations but allow up to three adjoining counties to combine and submit a single application;
- Revise weighting of the application, but not the site selection study;
- Outline weighted factors in the application packet;
- Limit counties to a single site proposal to ensure counties put their best product forward and apply resources to that site accordingly;
- Keep the site selection committee intact, but change the point of contact to a non-voting member;
- Redesign the application form;
- Revise the score sheet to add a scoring scale and train site selection committee members accordingly;
- Rank order sites in the next site selection process from one through four and award homes 8,9, and 10 to the top three sites with the fourth site being an alternate if site number three is disqualified by FDVA or the USDVA; and
- Allow runner-up sites in scoring to become alternate sites.¹⁶

On November 10, 2015, FDVA presented the recommendations to the Governor and Cabinet for approval. The Governor and Cabinet approved all but one of the recommendations. Specifically, the recommendation to rank order sites in the next site selection process from one through four and award homes 8,9, and 10 to the top three sites was not accepted.

Effect of Proposed Changes

The bill creates a single-step site selection process, in new s. 296.42, F.S. The bill requires FDVA to contract for a study to determine the most appropriate county for construction of a new nursing home based on the greatest level of need. The study must be delivered to the Governor, President of the Senate, and the Speaker of the House of Representatives by November 1, 2016, and a new study must be conducted and submitted every 4 years thereafter.

The bill requires the study to use the following criteria to rank each county:

- The distance from the geographic center of the county to the nearest existing state veterans' nursing home;
- The number of veterans aged 65 years and older living in the county;
- The availability of emergency health care in the county, as determined by:
 - The number of general hospitals;
 - The number of emergency room holding beds per hospital; and
 - The number of in-house physicians per hospital on staff in the emergency room 24 hours per day.
- The presence of an existing Veterans' Health Administration Medical Center or Outpatient Clinic in the county;
- The number of existing nursing home beds per 1,000 elderly male residents of the county;
- The presence of accredited education institutions with health care programs in the county; and

¹⁵ FDVA, *State Veterans' Nursing Home Site Selection Process Workshop Results and Recommendations, Final Report*, (March 12, 2015).

¹⁶ *Id.*

- The county poverty rate.

The county with the highest ranking must be selected as the site for the new home, subject to approval by the Governor and the Cabinet. The bill requires the next highest ranked county to be selected if a higher ranked county cannot participate. The study must be used to determine the site for any veterans' nursing home authorized before July 1, 2020. For any veterans' nursing home authorized before November 1, 2016, the bill requires the FDVA to use the 2014 Site Selection Study.

B. SECTION DIRECTORY:

Section 1: Creates s. 296.42, F.S., relating to the site selection process for state veterans' nursing homes.

Section 2: Provides an effective date of July 1, 2016.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

The bill requires FDVA to contract for a study to rank each county according to greatest need to determine the most appropriate site for a new veterans' nursing home. The Site Selection Study for the determination of the seventh state nursing home location was competitively procured and a contract was awarded to Hoy + Stark Architects, P.A. for a total cost of \$38,692.¹⁷ This additional cost can be absorbed with existing appropriations.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

¹⁷ E-mail correspondence, FDVA, March 19, 2015, (on file with Health Innovation Subcommittee staff).
STORAGE NAME: h0581b.HCAS.DOCX
DATE: 12/3/2015

Not applicable. The bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

Not applicable.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

27 the House of Representatives by November 1, 2016.

28 (2) The study shall use the following criteria to rank
29 each county according to need:

30 (a) The distance from the geographic center of the county
31 to the nearest existing state veterans' nursing home.

32 (b) The number of veterans age 65 years or older residing
33 in the county.

34 (c) The presence of an existing federal Veterans' Health
35 Administration medical center or outpatient clinic in the
36 county.

37 (d) Elements of emergency health care in the county, as
38 determined by:

39 1. The number of general hospitals.

40 2. The number of emergency room holding beds per hospital.

41 3. The number of in-house physicians per hospital on staff
42 in the emergency room 24 hours per day.

43 (e) The number of existing community nursing home beds per
44 1,000 males age 65 years or older residing in the county.

45 (f) The presence of an accredited educational institution
46 offering health care programs in the county.

47 (g) The county poverty rate.

48 (3) The department shall use the study ranking to select
49 each new state veterans' nursing home site authorized before
50 July 1, 2020, subject to approval by the Governor and Cabinet.

51 For each new nursing home, the department shall select the
52 highest-ranked county in the study which does not have a

53 veterans' nursing home. If the highest-ranked county cannot
 54 serve as the site, the department shall select the next-highest-
 55 ranked county. The department shall use the 2014 Site Selection
 56 Study to select a county for any new state veterans' nursing
 57 home authorized before November 1, 2016, subject to approval by
 58 the Governor and Cabinet.

59 (4) The department shall contract for and submit a new
 60 study in accordance with this section by November 1, 2020, and
 61 every 4 years thereafter.

62 Section 2. This act shall take effect July 1, 2016.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 595 Reimbursement to Health Access Settings for Dental Hygiene Services for Children

SPONSOR(S): Health Innovation Subcommittee; Plasencia

TIED BILLS: IDEN./SIM. **BILLS:** SB 580

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee	10 Y, 0 N, As CS	McElroy	Poche
2) Health Care Appropriations Subcommittee		Clark 	Pridgeon 
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Section 466.024(2), F.S., authorizes licensed dental hygienists to perform a limited number of unsupervised remediable tasks in health access settings, such as county health departments, Head Start programs, and other facilities, as defined in s. 466.003(14), F.S. These remediable tasks are reimbursable pursuant to s. 466.024(4), F.S.; however, reimbursement is barred under the Managed Medical Assistance (MMA) program as s. 409.906(6), F.S., authorizes reimbursement for dental services only when performed under the supervision of a licensed dentist.

CS/HB 595 eliminates the conflict by amending s. 409.906(6), F.S., to allow for reimbursement to the health access setting by the Agency for Health Care Administration for the remediable tasks that a licensed dental hygienist is authorized to perform under s. 466.024(2), F.S., on children under the age of 21 in the MMA program.

The bill has an indeterminate but likely insignificant fiscal impact on the Agency for Health Care Administration.

The bill provides an effective date of July 1, 2016.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Oral Health

Oral health has a significant impact on an individual's physical and mental health. It can influence how individuals grow, enjoy life, look, speak, chew, taste food and socialize, as well as their feelings of social well-being.¹ It can also affect, be affected or contribute to various diseases and conditions including:²

- Endocarditis;
- Cardiovascular disease;
- Diabetes;
- HIV/AIDS;
- Osteoporosis; and
- Alzheimer's disease.

For children, poor oral health can result in pain, discomfort, disfigurement, acute and chronic infections, eating and sleep disruption and an overall reduction of quality of life.³ Children with poorer oral health are also more likely to miss school, have a lower grade-point average and otherwise perform poorly in school.⁴ In fact, one study concluded that visits or dental problems accounted for 117,000 hours of school lost per 100,000 children.⁵

Tooth decay is one of the most common, and easily preventable, chronic conditions of childhood in the United States.⁶ About 20% of children aged 5-11 and 13% of adolescents aged 12-19 have at least one untreated tooth decay.⁷ The prevalence of tooth decay is more than twice as high, 25% compared to 11%, for children from low-income families.⁸

Dental Workforce

Currently, there is a national workforce shortage of dentists, and it is projected to worsen in the future. In 2012, there were 190,800 dentists with an estimated need of 197,800 dentists, resulting in a shortage of 7,000 dentists.⁹ By 2025, projections have 202,600 dentists in practice with a need for

¹ *Oral Health, General Health and Quality of Life*, World Health Organization, Aubrey Sheiham, Volume 83, Number 9, September 2005, 641-720. <http://www.who.int/bulletin/volumes/83/9/editorial30905html/en/> (last visited November 23, 2015).

² *What Conditions May be Linked to Oral Health*, Mayo Clinic. <http://www.mayoclinic.org/healthy-lifestyle/adult-health/in-depth/dental/art-20047475?pg=2> (last visited on November 23, 2015).

³ *Id.*

⁴ *Impact of Poor Oral Health on Children's School Attendance and Performance*, Stephanie L. Jackson, DDS, MS, corresponding author William F. Vann, Jr, DMD, PhD, Jonathan B. Kotch, MD, MPH, Bhavna T. Pahel, PhD, MPH, BDS, and Jessica Y. Lee, DDS, PhD, MPH, *American Journal of Public Health*, Am J Public Health. 2011 October; 101(10): 1900-1906.

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3222359/> (last visited on November 23, 2015); *The Impact of Oral Health on the Academic Performance of Disadvantaged Children*, Hazem Seirawan, DDS, MPH, MS, Sharon Faust, DDS, and Roseann Mulligan, DDS, MS, *American Journal of Public Health*, Am J Public Health. 2012 September; 102(9): 1729-1734. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3482021/> (last visited on November 23, 2015).

⁵ *Supra* footnote 1.

⁶ *Children's Oral Health*, Centers for Disease Control and Prevention, Division of Oral Health, National Center for Chronic Disease Prevention and Health Promotion. http://www.cdc.gov/oralhealth/children_adults/child.htm (last visited November 23, 2015).

⁷ *Id.*

⁸ *Id.*

⁹ U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. *National and State-Level Projections of Dentists and Dental Hygienists in the U.S., 2012-2025*. Rockville,

211,200 dentists.¹⁰ This projected shortage of 8,600 dentists, combined with the 2012 shortage, results in a shortage of 15,600 dentists by the year 2025. All 50 states and the District of Columbia are projected to have a shortfall of dentists with Florida projected to have the second highest shortfall in the nation (1,152) by 2025.¹¹

Dental hygienists are trending in the opposite direction of dentists. There is currently an excess supply of dental hygienists and by 2025 the national excess supply is projected to be 28,100.¹² Florida again follows the national trend and is projected to have the third largest excess supply of dental hygienists (2,768) by 2025.¹³ However, not all states are projected to have an excess supply.¹⁴

Medicaid

Medicaid is the health care safety net for low-income Floridians. Medicaid is a partnership of the federal and state governments established to provide coverage for health services for eligible persons. The program is administered by the Agency for Health Care Administration (AHCA) and financed by federal and state funds. AHCA delegates certain functions to other state agencies, including the Department of Children and Families, the Agency for Persons with Disabilities, and the Department of Elderly Affairs.

The structure of each state's Medicaid program varies and what states must pay for is largely determined by the federal government, as a condition of receiving federal funds. Federal law sets the amount, scope, and duration of services offered in the program, among other requirements. These federal requirements create an entitlement that comes with constitutional due process protections. The entitlement means that two parts of the Medicaid cost equation – people and utilization – are largely predetermined for the states: Some populations are entitled to enroll in the program; and enrollees are entitled to certain benefits.

The federal government sets the minimum mandatory benefits to be covered in every state Medicaid program. These benefits include physician services, hospital services, home health services, and family planning.¹⁵ States can add benefits, with federal approval. Florida has added many optional benefits, including prescription drugs, dental services, and dialysis.¹⁶

Statewide Medicaid Managed Care¹⁷

In 2011, the Legislature established the Statewide Medicaid Managed Care (SMMC) program as Part IV of Chapter 409, F.S. The SMMC program is an integrated managed care program which provides all the mandatory and optional Medicaid benefits to enrollees. Within the SMMC program, the Managed Medical Assistance (MMA) program provides primary and acute medical assistance and related services, including dental services.¹⁸

Maryland, 2015. <http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0ahUKEwjv-aSQyKfJAhUBZiYKHRIGCSMQFggdMAA&url=http%3A%2F%2Fbhr.hrsa.gov%2Fhealthworkforce%2Fsupplydemand%2Fdentistry%2Fnationalstatelevelprojectionsdentists.pdf&usq=AFQjCNG2CoEtGnpvOZgQmrtmRhCMWC85BA&bvm=bv.108194040,d.eWE> (last visited on November 23, 2015).

¹⁰ Id.

¹¹ Id.

¹² Id.

¹³ Id.

¹⁴ Id.

¹⁵ S. 409.905, F.S.

¹⁶ S. 409.906, F.S.

¹⁷ The delivery of Medicaid services through managed care is not expressly authorized by federal law. If a state wants to use a managed care delivery system, it must seek a waiver of certain requirements of Title XIX of the Social Security Act (Medicaid). To implement the SMMC program, AHCA applied for and obtained section 1115 waiver authority.

¹⁸ The other component of the SMMC program is the Long-Term Care Managed Care Program.

In the SMMC program, each Medicaid recipient has one managed care organization to coordinate all health care services, rather than various entities.¹⁹ Such coordinated care is particularly important in the area of oral health, which is connected to overall health outcomes.²⁰

In December 2012, AHCA released an Invitation to Negotiate (ITN) to competitively procure managed care plans on a regional basis for the MMA program.²¹ AHCA selected 19 managed care plans and executed 5-year contracts in February, 2014. The MMA program was fully implemented statewide as of August 1, 2014.

Dental Care in the MMA Program

Dental services are an optional Medicaid benefit. Florida provides full dental services for children and only dentures and medically necessary, emergency dental procedures to alleviate pain or infection for adults.²² As of November 2015, approximately 3.1 million Medicaid recipients are enrolled in the MMA program and receive their dental services through managed care plans that offer a full array of medical, behavioral, and dental health benefits.²³

Dental Service Accountability and Performance in the MMA Program

The MMA program contracts impose various accountability provisions and performance measures on the MMA plans specific to dental services, which include requirements for:²⁴

- Network adequacy;
- Annual medical loss ratio for the first full year of MMA program operation;
- Preventive dental services rate for children enrolled for 90 continuous days;
- Transportation to and from the child's dental appointment, if needed; and
- Healthcare Effectiveness Data and Information Set scores.²⁵

MMA plans are subject to corrective actions and liquidated damages for failure to meet accountability provisions and performance measures set forth in the contracts.

In addition, under federal terms and conditions, AHCA must work with MMA plans on an oral health quality improvement initiative. For this initiative, the MMA contracts²⁶ have specific performance goals for pediatric dental services and penalties for not reaching the performance standards.

Dental Care Reimbursement for Children's Dental Services

The MMA program authorizes reimbursement for children's dental services rendered by dentists, dental hygienists and dental assistants. A dentist may delegate remediable tasks²⁷ to dental hygienists or

¹⁹ This comprehensive coordinated system of care was successfully implemented in the 5-county Medicaid reform pilot program, 2006-2014.

²⁰ U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000. <http://profiles.nlm.nih.gov/ps/retrieve/ResourceMetadata/NNBBJT/> (last visited on November 23, 2015).

²¹ AHCA Invitation to Negotiate, *Statewide Medicaid Managed Care, Addendum 2 Solicitations Number: AHCA ITN 017-12/13*; dated February 26, 2013 <http://www.govcb.com/Statewide-Medicaid-Managed-Care-ADP13619273520001182.htm> (last visited on November 23, 2015); AHCA Invitation to Negotiate, *Statewide Medicaid Managed Care, Solicitation Number: AHCA ITN 017-12/13*; dated December 28, 2012 <http://www.govcb.com/Statewide-Medicaid-Managed-Care-ADP13619273520001182.htm> (last visited on November 23, 2015).

²² S. 409.906(1), (6), F.S.

²³ Comprehensive Medicaid Managed Care Enrollment Reports, AHCA, November 2015.

http://www.fdhc.state.fl.us/MCHQ/Managed_Health_Care/MHMO/med_data.shtml (last visited on November 23, 2015).

²⁴ The Managed Medical Assistance Model Contract is available at https://ahca.myflorida.com/medicaid/statewide_mc/plans.shtml (last visited on November 23, 2015).

²⁵ AHCA measures the performance of the MMA plans based on standards established by the National Committee for Quality Assurance called the Healthcare Effectiveness Data and Information Set (HEDIS).

²⁶ *Supra* footnote 25.

dental assistants when such tasks pose no risk to the patient.²⁸ AHCA is statutorily authorized to pay for diagnostic, preventive, or corrective procedures, including orthodontia in severe cases, provided to a recipient under age 21, by or under the supervision of a licensed dentist.²⁹ Thus, a dentist must supervise any delegable tasks performed by a dental hygienist or dental assistant if reimbursement is being sought under the MMA.

Dental Hygienists

Dental Hygienists are regulated by ch. 466, F.S., and by the Board of Dentistry (Board) within the Department of Health. Dental hygienists are focused on preventing dental disease. They are educated and trained to evaluate the patient's oral health; expose, process and interpret dental X-ray films; and remove calculus deposits, stains, and plaque above and below the gumline.³⁰ They also apply preventive agents such as fluorides and sealants to teeth when allowed by state regulations.³¹ Dental hygienists may also perform certain tasks which are delegated by a licensed dentist. These delegable tasks are established either in statute or by rule and include:³²

- Taking impressions for study casts but not for the purpose of fabricating any intraoral restorations or orthodontic appliance;
- Placing periodontal dressings;
- Removing periodontal or surgical dressings;
- Removing sutures;
- Placing or removing rubber dams;
- Placing or removing matrices;
- Placing or removing temporary restorations;
- Applying cavity liners, varnishes, or bases;
- Polishing amalgam restorations;
- Polishing clinical crowns of the teeth for the purpose of removing stains but not changing the existing contour of the tooth;
- Dental charting³³;
- Obtaining bacteriological cytological specimens not involving cutting of the tissue; and
- Administering local anesthesia pursuant to s. 466.017(5).

The Board establishes by rule whether these tasks are to be performed under direct, indirect, or general supervision of the dentist.³⁴ A dental hygienist may perform these tasks in multiple settings, including:³⁵

- In the office of a licensed dentist;

²⁷ "Remediable tasks" are those intraoral treatment tasks which are reversible and do not create unalterable changes within the oral cavity or the contiguous structures and which do not cause an increased risk to the patient. S. 466.003(12), F.S.

²⁸ S. 466.024(1), F.S.

²⁹ S. 409.906 (6), F.S.

³⁰ S. 466.023, F.S.

³¹ See Rule 64B5-16.006, F.A.C.

³² S. 466.024 (1), F.S.

³³ "Dental Charting" is a recording of visual observations of clinical conditions of the oral cavity without the use of X rays, laboratory tests, or other diagnostic methods or equipment, except the instruments necessary to record visual restorations, missing teeth, suspicious areas, and periodontal pockets. S. 466.0235.

³⁴ S. 466.023(1), F.S. "Direct supervision" means supervision whereby a dentist diagnoses the condition to be treated, a dentist authorizes the procedure to be performed, a dentist remains on the premises while the procedures are performed, and a dentist approves the work performed before dismissal of the patient. "Indirect supervision" means supervision whereby a dentist authorizes the procedure and a dentist is on the premises while the procedures are performed. "General supervision" means supervision whereby a dentist authorizes the procedures which are being carried out but need not be present when the authorized procedures are being performed. The authorized procedures may also be performed at a place other than the dentist's usual place of practice. The issuance of a written work authorization to a commercial dental laboratory by a dentist does not constitute general supervision. S. 466.003 (8), (9) and (10), F.S.

³⁵ S. 466.023(2), F.S.

- In public health programs and institutions of the Department of Children and Families, Department of Health, and Department of Juvenile Justice under the general supervision of a licensed dentist; and
- In a health access setting.

Scope of Practice in Health Access Settings

In 2011, the Legislature expanded the scope of practice for dental hygienists providing dental services to children under the age of 21 in health access settings³⁶ in an effort to maximize the existing dental workforce. The legislation authorized licensed dental hygienists to perform certain remediable tasks in a health access setting without the physical presence, prior examination or authorization of a dentist.³⁷ These tasks include:

- Perform dental charting as defined in s. 466.0235 and as provided by rule;
- Measure and record a patient's blood pressure rate, pulse rate, respiration rate, and oral temperature;
- Record a patient's case history;
- Apply topical fluorides, including fluoride varnishes, which are approved by the American Dental Association or the Food and Drug Administration;
- Apply dental sealants; and
- Remove calculus deposits, accretions, and stains from exposed surfaces of the teeth and from tooth surfaces within the gingival sulcus.³⁸

Numerous safeguards are in place to ensure patient safety when unsupervised services are provided in health access settings. For example, when a dental hygienist performs one of the above procedures, the patient must be notified that the visit with the dental hygienist is not a substitute for a comprehensive dental exam.³⁹ Additionally, a dentist is required to conduct an oral examination within 13 months of a dental hygienist removing calculus deposits, accretions, and stains from a patient's teeth.⁴⁰ Also, a dental hygienist providing such services must maintain professional malpractice insurance coverage that has minimum limits of \$100,000 per occurrence and \$300,000 in the aggregate through the employing health access setting or through an individual policy.⁴¹

Reimbursement for Children's Dental Care Services Provided in Health Access Settings

The absence of dentist supervision of the tasks performed by a dental hygienist in a health access setting does not preclude reimbursement for those services. Specifically, s. 466.024(4), F.S., states:

This section does not prevent a program operated by one of the health access settings as defined in s. 466.003 or a nonprofit organization that is exempt from federal income taxation under s. 501(a) of the Internal Revenue Code and described in s. 501(c)(3) of the Internal Revenue Code from billing and obtaining reimbursement for the services described in this section which are provided by a dental hygienist or from making or maintaining any records pursuant to s. 456.057 necessary to obtain reimbursement.

³⁶ "Health access setting" means a program or an institution of the Department of Children and Families, the Department of Health, the Department of Juvenile Justice, a nonprofit community health center, a Head Start center, a federally qualified health center or look-alike as defined by federal law, a school-based prevention program, a clinic operated by an accredited college of dentistry, or an accredited dental hygiene program in this state if such community service program or institution immediately reports to the Board of Dentistry all violations of s. 466.027, s. 466.028, or other practice act or standard of care violations related to the actions or inactions of a dentist, dental hygienist, or dental assistant engaged in the delivery of dental care in such setting. S. 466.003(14), F.S.

³⁷ S. 466.024 (2), F.S.

³⁸ Id.

³⁹ S. 466.024 (3)(a), F.S.

⁴⁰ S. 466.024 (2)(f) 2, F.S.

⁴¹ S. 466.024 (5)(c), F.S.

As such, programs providing dental care in health access settings may seek reimbursement for specified dental services provided by dental hygienists, irrespective of whether those services were supervised by a dentist.

Effect of Proposed Changes

Section 466.024(2), F.S., authorizes licensed dental hygienists to perform a limited number of unsupervised remediable tasks in health access settings, such as county health departments, Head Start programs, and other facilities, as defined in s. 466.003(14), F.S. These remediable tasks are reimbursable pursuant to s. 466.024(4), F.S.; however, reimbursement for these unsupervised tasks is barred under the MMA program as s. 409.906(6), F.S., authorizes reimbursement for children's dental services only if the tasks were performed under the supervision of a licensed dentist.

HB 595 eliminates this conflict by amending s. 409.906(6), F.S., to allow for the reimbursement to the health access setting by AHCA for the remediable tasks that a licensed dental hygienist is authorized to perform under s. 466.024(2), F.S., without supervision by a licensed dentist, when the services are provided to children under the age of 21 in the MMA program.

B. SECTION DIRECTORY:

Section 1: Amending s. 409.906, F.S., relating to optional Medicaid services.

Section 2: Provides an effective date of July 1, 2016.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

AHCA would be permitted to reimburse health access settings for remediable tasks performed by licensed dental hygienists, as outlined in s. 466.024(2), F.S., on children under age 21 in the MMA program. The majority of the expenditures for this reimbursement would be through Medicaid capitation payments to managed care organizations participating in the MMA program. It is unknown how many additional services would be provided by licensed dental hygienists in lieu of services provided and reimbursed under the supervision of a dentist. The potential costs to managed care organizations would not be reflected in the capitation rates for at least one year as capitation rates are set each September. Additionally, the increased costs would likely be minimal and result in an immaterial increase or no increase at all to managed care capitation rates.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Health access settings may be reimbursed for remediable tasks performed by licensed dental hygienists, as authorized under s. 466.024(2), F.S., on children under age 21 in the MMA program.

D. FISCAL COMMENTS:

In Fiscal Year 2014-15 AHCA reported that approximately \$16.2 million was reimbursed to health care access settings under the supervision of a dentist either through the fee-for-service system or through encounters with managed care organizations under contract with AHCA.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. The bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On December 2, 2015, the Health Innovation Subcommittee adopted one amendment and reported the bill favorably as a committee substitute. The amendment clarified that the health access setting could be reimbursed by AHCA for remediable tasks performed by licensed dental hygienists, as authorized under s. 466.024(2), F.S., on children under age 21 in the MMA program.

The analysis is drafted to the committee substitute as passed by the Health Innovation Subcommittee.

⁴² Email from Agency from Health Care Administration dated January 6, 2016, on file with Health Care Appropriations Subcommittee Staff.

1 A bill to be entitled
 2 An act relating to reimbursement to health access
 3 settings for dental hygiene services for children;
 4 amending s. 409.906, F.S.; authorizing reimbursement
 5 for children's dental services provided by licensed
 6 dental hygienists in certain circumstances; providing
 7 an effective date.

8
 9 Be It Enacted by the Legislature of the State of Florida:

10
 11 Section 1. Subsection (6) of section 409.906, Florida
 12 Statutes, is amended to read:

13 409.906 Optional Medicaid services.—Subject to specific
 14 appropriations, the agency may make payments for services which
 15 are optional to the state under Title XIX of the Social Security
 16 Act and are furnished by Medicaid providers to recipients who
 17 are determined to be eligible on the dates on which the services
 18 were provided. Any optional service that is provided shall be
 19 provided only when medically necessary and in accordance with
 20 state and federal law. Optional services rendered by providers
 21 in mobile units to Medicaid recipients may be restricted or
 22 prohibited by the agency. Nothing in this section shall be
 23 construed to prevent or limit the agency from adjusting fees,
 24 reimbursement rates, lengths of stay, number of visits, or
 25 number of services, or making any other adjustments necessary to
 26 comply with the availability of moneys and any limitations or

27 | directions provided for in the General Appropriations Act or
28 | chapter 216. If necessary to safeguard the state's systems of
29 | providing services to elderly and disabled persons and subject
30 | to the notice and review provisions of s. 216.177, the Governor
31 | may direct the Agency for Health Care Administration to amend
32 | the Medicaid state plan to delete the optional Medicaid service
33 | known as "Intermediate Care Facilities for the Developmentally
34 | Disabled." Optional services may include:

35 | (6) CHILDREN'S DENTAL SERVICES.—The agency may pay for
36 | diagnostic, preventive, or corrective procedures, including
37 | orthodontia in severe cases, provided to a recipient under age
38 | 21, by or under the supervision of a licensed dentist. The
39 | agency may also reimburse a health access setting as defined in
40 | s. 466.003 for the remediable tasks that a licensed dental
41 | hygienist is authorized to perform under s. 466.024(2). Services
42 | provided under this program include treatment of the teeth and
43 | associated structures of the oral cavity, as well as treatment
44 | of disease, injury, or impairment that may affect the oral or
45 | general health of the individual. However, Medicaid will not
46 | provide reimbursement for dental services provided in a mobile
47 | dental unit, except for a mobile dental unit:

48 | (a) Owned by, operated by, or having a contractual
49 | agreement with the Department of Health and complying with
50 | Medicaid's county health department clinic services program
51 | specifications as a county health department clinic services
52 | provider.

53 (b) Owned by, operated by, or having a contractual
54 arrangement with a federally qualified health center and
55 complying with Medicaid's federally qualified health center
56 specifications as a federally qualified health center provider.

57 (c) Rendering dental services to Medicaid recipients, 21
58 years of age and older, at nursing facilities.

59 (d) Owned by, operated by, or having a contractual
60 agreement with a state-approved dental educational institution.

61 Section 2. This act shall take effect July 1, 2016.



Outpatient Prospective Payment System Design for Florida Medicaid

Prepared for:

Florida Agency for Health Care Administration

November 30, 2015

navigant.com/healthcare

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1 Introduction

This document describes a recommended design for an Outpatient Prospective Payment System (OPPS) to meet the needs of the Florida Medicaid program. Florida Medicaid currently reimburses hospital outpatient services using hospital specific cost-based rates which pay a flat rate referred to as a “per diem” to each payable revenue code submitted on an outpatient claim. Hospital outpatient payments are then cost settled based on audited cost reports and retrospectively adjusted a few years after payments were made for outpatient medical care provided to Medicaid fee-for-service recipients.

The study and design of an OPPS for Florida Medicaid was authorized by the Florida Legislature during the 2015 Legislative Session. Specific language in the General Appropriations Act regarding this study is,

“From the funds in Specific Appropriation 181, \$500,000 in nonrecurring funds from the Medical Care Trust Fund is provided to the Agency for Health Care Administration to contract with an independent consultant to develop a plan to convert Medicaid payments for outpatient services from a cost based reimbursement methodology to a prospective payment system. The study shall identify steps necessary for the transition to be completed in a budget neutral manner. The report shall be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than November 30, 2015.”¹

The Florida Agency for Health Care Administration (AHCA), which administers the Medicaid program in Florida, contracted with Navigant Consulting, Inc. (Navigant) to perform this study and author this report.

During the time period of July through November 2015, Navigant and AHCA collaborated in the design of an OPPS that will allow the Agency to shift away from cost-based rates and the current retrospective cost settlement process. This effort included five meetings between Navigant and an Agency Governance Committee comprised of AHCA management staff. In addition, four public meetings were held during this timeframe to communicate to, and solicit feedback from, the medical provider community regarding the proposed new OPPS.

Recommendations for the new OPPS were determined based on the guiding principles described in Chapter 2 of this report. In addition, historical outpatient claim data was used to model options for the new prospective payment system, and many options selected for the payment method were based on results of these models. Chapter 3 includes a detailed description of the historical claims dataset and the data processing performed to model a new OPPS for Florida Medicaid. This is followed by Chapter 4, which describes outpatient prospective payment systems and compares the two most commonly used categorization schemes for OPPSs, Enhanced Ambulatory Patient Groupings (EAPGs) and Ambulatory Patient

¹ The Florida State Senate Bill No. 2500-A; Chapter 2015-232.

Classifications (APCs). Subsequent chapters, 5 through 14, describe options available within an OPPS payment method, which Navigant refers to as “payment policy options.” Included in each of these chapters is a discussion of the option and a recommendation for the Florida Medicaid OPPS. Chapter 15 offers more detail explaining concerns about the impact of the new OPPS on the 340B Drug Pricing Program, and Chapter 16 discusses potential timing for implementation. Following this text, Appendix A in this document summarizes the policy recommendations in a concise table. Finally, a few additional appendices are included which contain data tables and figures that compare payments under the current method to payments under the proposed new method.

2 Evaluating an Outpatient Prospective Payment Method

Developing a Medicaid outpatient payment method requires balancing a variety of trade-offs and competing priorities. Payment methods have an impact on beneficiaries, medical providers, taxpayers, and program administrators, each with their own point of view on what makes a payment method successful. To balance the priorities of these different stakeholders, it is helpful to establish a set of guiding principles that describe the goals of the payment method and offer a structure against which various system design options can be evaluated. The list below offers a series of guiding principles and discusses how these principles can affect an outpatient payment method.

- » **Efficiency.** A payment method should be consistent with promoting provider efficiency, rewarding providers that increase efficiency while continuing to provide quality care. To enable this, the payment method should minimize reliance on individual provider charges or costs, and create opportunities for providers to increase margins by more effectively managing resources. For example, in the design of an OPPS payment system, selecting a single standardized base rate can create incentives for providers to better manage their resources to achieve improved margins. Conversely, establishing facility-specific base rates that fluctuate annually with increases or decreases in facility-specific costs would provide little incentive for cost effectiveness.
- » **Access.** A payment method should promote beneficiary access to care. This guiding principle is consistent with the requirements specified in federal regulation. In the State Plan for Medical Assistance (State Plan), AHCA must make certain assurances to the federal Centers for Medicare and Medicaid Services (CMS) with respect to its level of payments to Medicaid providers. In particular, the State Plan must:

“... provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan ... as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are

available to the general population in the geographic area[.]” 42 U.S.C. § 1396a(a)(30)(A) (“Section 30(A)”) (emphasis added).

Within an outpatient payment method, policy adjustors, provider peer groups (used for setting base rates), and outlier payment parameters are items that can be adjusted to affect access to care.

- » **Equity.** A payment method should generate fair payments both across providers and across types of care. Generally, providers should be paid similar amounts for the same services, with the potential exception being when there are necessary and measurable differences in the costs associated with those similar services. Within an OPPS utilizing either EAPGs or APCs, the payment amount for an individual outpatient service is calculated by multiplying a provider base price times an EAPG or APC relative weight. Both types of relative weights are determined using average costs from many providers, so the relative weights help ensure similar payment for similar services, independent of where those services are provided. If adjustments do need to be made for reasonable, measurable differences in provider cost structures, those can be made through modifications to the provider base price via rate adjustments (for example, wage area adjustments) and/or provider peer groupings (for example, giving specialty children’s hospitals a separate base rate than other hospitals or giving Ambulatory Surgical Centers (ASCs) a separate base rate than hospitals).
- » **Predictability.** A payment method should generate stable, predictable payments. Both the state Medicaid agency and providers have to manage their budgets, and that can best be facilitated through a payment method which generates consistent, predictable reimbursements. OPPS payment methods are predictable if patient acuity and volume are understood.
- » **Transparency.** A payment method that is transparent promotes trust from provider administrators, clinicians, legislators, and Medicaid program administrators. An OPPS payment method can be made transparent by selecting a grouping algorithm that is openly documented, and by making relative weights, provider base rates, and pricing logic publicly available.
- » **Simplicity.** A payment method that is relatively simple will be easier to implement, easier for provider organizations to understand, and easier to administer and maintain. For a Medicaid program, implementing a new OPPS will require significant MMIS changes, regulation changes, and program monitoring changes. For providers, a change in payment method may impact medical coding practices, billing procedures, and internal information systems. The complexity of these changes is limited if the payment method is kept relatively simple. At the same time, over-simplifying the payment method may negatively impact payment equity and, in turn, negatively impact access to care.

- » **Quality.** It is generally known that it is a mission of all healthcare providers to offer high quality care. Payment methods should be consistent with promoting quality care where possible. In truth, very few payment methods specifically reward quality. Most payment methods, including most outpatient payment methods, pay the same independent of whether high quality care is provided. At the same time, some payment components, such as outlier payment parameters, can contribute to (or detract from) facilitating the effective use of provider resources in a way that is consistent with the provider's mission to provide high quality care.

From a logistical point of view, a payment method is a framework or structure created to determine reimbursement for medical services and supplies. The structure includes organization of data, numerical formulas, and specific parameters or values used in the formulas. This structure should be carefully developed as it controls the distribution of large amounts of state and federal funding, and is intended to meet the needs of people and organizations with competing priorities. The guiding principles presented above can be helpful in evaluating various options for the payment structure so that the final design best meets the needs of beneficiaries, providers, taxpayers and program administrators.

3 OPPS Payment Modeling

3.1 Dataset Description

Modeling of a new payment method is generally performed using historical claim data. For this study, the dataset used included claims from State Fiscal Year (SFY) 2013/14 – that is, claims with first date of service between July 1, 2013 and June 30, 2014. The claim data included services provided to recipients in both the fee-for-service program and Medicaid managed care program. Given this time frame, the managed care encounter claims came from both Medicaid managed care plans defined for the five pilot counties prior to implementation of the Managed Medical Assistance (MMA) program, and from MMA plans.² Also, Medicare crossover claims were excluded from the dataset as were claims denied for payment. Lastly, in cases where claims were adjusted, only the final claim in each “adjustment chain” was included.

Claims included in the final dataset were from both hospitals (provider types “01” and “04”) and from Ambulatory Surgical Centers (ASCs) (provider type “06”). The hospital claims included were submitted on an institutional claim form (837I or UB-04) and had an outpatient type of bill. The ASC claims were submitted on a professional claim form (837P or CMS-1500). In total there were 4,794,891 outpatient hospital claims with 21,724,655 claim lines and 63,453 ASC claims with 99,979 claim lines. Thus, the initial dataset included 4,858,344 claims and 21,824,634 claim lines prior to manipulation by Navigant.

² The Managed Medical Assistance (MMA) program was implemented over a four month period beginning on May 1, 2014 and completing on August 1, 2014. Each month during that timeframe, Medicaid recipients in a few of the 11 regions defined within the State were migrated to an MMA plan. As of August 1, 2014, all 11 regions had been migrated to MMA.

During the outpatient claims analysis, 19 hospitals were identified as having a high percentage of claim lines without procedure codes. These 19 hospitals and all claim lines associated with them were removed from the dataset and not included in any EAPG modeling. (Please see section 3.3 for more information regarding removal of all data from specific hospitals.) In addition, claims were removed from the modeling dataset in cases where every line on the claim received an error EAPG (equal to 999) even after all attempts by Navigant to manually assign a procedure code or EAPG to claim lines. (Please see section 3.4 for more information regarding Navigant’s efforts to assign procedure codes and EAPG codes to claim service lines submitted without a procedure code.) In total, 605,974 claims and 2,381,425 claim lines were excluded either because of an insufficient total percentage of procedure codes submitted by the hospital, or because no valid EAPG codes were assigned to the claim.

In addition, 28,895 claim lines were added to the dataset in order to more accurately assign EAPG codes on claims for observation services. The final EAPG dataset includes 19,472,104 claim lines representing 4,252,370 claims. All of these removals and additions of claims is summarized in Table 1.

Table 1. Claim dataset build summary.

Description	Claims	Claim Lines	Submitted Charges	Baseline Payment Amount GR/PMATF	Baseline Auto Rate Enhancements	Baseline Payment Total
Hospitals - SFY 2013/14	4,794,891	21,724,655	\$ 13,048,656,330	\$ 1,248,916,963	\$ 133,997,697	\$ 1,382,914,659
Ambulatory Surgery Centers - SFY 2013/14	63,453	99,979	\$ 230,088,766	\$ 35,658,535	\$ -	\$ 35,658,535
Total starting point - SFY 2013/14	4,858,344	21,824,634	\$ 13,278,745,095	\$ 1,284,575,497	\$ 133,997,697	\$ 1,418,573,194
Lines Removed - Greater than one-third of claim lines with blank procedure code ¹	557,942	2,325,398	\$ 1,413,116,586	\$ 117,362,335	\$ 38,105,236	\$ 155,467,571
Lines Removed - All lines have EAPG '999'	48,032	56,027	\$ 52,678,243	\$ 6,010,028	\$ -	\$ 6,010,028
Lines Removed - Total	605,974	2,381,425	\$ 1,465,794,828	\$ 123,372,364	\$ 38,105,236	\$ 161,477,599
Lines added - correction for EAPG grouping errors - observation services	-	28,895	\$ -	\$ -	\$ -	\$ -
Final Dataset	4,252,370	19,472,104	\$ 11,812,950,267	\$ 1,161,203,134	\$ 95,892,461	\$ 1,257,095,595
Note(s):						
1) Percentage of claim lines with blank procedure codes was calculated when excluding the following service lines: Pharmacy, Laboratory, Supplies, Therapies, Dialysis, Radiology and Nuclear Medicine.						

3.2 Re-Pricing Historical Claims

As mentioned in the previous section, the historical claims in our OPPS modeling dataset had dates of service in SFY 2013/14. Total historical payment from state general revenue (GR) and the Public Medical Assistance Trust Fund (PMATF) was used as the basis for the amount of money modeled to be spent under the new OPPS. To get this total historical payment amount, the portion of the current year (SFY 2015/16) outpatient per diem coming from GR and PMATF was applied to each line item with a covered revenue code on both FFS and managed care encounter claims. This resulted in a total historical payment amount (which Navigant refers to as the “baseline payment amount”) of \$1.16 billion, as shown above in Table 1.

In the calculation of the baseline payment amount, the individual recipient hospital outpatient annual benefit limit of \$1,500 was included in the formulas and was applied with the same rules as currently exist in the legacy payment method. As in the legacy payment method, claims were excluded from this limit if they contained at least one surgical procedure code in the exclusion list and/or at least one line item with a revenue code or Healthcare Common Procedure Coding System (HCPCS) procedure code in the exclusion list. Also, the \$1,500 annual benefit was not applied to recipients under the age of 21. AHCA understands that some MMA managed care plans have chosen a higher outpatient benefit limit (a value above \$1,500), and other plans have chosen to do away with the annual hospital outpatient annual benefit limit all together. However, the benefit limit is considered when calculating MMA capitation rates, so it was applied to the OPSS payment modeling.

3.3 Hospitals Removed from Dataset

Navigant and the AHCA Governance Committee chose to remove 19 hospitals from EAPG modeling due to an insufficient percentage of procedure codes present on claim lines. Under Florida Medicaid's current hospital outpatient payment method, a procedure code must be submitted on a claim line to receive payment for only a small set of services – specifically laboratory services. Most other services may be submitted without a procedure code and will still be considered for reimbursement. However, under the OPSS payment method, the primary field on which payment is determined is the procedure code. Any claim service line submitted without a procedure code will be ignored for the purposes of calculating reimbursement.

In truth, under an APC and/or EAPG-based OPSS, some services may not be covered or may receive payment equal to \$0 because payment for the service was bundled in with payment for another service. (Please see Chapter 4 for a detailed discussion of APC and EAPG-based OPSS payment methods.) For these services, payment will be the same whether the services are billed with or without a procedure code. Given this fact, we did not require the claim data to include a procedure on every single service line. But we did feel a reasonably high complement of procedure codes was necessary on each hospital's data in order to accurately model the new OPSS payment method and to estimate a hospital's shift in Medicaid outpatient reimbursement resulting from implementation of an OPSS.

Navigant and the AHCA Governance Committee settled on a threshold of two-thirds. A hospital needed to have procedure codes on at least two-thirds of its service lines to be included in the OPSS modeling. Any hospital with one-third or more of its claim lines missing a procedure code was removed from the modeling.³ Using this criteria, 19 hospitals were identified as having incomplete data and were dropped from the OPSS modeling dataset.

³ As described in Section 3.4, procedure codes and/or EAPG codes were "manually" assigned based on revenue code to some claim lines submitted without a procedure code. This "manual" manipulation was only performed for specific service lines for which estimation of a procedure code could be made reasonably accurately. With this "manual" manipulation in mind, the calculation of percentage of service lines without a procedure code by hospital was calculated excluding the service lines for which a procedure code and/or EAPG code could be "manually" assigned.

These hospitals are listed in Table 2. In total, 557,942 claims and 2,325,398 claim lines associated with these 19 hospitals were removed from the dataset.

Table 2. Hospitals removed from OPPS payment modeling due to lack of procedure codes.

"Base" Provider Medicaid ID	Provider Name	Claim Lines Excluding Specific Services ¹			Overall Outpatient Totals		
		Blank Claim Lines	Total Claim Lines	Percent of Claims with Blank Procedure Codes	Claim Lines	Submitted Charges	Baseline Payment
000949600	Florida Hospital at Connerton - LTAC	28	28	100%	68	\$45,353	\$668
008135900	University Behavioral Center	2	2	100%	2	\$3,000	\$0
008135300	Emerald Coast Behavioral Hospital, LLC	154	154	100%	154	\$9,555	\$0
010102800	Florida Hospital Tampa	18,271	52,903	35%	173,105	\$115,882,262	\$7,633,814
010345400	Memorial Hospital Miramar	24,111	30,829	78%	101,409	\$60,200,676	\$2,991,886
010020000	Memorial Regional Hospital	105,348	137,570	77%	419,733	\$335,944,853	\$26,409,856
010252100	Memorial Hospital West	40,381	53,903	75%	191,714	\$144,551,040	\$9,229,487
010222900	Memorial Hospital Pembroke	22,706	31,917	71%	94,442	\$52,790,777	\$2,912,238
010260100	Florida Hospital Wauchula	6,895	10,392	66%	35,962	\$16,621,964	\$2,045,480
010003000	UF Health Shands Hospital	60,494	93,064	65%	397,145	\$180,094,812	\$19,525,367
010090100	Florida Hospital Heartland Med Cntr	14,336	26,776	54%	95,693	\$46,143,550	\$4,485,171
010190700	Northwest Florida Cmnty Hospital	3,863	7,694	50%	32,071	\$10,017,686	\$1,790,768
010823300	Windmoor Healthcare, Inc.	14	28	50%	28	\$29,100	\$0
010067600	UF Health Jacksonville	44,781	92,479	48%	398,500	\$230,451,128	\$20,048,730
010109500	Florida Hospital Waterman	17,142	36,647	47%	139,059	\$70,530,246	\$6,867,582
005456800	Florida Hospital Wesley Chapel	6,325	15,385	41%	55,227	\$33,596,727	\$3,973,165
010094300	Florida Hospital Carrollwood	8,827	22,390	39%	76,348	\$49,583,510	\$4,193,585
010161300	Florida Hospital North Pinellas	4,779	12,812	37%	42,694	\$24,151,233	\$2,393,240
010149400	Florida Hospital Zephyrhills	7,091	21,235	33%	72,044	\$42,469,113	\$2,861,300
Total		385,548	646,208	60%	2,325,398	\$1,413,116,586	\$117,362,335

Note(s):
1) Amounts in these columns exclude the following service lines: Pharmacy, Laboratory, Supplies, Therapies, Dialysis, Radiology and Nuclear Medicine.

AHCA is hopeful to be able to collect the procedure codes for services performed from these hospitals during the months of December 2015 and January 2016 so that the hospitals may be included in future OPPS modeling. As an example, one hospital, All Children’s Hospital, has already submitted to AHCA a separate claim extract that was used to reduce the percentage of service lines with blank procedure codes from 32 percent to 20 percent for this facility. All Children’s Hospital is included in the modeling presented in this report.

Lastly, the lack of procedure code data was not an issue for the Ambulatory Surgical Centers (ASCs). ASCs bill on a professional claim form (837P or CMS-1500) for which procedure code is already a required field. Thus, all the historical ASC claim data was sufficient for inclusion in the OPPS modeling.

3.4 Manual Adjustments

Before manual manipulation by Navigant, a total of 3,252,012 claim lines without a procedure code were included in the modeling dataset. Navigant, with help from 3M Health Information Systems (HIS), was able to assign procedure codes and/or EAPG codes to 2,692,359 of those claim lines. In some cases, a procedure code was added and then the claim was processed through the EAPG grouper to assign a valid EAPG code. In other cases, an EAPG code was assigned by Navigant without addition of a procedure code.

This manual manipulation of the data was performed on a select subset of services for which a small number of revenue codes and procedure codes are normally billed, and a small number of EAPG codes gets assigned. Specifically claim service lines with a revenue code identifying one of the following types of service were considered for manual adjustment: pharmacy, laboratory, supplies, therapies, dialysis, or radiology and nuclear medicine. In addition, the adjustments were applied only to service lines billed without a procedure code. For each claim line meeting this criteria, a procedure code was manually assigned based on the types of procedure codes billed on similar claims in the dataset or based on logic provided by 3M HIS. The intention of manually assigning procedure codes was to keep as many claims in the modeling dataset as possible while still maintaining accuracy of modeled payments.

In the manual claim adjustment process, none of the baseline payment amounts on claim lines were changed, thus ensuring that the total baseline payment amount for these services was not altered. In total, 673,330 claim lines were manually assigned an EAPG for supplies, 1,889,302 claim lines were manually assigned an EAPG for pharmacy services, 93,114 claim lines were assigned a procedure code for therapy services, 28,895 claim lines were added for observation procedures, 7,082 claim lines were assigned a procedure code for radiology and nuclear medicine services, and 636 claim lines were assigned a procedure code for dialysis services. Details of the logic used to assign procedure codes and EAPG codes is given in “Appendix H – Manual Adjustments to Improve EAPG Assignment.”

3.5 Description of Grouping and Discounting Options Used

The grouping of claims for OPPS modeling followed the recommendations listed later in this document. Claims were grouped to version 3.10 of the Enhanced Ambulatory Patient Groups (EAPGs) using the 3M Core Grouping Software. Within the Core Grouping Software, several configuration options can be set to customize the grouping and pricing logic. For the most part, we used default options for assignment of EAPG codes (grouping). A few of those options are listed below:

- Claims with more than one date of service were considered separate, independent outpatient visits unless the claim was for observation or emergency department services. Claims were identified as being for observation or emergency department services if at least one of the service lines on the claim contained one of these revenue codes:
 - 0450 – 0459 Emergency Room
 - 0760 – 0769 Specialty Services (includes observation and Treatment Room)

- The following procedure modifiers were allowed to affect assignment of EAPG codes:
 - 25 Separately identifiable evaluation and management service
 - 27 Multiple outpatient hospital evaluation and management encounters on the same date
 - 59 Distinct procedure service
 - GN Service delivered under an outpatient speech-language pathology plan of care
 - GO Service delivered under an outpatient occupational therapy plan of care
 - GP Service delivered under an outpatient physical therapy plan of care
- No limit was put on the minimum number of hours of observation
- Packaging was not performed for radiology services

In addition, multiple discounting options are available to customize the EAPG pricing logic. The options used in our modeling are listed below:

- Discounting at 50 percent was performed for:
 - Clinically similar significant procedures
 - Repeat ancillary procedures
 - Terminated procedures
- Payment enhancement to 150 percent was applied to bilateral procedures
- Procedure discounting was not applied to the following services:
 - Repeat ancillary drugs
 - Repeat ancillary durable medical equipment (DME) codes
 - Cross-type multiple procedures

3.6 Modeling OPSS Pricing

The modeling of OPSS pricing was performed using the recommendations explained in later sections within this document. The only exception is that the documentation and coding adjustment was not applied in the payment modeling. The purpose of the payment modeling is to estimate how Medicaid reimbursements will change with a shift from the current payment method to an OPSS payment method. Including adjustments for documentation and coding in this modeling would have unnecessarily complicated the comparison of payment methods. Summary results of the modeling are included in various Appendices at the end of this document.

The total amount of money available for distribution through EAPG pricing equaled the baseline payments from GR and PMATF. The exact value was \$1,161,203,134. This money was distributed through EAPG pricing using two base rates, one for hospitals and one for ASCs, and using one provider policy adjustor applied to hospitals with a high percentage of outpatient utilization coming from Medicaid recipients. The EAPG base rates came out to \$388.07 for hospitals and \$278.88 for ASCs. In addition, the high Medicaid outpatient utilization policy adjustor came out to 1.4182. These parameters will change in the final rate setting process based on adjustments for improved documentation and coding.

In the OPSS payment modeling, automatic rate enhancements were applied to providers who are receiving automatic rate enhancements on outpatient services during state fiscal year (SFY) 2015/16. Applied rate enhancements totaled \$95,892,461 and were distributed to the same hospitals and in the same amounts as defined in the SFY 2015/16 General Appropriations Act.⁴ To ensure that specific rate enhancement amounts were distributed to specific hospitals, as is done in the legacy payment method, the automatic rate enhancements were distributed in the model as per-service-line supplemental payments. This method is similar to the method used to distribute hospital inpatient automatic rate enhancements within AHCA's inpatient DRG payment method. For the outpatient payment method, we modeled a supplemental payment on every claim service line that contained a covered revenue code, even if the EAPG payment for that service line was \$0 because of bundling. We considered this method of providing a supplemental on every line with a covered revenue code a more accurate way to distribute the funds than including a supplemental payment only on service lines that received a non-zero EAPG payment.

3.7 Calculation of Cost

During the OPSS modeling process, Navigant used comparisons of hospital costs of providing services to the baseline payments under the legacy payment method and to the simulated payments under an EAPG payment methodology as one measure of the impact of the change in payment method. Also, simulated EAPG pay-to-cost ratios for various sub-categories such as service line and provider category were compared to the overall statewide average hospital outpatient pay-to-cost ratio. Results of these comparisons are shown in various summary tables provided in the Appendices. Estimates of provider costs were used only for these comparisons, and for no other purpose, as the recommended payment method does not include outlier payments.⁵

To estimate provider costs, Navigant calculated outpatient ancillary cost-to-charge ratios (CCRs) for in-state hospitals based on Medicare cost report information found in the Healthcare Cost Report Information System (HCRIS). Costs and charges were retrieved from Worksheet C, Part I. Within this worksheet, values were retrieved from cost centers 50 through 76, 90 through 93, and 96 through 99 for inclusion in the CCR calculations. An overall CCR was calculated for most outpatient services provided by hospitals along with separate CCRs calculated for lab, therapy, dialysis, and radiology services. In cases where an outpatient claim was from an out of state hospital, cost-to-charge ratios were assigned to service lines based on the state wide average CCRs for in-state providers. Once the appropriate service line CCR was assigned to a claim service line, cost was calculated as the product of the line's submitted charges times the CCR.

⁴ The full allotment of hospital outpatient rate enhancements for SFY 2015/16 is \$133,997,697. Our models distribute less than this full amount because some hospitals who receive automatic rate enhancements were removed from our modeling dataset because of a lack of procedure codes.

⁵ Outlier payment calculations commonly use estimates of provider cost as part of the formula that determines the outlier payment amount on individual claims.

4 Grouping Algorithms in Outpatient Payment Methods

Most Outpatient Prospective Payment Systems (OPPS) used in the U.S. healthcare industry utilize a grouping algorithm that categorizes services, devices, and supplies for the purpose of calculating reimbursement. The two most common grouping algorithms used are Enhanced Ambulatory Patient Groups (EAPGs) and Ambulatory Patient Classifications (APCs). EAPGs are a proprietary product created and maintained by 3M Health Information Systems. APCs are maintained by a combination of the Centers for Medicare and Medicaid Services (CMS) and 3M Health Information Systems, and are publicly available with less copyright restrictions. APCs are used by the Medicare program, about 10 state Medicaid agencies and several commercial payers. EAPGs are used by six state Medicaid agencies and several commercial payers. In addition, four more state Medicaid agencies, including Florida, are considering implementation of EAPGs. One of the most fundamental payment policy decisions that must be made for the Florida OPPS is which grouping algorithm to use.

4.1 Basics of an Outpatient Prospective Payment System

Outpatient Prospective Payment Systems (OPPS) share financial risk between payers and providers, giving both an incentive to manage overall cost of care. Prospective payment methodologies ensure that payment rates for services do not change based on the overall cost of providing those services. This is in contrast to AHCA's current outpatient payment method, which assigns each hospital its own cost-based rate and cost settles reimbursements retrospectively when audited cost reports are available.

In both the EAPG-based and APC-based OPPS's, each service line on an outpatient claim is assigned an EAPG/APC code. This is in contrast to Inpatient Prospective Payment Systems (IPPS) utilizing Diagnosis Related Groups (DRGs) which assign a single DRG code to a medical claim and a single payment based on that DRG code. The wide variation in locations of service, reasons for outpatient care, and the high cost associated with ancillary services requires outpatient classification systems to closely reflect services provided to a patient. This is done by assigning an EAPG or APC code to each claim service line. However, to promote efficiency and to reduce the likelihood of unnecessary services being performed, not all claim lines are assigned a full payment rate or used in the payment calculation. Both grouping algorithms, EAPGs and APCs, provide ways to bundle payment for some services and supplies in with payment for other services. Payment bundling within the APC payment method is somewhat limited, but is increasing with newer releases of the APC grouping algorithm. The EAPG grouping algorithm, in contrast, has a relatively robust set of logic which bundles payment of service lines in some scenarios and discounts payment in other scenarios based on the procedure codes submitted on the claim.

For purposes of payment, both the EAPG and APC codes are assigned a relative weight. The relative weights estimate the relative amount of resources required by a healthcare provider to perform the service. Base payment is calculated by multiplying the relative weight times a base rate (a base rate in an OPPS is also often referred to as a conversion factor). Using these values,

a payment amount is calculated for each service line on a claim and total payment for the claim equals the sum of the payments on all lines of the claim.

4.2 Ambulatory Patient Classifications (APCs)

4.2.1 Basics of an APC Payment Method

On August 1, 2000 Medicare began using an APC-based OPSS for payment of hospital outpatient services. Under the APC payment method, Medicare assigns procedure to APC codes based on similar clinical characteristics and costs. Under the APC methodology, services may be paid separately or bundled together based on the different information that is present on an outpatient claim. APCs are designed for use by Medicare and are updated annually to assign new payment weights, payment rates, wage and other adjustments to APC groups. This annual review of APCs and their relative weights considers hospital, medical practice, and service and technology changes that may affect payment rates or APC groups. Additional information such as new cost data may also be used to ensure adequate payments are made.⁶

Under an APC-based OPSS, some services are paid separately and not bundled including many surgical procedures, diagnostic procedures, non-surgical therapeutic procedures, blood and blood products, most clinical and emergency department visits, certain preventative services and some drugs, biologicals and radiopharmaceuticals, along with other services and products. Under the same APC method, services typically packaged and combined for APC payment include supplies, ancillary services, anesthesia, operating and recovery room use, add-on procedures, medical device implants, and inexpensive drugs, radiology, imaging and observation services.⁷

In most cases, APC payment rates for separately payable medical and surgical services are calculated by multiplying the APC relative weight by a conversion factor to get a national adjustment payment for each APC. Further adjustments are made to adjust for geographic differences in input prices for labor using a wage index applicable to the location where the service was performed. For Medicare payments additional add-on or outlier payments may be available for specific drugs, high cost services, transitional payments for cancer hospitals, and other adjustments for certain types of hospitals.⁸

A generic APC payment is calculated as:

$$\text{APC Payment} = ([\text{Conversion Factor}] \times [\text{APC Relative Weight}]) \times ([60\% \text{ Labor related Adjustment}^9] + [40\% \text{ non-labor related Adjustment}])^{10}$$

⁶ Hospital Outpatient Prospective Payment System – Payment System Fact Sheet Series. Department of Health and Human Services – Centers for Medicare & Medicaid Services, December 2014.

⁷ Ibid.

⁸ Ibid.

⁹ Based on hospital wage index.

¹⁰ Hospital Outpatient Prospective Payment System – Payment System Fact Sheet Series. Department of Health and Human Services – Centers for Medicare & Medicaid Services, December 2014.

Under the Medicare APC-based OPPS, payment exceptions may be applied for high cost cases, resulting in the inclusion of an outlier payment, for Sole Community Hospitals (SCH), and in cases where a cancer or children's hospital is eligible for a transitional outpatient payment.¹¹ These special calculations are as follows:

1. APC payment with outlier = [APC Payment] + [Outlier Payment]
2. APC Payment of SCH = [APC Payment] x [1.071]
3. Cancer or Children's hospital eligible for transitional outpatient payment
= [APC Payment] + [Transitional Outpatient Payment]

While many providers may be familiar with the Medicare APC system, the program would need to be modified for use by the Florida Medicaid Agency to ensure that groups and services not served by the Medicare program are included in the APC payment method. This may result in significant variation from the Medicare structured system and increase the need for annual updates to fee-schedules and payment rates.

4.2.2 Services Covered Under APCs

APCs are only designed to categorize some of the services provided in an ambulatory care setting. Many other ambulatory care services are paid for using fee schedules in an APC-based OPPS. Services that are paid via a fee schedule include laboratory, pathology, physical therapy, mammography, non-implantable prosthetics, and durable medical equipment (DME). Thus, maintenance of an APC-based OPPS includes documentation and updates to both APC payment parameters and fee schedules.

4.2.3 Medical Visits in an APC Payment Method

APCs also differ from EAPGs in payment for medical visits, which are outpatient visits in which a patient receives medical treatment but there was no significant procedure performed. An outpatient visit that required only observation services is an example of a medical visit. The APC categorization method includes 15 codes for medical visits and many of those are assigned based on procedure codes that identify the duration of patient contact. The EAPG grouping algorithm has 191 codes for medical visits and bases EAPG assignment on the primary diagnosis (the condition) of the patient.

4.3 Enhanced Ambulatory Patient Groups (EAPGs)

4.3.1 Basics of an EAPG Payment Method

EAPGs are a product of 3M Health Information Systems that is designed to categorize outpatient services and procedures into groups for payment based on clinical information present on an outpatient claim. EAPGs are designed for the categorization of services provided to all patient groups and across multiple ambulatory care settings such as ambulatory clinics,

¹¹ Hospital Outpatient Prospective Payment System – Payment System Fact Sheet Series. Department of Health and Human Services – Centers for Medicare & Medicaid Services, December 2014.

surgery centers, emergency rooms, physicians' visits and other outpatient facilities. There is no need to maintain fee schedules for some types of care when implementing an EAPG-based OPSS. In addition, like APCs, EAPGs are not designed to pay for all types of care and exclude nursing home care, inpatient care, self-administered pharmaceuticals, and various other services such as transportation. EAPGs are designed to pay for facility time and resources and not for professional services which are billed through other methods.¹²

In the EAPG classification scheme, there are three primary types of procedures – significant, ancillary, and incidental. In an ambulatory setting, a significant procedure is usually the primary reason for the visit. Significant procedures normally require a majority of the time and resources used during the visit. In the EAPG classification scheme, significant tests may also constitute a significant procedure.¹³ Ancillary procedures are generally ordered by the primary physician to assist in patient diagnosis or treatment. Ancillary procedures include pathology, laboratory, chemotherapy & pharmacotherapy, durable medical equipment, and other ancillary tests. Ancillary procedures increase the resources used during an outpatient visit, but do not constitute a majority of the time or supplies used during the visit. Incidental procedures are an integral part of a medical visit and are usually associated with professional services. Examples of incidental procedures include range of motion measurements, category II CPT codes for performance measurement, PQRI (Physician Quality Reporting Initiative) codes (HCPCS G-codes), and evaluation and management codes.¹⁴

4.3.2 Calculating Payment in an EAPG-Based OPSS

4.3.2.1 Visit Type

Based on the primary type of procedure performed, each outpatient visit is categorized as either a significant procedure visit, a medical visit, or an ancillary-only visit. When the visit type is "significant procedure visit," payment is usually applied to the claim lines with significant procedures and services commonly packaged include routine ancillaries, incidental procedures, supplies, many drugs and anesthesia. However, additional payments are permitted for unrelated significant procedures with applicable discounts, non-packaged ancillaries, chemotherapy, and select drugs and biologicals.¹⁵

The visit type assigned is "medical visit" if a patient received medical treatment but there was no significant procedure performed during the visit. With a medical visit, payment is generally applied to the medical visit EAPG and items generally packaged include routine ancillaries, incidental procedures, supplies and most drugs (excluding chemotherapy and select drugs and biologicals). In this case, additional payment may be available for non-packaged ancillaries, chemotherapy and other select drugs and biologics.¹⁶

¹² 3M™ Enhanced Ambulatory Patient Grouping System – Definitions Manual, July, 2015.

¹³ Ibid.

¹⁴ Introduction to 3M Enhanced Ambulatory Patient Groups, Presentation from 3M to Ohio Hospital Association, June 2015.

¹⁵ 3M™ Enhanced Ambulatory Patient Grouping System – Definitions Manual, July, 2015.

¹⁶ Ibid.

When the visit type assigned is “ancillary services only,” all ancillary items receive separate payment. A summary of this information can be found in Table 3.¹⁷

Table 3. EAPG payment system overview¹⁸

Visit Type	Items Included in the Base EAPG Payment	Items for Which Additional Payment is Permitted
Significant Procedure	Routine Ancillaries, Incidental Procedures, Supplies, Drug (except chemo and selected drugs and biologicals), Anesthesia	Significant Unrelated Procedures with any Applicable Discounts, Non-Packaged Ancillaries, Chemo and selected drugs and biologicals
Medical Visit	Packaged Routine Ancillaries, Incidental Procedures, Supplies, Drugs (except chemo and selected drugs and biologicals)	Non-Packaged Ancillaries, Chemo and selected drugs and biologicals
Ancillary Only	None	All “Ancillary Only” Items Are Paid Separately

4.3.2.2 *Medical Visits in an EAPG Payment Method*

Medical visits are outpatient visits in which a patient received medical treatment but there was no significant procedure performed. In this scenario, patients may require a wide array of different services, making it difficult to estimate the resource needs for these types of services. The EAPG grouping algorithm handles these cases by defining 191 different codes for medical visits (there are 15 different APC codes), and basing EAPG assignment on the diagnoses submitted on the claim instead of on the HCPCS procedure codes. Thus, payment is based on the condition of the patient and not on the duration of patient contact self-reported by providers, as is the case with APCs.

4.3.2.3 *Bundling and Discounting*

To promote efficiency and to reduce the likelihood of up-coding EAPGs or the provision of unnecessary services, not all claim lines are assigned a full payment rate or used in the payment calculation. This is true in both the APC and EAPG payment methods. Within the EAPG payment methodology, bundling and discounting is more sophisticated, and uses three different techniques, ancillary packaging, significant procedure consolidation, and procedure

¹⁷ 3M™ Enhanced Ambulatory Patient Grouping System – Definitions Manual, July, 2015.

¹⁸ Ibid.

discounting to group different services provided during outpatient visits into a single claim payment.¹⁹

4.3.2.3.1 *Ancillary Packaging*

When a significant procedure or medical visit is present on an outpatient claim, ancillary services that are performed at the same visit may be packaged with the significant procedure. Ancillary packaging combines the payment of certain ancillary services into the payment of a significant EAPG procedure. Payments for packaged ancillary procedures become paid through an increased payment associated with the significant procedure or medical EAPG on a claim.²⁰

The goal of EAPG packaging is to incent providers to improve quality and reduce cost by either eliminating unnecessary services or replacing more expensive services with lower cost ones. At the same time packaging should not be defined in a way that discourages providers from giving patients expensive tests or procedures when clinically warranted. Because packaging, which results in \$0 payment, risks discouraging providers from offering some services, expensive tests and procedures, for example an MRI, are paid separately and not packaged with another procedure. Packaging is reserved for only inexpensive and frequently performed ancillary procedures.²¹

Packaging schedules can be developed using two different methods, using a clinical packaging approach or through designing a list of procedures which are always packaged. Clinical packaging chooses which ancillary services to package on an EAPG specific basis using clinical methodologies to determine which ancillary services are expected as a routine part of an outpatient visit. Creating a list of services which will always be packaged with a significant procedure or medical visit is another way of customizing the EAPG grouping algorithm. By creating a uniform list of services that will always be packaged both payers and providers will be aware of what services will always be packaged allowing for easy tracking of these procedures. Creating a defined list of ancillary procedures that will be packaged can help to prevent providers from trying to use tests or procedures that will not be packaged into a significant procedure or using other coding and billing methods to avoid packaged payments.²²

4.3.2.3.2 *Significant Procedure Consolidation*

Procedure consolidation may occur when multiple significant procedures of the same type are present on the same outpatient claim. Procedures of the same type which are provided during the same encounter may be consolidated, which means paid at \$0, to provide a single payment for multiple services due to a decrease in the additional time and resources needed to perform the second service.²³

¹⁹ 3M™ Enhanced Ambulatory Patient Grouping System – Definitions Manual, July, 2015.

²⁰ Ibid.

²¹ Ibid.

²² Ibid.

²³ Ibid.

4.3.2.3.3 *Discounting*

Under an EAPG payment methodology, when multiple significant, ancillary, or other procedures are performed multiple times during an outpatient visit, an EAPG payment rate may be reduced through a process known as discounting. Discounting is justified by the fact that the cost of providing an additional service to a patient is less than providing the same procedure by itself, in general because much of the patient preparation that may be necessary for outpatient services has already been performed. In instances where these services are identified and selected for discounting, the reduction of payment through discounting may range from zero to 100 percent of payment.²⁴ In the Navigant modeling the discounting was set to 50 percent.

4.4 Grouping Algorithm Recommendations

Given the dynamics of the two OPPSs commonly in use in the U.S. healthcare industry, Navigant recommends the use of an EAPG payment method by Florida Medicaid. An EAPG payment method provides a less complex OPPS as it can be used for all services offered in an outpatient setting without the need for maintaining separate fee schedules. In addition, EAPGs bundle services more frequently than the alternative APC system, creating greater incentives for providers to control costs and services offered to Medicaid recipients.

In addition, while many providers may be familiar with the APC-based OPPS method used by Medicare, changes and modifications to this system would be needed for it to work with the Florida Medicaid population. It would need to be customized to support payment of services covered by Florida Medicaid, but not covered by Medicare. In addition, the Florida Legislature may choose to apply adjustors to the standard APC payment rates to meet Florida Medicaid goals. Thus, even if Florida Medicaid implemented an APC-based OPPS, providers would not be able to use software they already have for their Medicare business as a way to predict payment for their Medicaid patients.

5 Payment Policy Option – Included and Excluded Provider Types

An EAPG payment methodology allows for multiple types of facilities to be reimbursed for the outpatient services they provide. EAPG payment is intended to reimburse facility costs including labor for healthcare providers commonly employed by a healthcare facility. Physician services are generally billed separately and are not included in the EAPG reimbursement. Currently, the following types of facilities submit institutional outpatient claims to Florida Medicaid: free-standing dialysis centers, free-standing hospice providers, and hospitals. This makes each group a candidate for reimbursement through an EAPG payment method. In addition, free-standing (independent) laboratories and Ambulatory Surgical

²⁴ 3M™ Enhanced Ambulatory Patient Grouping System – Definitions Manual, July, 2015.

Centers (ASCs) perform services very similar to those offered in a hospital. As a result both independent laboratories and ASCs are candidates for inclusion in an EAPG-based OPPS.

5.1 Included and Excluded Provider Types – Discussion

From a broad payment policy prospective, a defensible payment method offers consistency and fairness of reimbursement for medical services. The method may include adjustments that account for fundamental differences in cost structures and/or payer mix of certain categories of providers. However, within a single category of providers, a common goal of a payment method is to pay the same amount for the same service independent of where the service was performed.

Specific to Florida Medicaid, free-standing hospice facilities and free-standing dialysis facilities are currently paid using separate methods that are unique to these types of facilities. Free-standing hospice facilities are assigned a facility-and-revenue-specific rate for six specific revenue codes. In addition, there are unique federal requirements related to payment for hospice services which further differentiate free-standing hospice and hospital provided hospice services. Free standing dialysis centers are paid statewide standardized rates for a specific set of revenue code and procedure code combinations. In contrast to these two payment methods, hospital outpatient services are paid using a hospital-specific, cost-based, per-service rate which is applied to each payable revenue code.

In the Florida Medicaid program, independent laboratories are currently paid using the same lab fee schedule that is used for laboratory services provided within an acute care hospital. However, the cost structures of these hospital-based lab services and free-standing labs is not the same, as hospitals have greater overhead to support offering a wide array of services at any time of the day.

Ambulatory Surgical Centers (ASCs) are currently paid using a method similar to that applied by Medicare, which groups a finite set of procedure codes into a set of fourteen categories and assigns a different state-wide rate to each of the fourteen categories. Also, ASCs currently bill using a professional claim form, again consistent with the process utilized by Medicare.

Assuming that the goal of an outpatient prospective payment system is to provide fair and consistent payments for provided medical services, current payment and cost structures must be accounted for when deciding what provider types to include in an EAPG-based OPPS payment methodology.

5.2 Included and Excluded Provider Types – Recommendation

Navigant and the AHCA Governance Committee believed the primary focus of the Florida Legislature in considering an OPPS was to move away from cost-based facility specific payment rates for hospitals. In addition, we believe the EAPG payment method is particularly well-suited for surgical services for which significant, ancillary, and incidental procedures are

generally clearly identified. As a result, we recommend including only hospitals (provider types 01) and Ambulatory Surgical Centers (provider type 06) in the new EAPG-based OPPS.

Assuming a successful transition to the new OPPS, Florida Medicaid might consider converting reimbursement for free-standing dialysis centers, independent laboratories, and free-standing hospice facilities to the OPPS. If included in the future, the varying cost structures of these types of facilities would likely require separate EAPG base rates for each.

6 Payment Policy Option – Included and Excluded Services

For the provider types included in the new OPPS, it is worthwhile to review whether or not there are any specific procedures, materials, and/or devices which might be more appropriately reimbursed using a method other than an EAPG-based OPPS. If yes, these services could be excluded from the new payment system and reimbursed through another method.

6.1 Included and Excluded Services – Discussion

Unlike the APC-based OPPS, the EAPG-based OPPS is designed to calculate reimbursement for all services provided in the outpatient setting. The EAPG system incorporates into its design logic on how to pay services differently based on cost, resource use, and clinical guidelines. In addition, the EAPG relative weights are calculated under an assumption that the cost and payment for common ancillary procedures will be covered under reimbursement for the significant procedures. Thus, carving specific outpatient procedures out of the EAPG payment method may counteract some of the logic and weighting built into the EAPG design. For this reason, our general preference is to reimburse all outpatient services from applicable providers under EAPG payment method.

During the payment method design process, the one set of procedures that were given consideration for exclusion were pharmaceuticals. The concern with pharmaceuticals related to the impact the EAPG payment methodology may have on rebates AHCA and 340B qualified hospitals currently receive. There are regulations which state that Medicaid agencies may only apply for rebates on drugs that receive explicit payment. Thus, drugs whose payment is bundled in with payment for a significant procedure under an EAPG payment method would not be eligible for drug rebate. Also, similar restrictions are being considered for hospitals who qualify for the 340B drug payment program and receive rebates from drug manufactures separately from the Medicaid Agency. Please see Chapter 15, “Impact of OPPS on 340B Drug Pricing Program” for a more detailed discussion of this topic.

6.2 Included and Excluded Services – Recommendation

Because of the robust and all-encompassing design of the EAPG payment method, we recommend including all outpatient services from included provider types in the OPPS.

In terms of the drug rebate program, current rules limit AHCA to applying for rebates only for pharmaceuticals on hospital outpatient claims that are billed with a procedure code and a National Drug Code (NDC). These codes are generally only included on relatively expensive drugs which will receive payment through the EAPG-based OPSS. Thus, the number of drugs currently applying for rebate today whose reimbursement will be bundled in the OPSS, thus making them no longer applicable for rebate, is anticipated to be low. In addition, the new requirements under the OPSS to include procedure codes on service lines for reimbursement may increase the number of drug service lines submitted with procedure codes. This may increase the number of drugs billed with necessary information to apply for rebates, thus offsetting the effect of payment bundling on drug rebates.

In terms of hospitals who qualify for the 340B Pharmacy Pricing Program, it is unclear at this time if rebates will be disallowed for drugs provided in an outpatient setting and whose reimbursement is bundled in with reimbursement for another procedure. In addition, if rebates are not allowed for drugs in this scenario, it is our expectation that impact to hospitals will be low as only low-cost drugs receive bundled payment in an EAPG-based OPSS. Of the six state Medicaid agencies who have implemented an EAPG-based OPSS to date, only one, Virginia, carved pharmaceuticals out of the OPSS.

7 Payment Policy Option – Base Rate(s)

The EAPG provider base rate, also referred to as the “conversion factor,” is one of the most significant contributors to the reimbursement amount in an OPSS. Thus, selection of provider base rate(s) is a critical step in ensuring fair reimbursement when implementing an OPSS payment method. The simplest approach from the point of view of maintaining budget neutrality would be to assign each healthcare provider its own base rate. However, this would defeat one of the basic goals of an OPSS payment method – that is incenting and rewarding provider efficiency. The opposite approach would be to develop a single base rate to be applied to all providers. Many states have found that a solution somewhere between individual provider base rates and a single state-wide base rate is a more appropriate answer. Most states select a small number of base rates for specific provider categories that address reasonable differences in cost between providers in different categories. In the Florida inpatient DRG payment methodology, one base rate is utilized, but a small number of provider category policy adjusters are incorporated, which have a similar effect as separate base rates.

7.1 Provider Base Rates – Discussion

7.1.1 Base Rates for Different Provider Categories

Separate provider base rates are most often selected to adjust for definable differences in cost structure, to adjust for differences in payer mix, and to ensure access to care. For example, the two types of providers recommended for inclusion in AHCA’s OPSS are hospitals and ASCs. ASCs are believed to have lower overall cost structures than hospitals because ASCs offer a smaller range of services, ASCs may turn away patients they deem to be overly costly, and

ASCs do not need to remain open 24 hours a day seven days a week. These factors allow ASCs to maintain lower overall cost structures than hospitals. As a result, separate base rates for hospitals versus ASCs may be warranted. Similarly, if a decision is made to add free-standing dialysis centers and/or independent laboratories to the OPPS, separate base rates should be considered for these types of facilities as well.

In addition, within the hospital category some facilities may have different cost structures based on the services they provide to patients, such as trauma care, and complex pediatric care, or because of services they provide to the healthcare community such as training for interns and residents. Other hospitals, most notably small rural hospitals, have relatively low costs, but also have relatively few patients from which to spread their overhead, and they provide access to care to recipients who would otherwise have to travel long distances to reach larger urban facilities. Also within the hospital category, there is a broad range of payer mix. Some facilities have significantly high Medicaid utilization, and rely heavily on Medicaid reimbursement, which on average is less than hospital cost, to remain in operation. All of these differences between hospitals are worthy of consideration when selecting categories for base rates, and/or provider policy adjustors, as described in Chapter 9.

If separate base rates are selected for some groups of providers, we recommend the criteria used to categorize hospitals within groups be very clear and maintainable. Understandably, hospitals will be motivated to be defined into the peer group offering the most attractive reimbursement. Having clearly defined criteria for each grouping will help maintain the integrity of the payment policy and lessen the administrative burden of categorizing all hospitals.

7.1.2 Base Rate Adjustment for Wage Area Differences

Another option employed by some state Medicaid agencies (and by the Medicare program) to adjust hospital base rates is a geographic wage area index or factor. The wage areas and associated wage indices can be state-defined values or can be linked to the Medicare values. Adjustment by wage area allows for higher payment in geographic regions that have historically reported higher wage rates for healthcare employees.

Wage area indices act as multipliers to common base rate(s) and can be applied either to the entire base rate or to a portion of the base rate. For example, Medicare applies the wage area index only to a percentage of the common base rate where the percentage is a standardized estimate of the percentage of hospital costs attributed to labor. In particular, Medicare applies the wage index to 60 percent of the common base rate and leaves 40 percent unadjusted as is shown in the following formula:

$$\begin{aligned} \text{Base rate} &= ([\text{Common base rate}] * [\text{hospital wage index}] * 0.60) \\ &+ ([\text{Common base rate}] * 0.40) \end{aligned}$$

Medicare wage indices for Florida hospitals for federal fiscal year 2016 range from 0.8325 to 0.9765 and the average is 0.9123.²⁵ The difference from the lowest wage index to the highest is 0.1440 which is approximately 16 percent of the average. This is a relatively small range from low to high values.

If a wage area adjustment is desired by Florida Medicaid, an alternative to adopting Medicare's wage indices would be to develop Florida-specific wage indices. However, determination of wage areas can be very complicated and would likely require AHCA to take on a significant amount of additional effort. In addition, CMS is currently undergoing a major effort to redesign wage areas that will presumably result in a solution more widely accepted in the hospital community.

7.2 Provider Base Rates - Recommendation

Given the current list of provider types recommended for Florida Medicaid's OPPS, we are recommending two OPPS base rates (referred to as "conversion factors" by Medicare), one for hospitals and another for ASCs. This recommendation is made in concert with our recommendation regarding provider policy adjusters, which is given in Chapter 9. In earlier pricing simulations, we used a single base rate and the result was a shift of approximately \$16 million from hospital payments to ASC payments. Without any specific direction from the Legislature to shift funds between these two types of providers, we assumed this shift is not intended to be part of the conversion to a new OPPS. Thus, we are recommending separate base rates for hospitals and ASCs in order to keep each type of provider budget neutral in aggregate.

Also, we are assuming hospital outpatient rate enhancements will be disbursed as supplemental claim payments, separate from the funds distributed through the base rates and standard EAPG pricing. This will allow the rate enhancements to be distributed in specific amounts to specific hospitals, as is done under the legacy outpatient payment method. If automatic rate enhancements are rolled into the base rate instead of being paid as a supplemental payment, then each hospital would need to be given their own base rate in order to distribute specific automatic rate enhancement amounts to specific hospitals.

Lastly, because of varying opinions on the fairness of Medicare wage areas, the limited range of wage indices in Florida, and AHCA's strong preference for a simplified payment method, we are recommending against having a wage area adjustment. This is consistent with Florida Medicaid's inpatient DRG payment method, which does not include wage area adjustment to the DRG base rate.

²⁵ The wage index values were retrieved from the Table 2 Correction Notice in spreadsheet "CMS-1632-F and CN Tables 2 and 3.xlsx" downloaded from URL <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files-Items/FY-2016-Wage-Index-Home-Page.html> on November 28, 2015.

8 Payment Policy Option – Distribution of Automatic Rate Enhancements

Hospital outpatient automatic rate enhancements total just under \$134 million in state fiscal year (SFY) 2015/16. New in SFY 2015/16, the state share of these funds came from general revenue. In previous years, the state share of these funds came from inter-governmental transfers from individual counties and taxing districts.

8.1 Distribution of Automatic Rate Enhancements – Discussion

Prior to the start of each state fiscal year, the Florida Legislature decides on a distribution of automatic rate enhancements to individual hospitals. A total amount to be paid out over the course of the SFY is assigned to each hospital, with some hospitals allocated more and others allocated less, including many hospitals which receive no supplemental rate enhancements.

Under AHCA's current hospital outpatient per diem payment method, automatic rate enhancement funds are distributed as an increase in the hospitals' outpatient per diems. This is possible because each hospital is assigned its own separate outpatient per diem.

In the EAPG-based OPPS, we are not recommending every hospital be given their own EAPG base rate. Because of this, it will not be possible to allocate specific dollar amounts to individual hospitals and distribute that money through standard EAPG pricing. If the automatic rate enhancement funds are distributed through the EAPG base rate, they will be distributed to all hospitals based on utilization and casemix. If on the other hand, the Florida Legislature wishes to continue to allocate specific amounts to specific hospitals, the automatic rate enhancements can be distributed through per-service-line supplemental payments, similar to the way inpatient automatic rate enhancements are distributed today within AHCA's inpatient DRG payment method.

8.2 Distribution of Automatic Rate Enhancements – Recommendation

We are assuming the Florida Legislature wishes to continue to allocate specific amounts of automatic rate enhancements to specific hospitals. As a result, we recommend including a per-service-line supplemental payment in the OPPS payment method that will be used to distribute automatic rate enhancements.

9 Payment Policy Option – Policy Adjustor(s)

Policy adjustors are an optional feature that can be used to help protect access to care for specific services. Often these are used for services where Medicaid funding can have a significant impact on beneficiary access, such as obstetrics, newborn care, mental health and pediatrics. In addition, policy adjustors may be used to direct additional funds to categories of providers that are particularly dependent on Medicaid reimbursement. The adjustors are above and beyond EAPG relative weights and represent an explicit decision to direct funds to a

particular group of patients who are otherwise clinically similar or to a specific category of providers to promote access to care for Medicaid recipients.

Specifically, policy adjustors are multipliers applied to specific claim lines with the effect of increasing or decreasing payment. Four types of policy adjustors are commonly used:

- Service adjustors
- Age/service adjustors
- Provider/service adjustors
- Provider adjustors

Service policy adjustors are applied to specific services, which would likely be identified by revenue code.

In theory, age/service adjustors can be applied to any age range, but are typically used by Medicaid programs to promote access for pediatric beneficiaries. Age/service adjustors provide a different payment for similar services when provided to a child versus an adult. For example, an age/service adjustor of 1.25 on EAPG 060 (pulmonary test) would increase payment by 25 percent if the patient was a child. In contrast, an adult who was given the same service, EAPG 060 pulmonary test, would receive the EAPG base payment without any adjustment.

Provider/service adjustors can be used to increase (or decrease) payment for specific services when offered by specific groups of providers. For example, a Medicaid agency might choose to increase payment for services provided in an emergency department when offered at a Level I trauma center, which might incur greater costs to support the clinical expertise and equipment needed to treat complex trauma cases. In such a scenario, the provider/service adjustor is used to increase payment for care specifically in an emergency department without increasing payment for other types of care (such as physical therapy) at the same hospital.

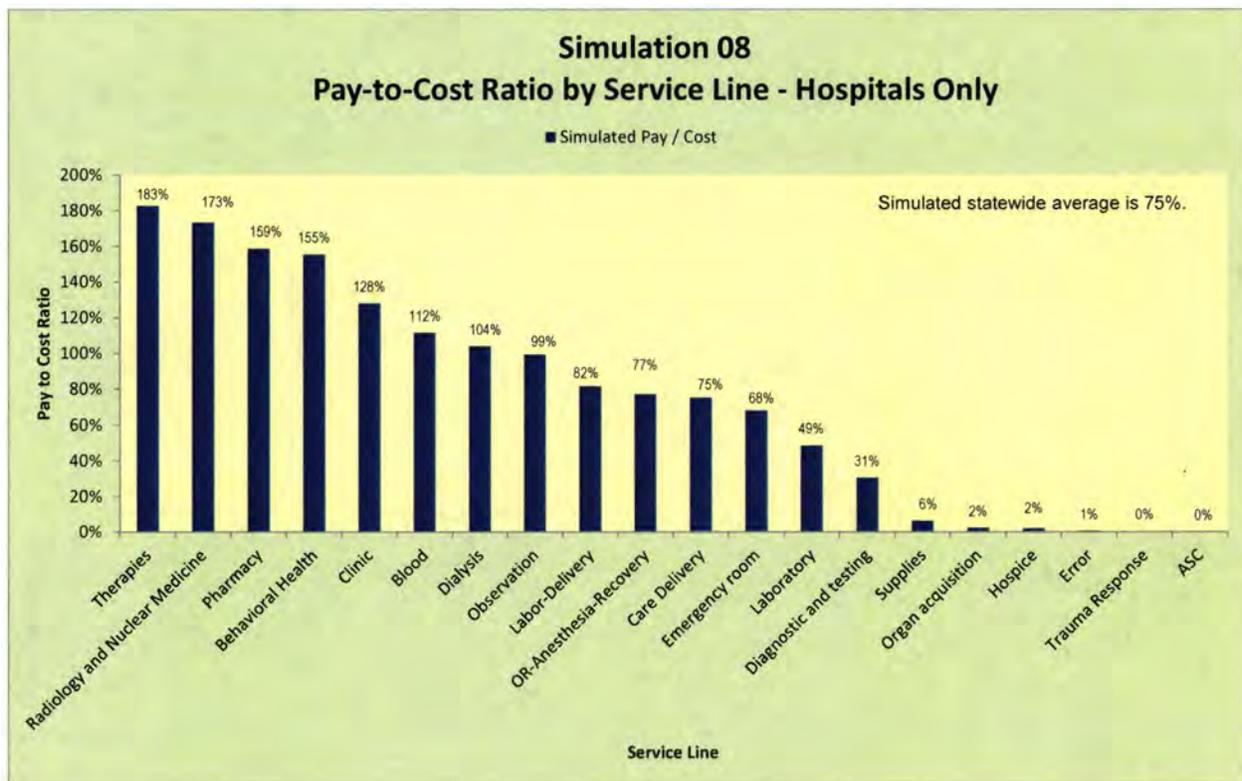
Finally, provider adjustors can be used to increase (or decrease) payments for all services performed by specific individual providers or categories of providers. Provider adjustors differ from provider/service adjustors in that they apply for all services offered by an applicable provider, not just specific types of services.

Assuming a goal of budget neutrality, use of policy adjustors causes provider base rates to be reduced, and has the effect of shifting some money from one area to another. We generally recommend including policy adjustor functionality in an OPPS implementation because it creates an ability to meet current and future Medicaid program goals by adjusting payments without requiring significant software changes within the MMIS. However, policy adjustors do not necessarily need to be a major contributor to overall program reimbursements. They can be used sparingly to meet specific needs.

9.1 Policy Adjustors – Discussion

The EAPG pricing simulations did not highlight any services that were particularly under-paid when compared to AHCA’s average hospital outpatient pay-to-cost ratio, as shown in Figure 1.²⁶ Supplies, laboratory services, and diagnostic and testing services are all paid well below the state-wide average of 75 percent, however, they are all services that are commonly bundled within an EAPG payment methodology. The other service lines showing payment well below the average pay-to-cost ratio, hospice, error (invalid revenue code submitted on claim), and organ acquisition are all services with extremely low volume.

Figure 1. EAPG simulated pay-to-cost by type of service.



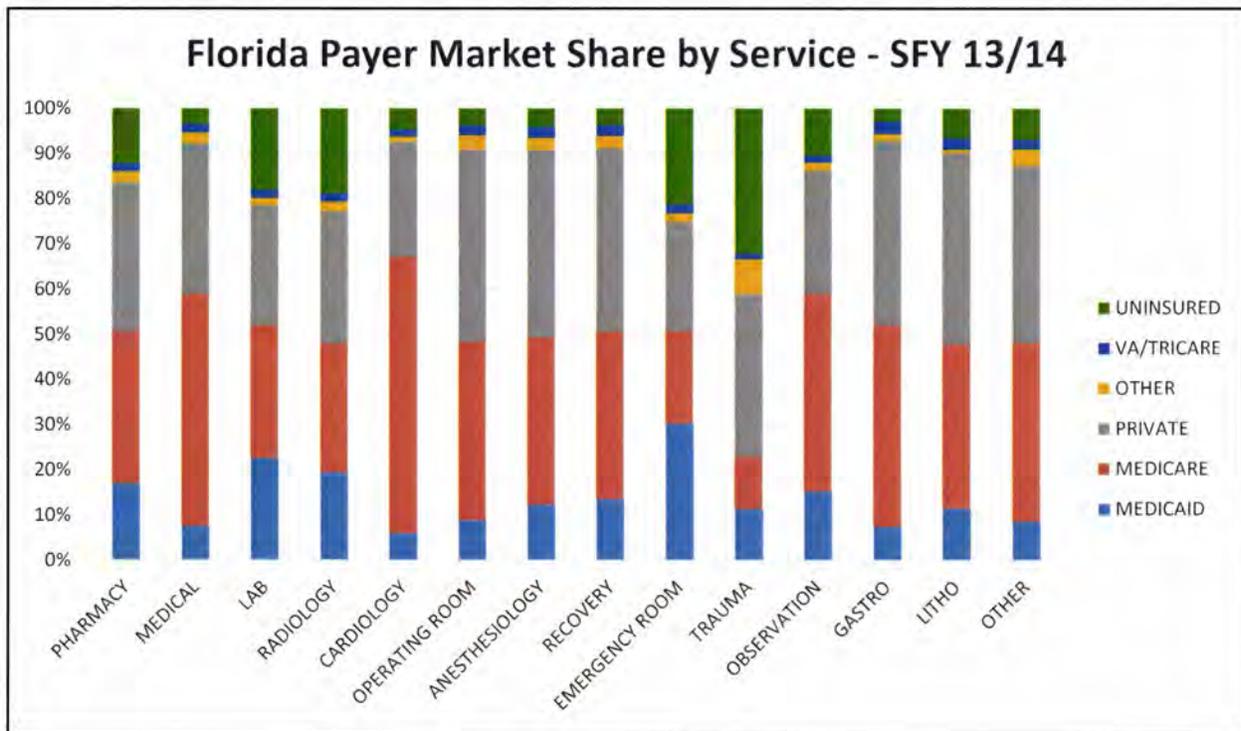
In comparison to the hospital inpatient setting, there are fewer services provided in a hospital outpatient setting for which Medicaid is clearly the primary payer. For example, in a hospital inpatient setting Medicaid is clearly a major payer for maternity and newborn care, as Medicaid pays for more than 50 percent of the deliveries and births in the State of Florida.²⁷ Medicaid is not as significant a payer for any service in the outpatient setting as shown in Figure 2.

²⁶ ASCs are not included in this chart because there is currently, no practical way to measure their costs, as they are not required to submit cost Medicare cost reports, as are required of hospitals.

²⁷ Presentation prepared by Navigant Healthcare for AHCA’s second public regarding development of a DRG hospital inpatient payment method, August 29, 2012; Slide 14; Retrieved November 14, 2015 from http://ahca.myflorida.com/medicaid/cost_reim/pdf/DRG_Payment_Implementation_Project_Status_2012-08-29.pdf

Medicaid’s greatest impact in the hospital outpatient setting is for Emergency Room (ER) services, where Medicaid pays for 30 percent of the ER services in the State. Thus, a Medicaid service-based OPSS policy adjustor would not necessarily have as much impact on access to care in the outpatient setting as Medicaid service adjustors are likely to generate for certain inpatient services.

Figure 2. Payer mix in Florida for hospital outpatient services.²⁸



In addition, our modeling showed relatively little shift in reimbursement from adult to pediatric care as shown in Table 4. Thus, the modeling does not suggest a particular need for a pediatric policy adjustor, as is utilized in Florida Medicaid’s inpatient DRG payment method.

Table 4. Estimated change in payment from move to OPSS for pediatric versus adult recipients.

Description	Claim Lines	Billed Amount	Baseline Payment	Simulated EAPG Payment	Payment Change (Dollars)	Payment Change (Percent)
Pediatric Recipients	7,367,877	\$4,115,419,120	\$568,333,943	\$567,733,334	-\$600,609	-0.1%
Adult Recipients	12,104,227	\$7,697,531,147	\$688,763,380	\$689,362,472	\$599,093	0.1%
Total	19,472,104	\$11,812,950,267	\$1,257,097,323	\$1,257,095,806	-\$1,517	0%

²⁸ Data for this graph was provided by the Florida Data Center.

In contrast, when considering specific categories of providers, there are some providers who may be justified in receiving a policy adjustor because a relatively high percentage of their patients are enrolled in Medicaid. A ranking of the top 15 hospitals when looking at outpatient Medicaid utilization is shown in Table 5.

Table 5. Ranking of hospital outpatient Medicaid utilization – top 15 hospitals.

Provider Medicaid ID	Provider Name	Outpatient Charges - Medicaid Recipients	Outpatient Charges - Non-Medicaid Recipients	Outpatient Charges - Total	Percent of Outpatient Utilization from Medicaid Recipients
010060900	Nicklaus Children's Hospital	\$175,459,357	\$86,883,316	\$262,342,673	67%
004087600	Nemours Children's Hospital	\$50,493,593	\$29,664,040	\$80,157,633	63%
002576600	Shriners Hospital for Children-Tampa	\$3,301,513	\$2,262,642	\$5,564,155	59%
010151600	All Children's Hospital	\$122,034,787	\$89,389,720	\$211,424,507	58%
012000600	Plantation General Hospital	\$135,928,256	\$203,348,796	\$339,277,052	40%
010033100	Shands Lake Shore Rgnl Med Cntr	\$34,615,737	\$53,627,998	\$88,243,735	39%
010049800	North Shore Medical Center	\$101,669,083	\$167,867,576	\$269,536,659	38%
010133800	Orlando Health	\$115,349,667	\$196,710,977	\$312,060,644	37%
010260100	Florida Hospital Wauchula	\$13,543,077	\$23,198,666	\$36,741,743	37%
011980600	Capital Regional Medical Center	\$13,594,172	\$23,424,311	\$37,018,483	37%
009268300	Poinciana Medical Center	\$86,461,749	\$149,191,565	\$235,653,314	37%
010111700	Lehigh Regional Medical Center	\$56,793,421	\$98,360,066	\$155,153,487	37%
010144300	Lakeside Medical Center	\$16,611,281	\$31,960,571	\$48,571,852	34%
010086200	Hendry Regional Medical Center	\$8,915,067	\$17,216,536	\$26,131,603	34%
010087100	Bayfront Health Brooksville	\$79,766,762	\$156,517,725	\$236,284,487	34%

Note(s):
1) Data in this table was provided by the Florida Data Center.
2) The data is a sum of the hospital ambulatory care and emergency department categories from state fiscal year 2013/14 – July 1, 2013 through June 30, 2014.

9.2 Policy Adjustors – Recommendation

We do not see any particular value in adding any service policy adjustors, and thus recommend initial implementation of the OPSS with all service, service/age, or provider/service policy adjustors set to 1 (no adjustment). However, we do recommend including a provider policy adjustor for hospitals that have high Medicaid utilization for outpatient services. Hospitals with a high percentage of Medicaid patients have less ability to cover costs with payments from patients with Medicare and commercial insurance. Because of this, Navigant is recommending a provider policy adjustor that keeps the pay-to-cost ratio at 90 percent for any hospital with greater than 50 percent of their outpatient utilization coming from Medicaid recipients. Given the numbers in Table 5 above, this would apply to Nicklaus Children’s, Nemours Children’s, Shriners Hospital for Children, and All Children’s hospitals. Also, the pay-to-cost ratio goal of 90 percent would be measured including both EAPG payment and supplemental automatic rate

enhancements. Currently, these four hospitals are paid 92 percent of cost under the legacy payment method.

10 Payment Policy Option – Outlier Payments

OPPS payment methods may include outlier provisions to adjust payment for patients that are unpredictably expensive. The EAPG grouping algorithm and associated EAPG relative weights are designed to predict hospital resource use so that the relative weight and therefore the EAPG base payment may be set accordingly. However, the EAPG grouper is limited to using only the information on medical insurance claims including procedure codes and diagnosis codes. Given the wide range of cases seen in an outpatient setting, EAPG grouping does not always accurately predict hospital resource use. In those cases, where the prediction differs significantly from reality, outlier payments may be used to generate a more reasonable reimbursement.

10.1 Outlier Payments – Discussion

If implemented, the outlier calculation would likely be cost-based and the formula would be,

$$\begin{aligned} \text{[Outlier pymt adjstmnt]} &= \{[\text{Hospital cost}] - [\text{EAPG payment}] - [\text{Outlier threshold}]\} \\ &* [\text{Marginal cost \%}] \end{aligned}$$

In theory, this formula could be applied at the claim line level or at the claim header level. Arguably, the calculation will be more meaningful and accurate if calculated at the claim header level so that it is based on full cost of the outpatient visit, including some services that might get bundled under EAPG payment. However, EAPG pricing is performed at the line level, and performing pricing operations at both the header and line levels on the same claim adds significant complexity to the payment method. To reduce complexity, this calculation could be performed at the claim line level for line items that are not paid at \$0 because of bundling. Unfortunately, this would result in the outlier calculation including only the cost of services on each non-bundled line item individually, and would never consider costs from lines whose payment was bundled in with another line.

In general, there is less need for outlier payments under an outpatient EAPG payment method versus an inpatient DRG payment method. This is because outpatient EAPG payment amounts are calculated individually for each service at the claim line level, whereas inpatient DRG payments are calculated as a single payment for an entire hospital admission based on a categorization of the patient's condition. In the outpatient EAPG pricing method, each additional service added as an additional claim detail line will be considered for additional payment. Some lines will get bundled, thus paying at \$0, and others may pay at a discounted rate. Even so, EAPG payment is far more tied to the services performed than the DRG inpatient payment method, and, thus, is more capable of adjusting for unusually costly cases, which, presumably, result in more procedures being performed.

Of the six state Medicaid agencies that have implemented EAPG payment for their OPPS, none have chosen to include outlier payments. In contrast, Medicare's OPPS, does include an outlier payment calculation. In calendar year 2015, Medicare pays an outlier if the hospital's cost of furnishing a service exceeds the APC payment by 1.75 times and the hospital's costs exceeds the sum of the APC payment and a fixed loss threshold equal to \$2,775. When this occurs, Medicare calculates an outlier payment for the service that is equal to 50 percent of the amount by which the cost to the hospital exceeds 1.75 times the APC payment rate. In calendar year 2016, Medicare plans to increase the fixed loss threshold to \$3,250. Medicare states that the fixed loss threshold is set with a goal of distributing one percent of total reimbursements in the form of outlier payments.

Navigant estimated the amount of payment that might be paid out through outpatient outliers in the Florida Medicaid program by using a slightly less complex method that utilizes a mixture of the Medicare outpatient outlier calculation and the Florida Medicaid inpatient outlier calculation. We estimated the total outlier payment for Florida Medicaid for a year under EAPG pricing using a fixed loss threshold equal to \$2,775 (Medicare's calendar year 2015 value), a marginal cost percentage of 80 percent, and the outlier payment formula described above (which is the same formula Florida Medicaid uses when calculating inpatient DRG outlier payments). In our model, the outlier calculation was performed at the claim service line level, for lines that received an EAPG payment greater than \$0 (thus, were not bundled). Also, the outlier calculation was made without consideration of the supplemental automatic rate enhancements. Excluding supplemental automatic rate enhancements is consistent with Florida Medicaid's inpatient DRG outlier calculation, and results in more claims receiving outlier payments, for the same fixed loss threshold. Even with a marginal cost percentage of 80 percent, which is higher than the 60 percent value used in Florida Medicaid's inpatient DRG payment method, only \$9,056,906 was paid out as outlier payments in our model. This is less than one percent of total payments.

10.2 Outlier Payments – Recommendation

Given the added complexity of including outlier payments in the OPPS, the reduced need for outlier payments in an OPPS, and the very small amount of money estimated to be distributed through outlier payments, (less than one percent of total EAPG payments), Navigant recommends implementing the OPPS without outlier payments.

11 Payment Policy Option – Transitional Period

Making a change in payment method from hospital-specific cost-based outpatient rates to an OPPS with relatively standardized rates will likely result in redistribution of some Medicaid outpatient reimbursements. Even if implemented with budget neutrality, we expect some providers will receive higher payments under the new OPPS method (when compared to legacy outpatient payments) and some providers will receive lower payments. A transitional period is a pre-set timeframe in which one or more strategies are implemented to limit individual providers' changes in Medicaid outpatient reimbursement for a period of time. The period of

time commonly used by payers who have chosen to include a transitional period when updating a payment method is between one and three years.

11.1 Transitional Period – Discussion

There are some advantages to utilizing transitional strategies. Phase-in or transitional periods provide time for providers to internally respond to anticipated changes in Medicaid reimbursement. A transitional period allows time for providers to take the steps necessary to improve documentation and coding practices, and potentially to implement improvements to operating performance relative to efficient delivery of services. In addition, a transitional period gives providers time to make modifications to the complement of service lines offered in future periods – to the extent that Medicaid payments affect such decisions.

On the other hand, there are disadvantages to utilizing transitional strategies. From a payer perspective, transitional periods tend to increase program administrative complexity for both policy and system implementation. A transitional period requires payers to either maintain two payment systems simultaneously (which would be required to blend payments between the legacy per diem method and the new EAPG model), or alternatively, to determine provider-specific base rates that would limit reimbursement changes during the transitional period. AHCA's Managed Medical Assistance program exacerbates the complexity further as the managed care plans tend to base their contracting rates on the Medicaid fee-for-service rates. From the providers' perspective, facilities that stand to see increased payments under the new payment model will not realize the full benefit of the change in payment model until after the transitional period has run its course.

A less complex, but more costly method to lessen the impact of a change in payment method includes making available additional funds distributed as supplemental payments separate from claim payments to individual providers who experience a reduction in Medicaid reimbursement. This was the method selected by the Florida Legislature when Florida Medicaid converted from hospital-specific cost-based per diem payments to DRG payments for inpatient services. \$65 million, including state and federal share, in non-recurring funds was made available in the first year of DRG implementation to offset reductions in Medicaid inpatient reimbursement to specific hospitals. Distribution of that \$65 million to individual hospitals was determined before the start of state fiscal year 2013/14 and then was reconciled near the end of 2013/14 based on partial year actual results.

Unfortunately, some hospitals have so far been excluded from EAPG payment modeling because their data was not sufficiently complete to include in the modeling (please see Chapter 3 for details of this issue). As a result, at the time of writing this report, we are unable to estimate changes in outpatient reimbursement for all hospitals in Florida, and, thus, could not calculate a defensible disbursement of transitional funds if they were made available. Data from specific individual hospitals will need to be collected and merged with existing historical claim data if we are to include all hospitals in the OPPS payment modeling. This limitation did

not exist in the claim data from the Ambulatory Surgical Centers, so we are able to model changes in reimbursement for all the ASCs.

11.2 Transition Period – Recommendation

We recommend Florida Medicaid implement its new OPPS fully from the start, without a transitional period due to the increased complexity resulting from transitional strategies, particularly in an environment with significant managed care. Furthermore, the level of reimbursement for outpatient services is significantly below that of inpatient services. As a result, the impact to hospitals from a change in outpatient payment methodology will be significantly less than the change in inpatient payment method.

12 Payment Policy Option – Adjustment for Anticipated Improvement in Documentation and Coding

When developing a new payment method, historical claims data is commonly used to model the new payment method and to set payment rates. This is done under the assumption that the historical claims data accurately represents that which will be billed and paid under the new method. For the most part, this assumption is accurate, as the medical services rendered and the medical providers rendering those services do not change significantly from year to year. However, the change in payment method itself may have an effect on billing practices and that change may influence overall reimbursements. When this is the case, the payment rates need to be adjusted in anticipation of the new billing practices so that overall reimbursements remain budget neutral, as is the direction of the Florida Legislature.

12.1 Adjustment for Anticipated Improvement in Documentation and Coding – Discussion

There is one notable difference between the current legacy outpatient payment method and the proposed new EAPG-based OPPS that we believe will result in a change in billing practices. That is the inclusion of HCPCS procedure codes on individual claim service lines. The legacy outpatient payment method only requires HCPCS procedure codes for laboratory services. Other than laboratory services, payment is calculated without consideration of the procedure performed. In contrast, under an EAPG-based OPPS, the procedure code is the most fundamental data element used in determining payment for all outpatient visits except those determined to be medical visits. (Please see section “Medical Visits in an EAPG Payment Method” for a description of medical visits in the EAPG grouping algorithm.)

The inclusion of procedure codes on more service lines in the future will not necessarily increase casemix as was the concern when moving from a per diem to a DRG payment methodology for hospital inpatient services. However, the presence of more service lines with procedure codes will result in more lines receiving payment when the OPPS is implemented than received payment in the OPPS modeling performed on claim data from state fiscal year

2013/14. To remain budget neutral, EAPG rates will need to be adjusted to account for additional service lines receiving reimbursement.

The expectation of improved documentation and coding is anticipated for hospitals only, not for ASCs. ASCs bill on a professional claim form (CMS-1500) for which a procedure code is already required on all service lines. Thus, there is no expectation of change in billing practices of ASCs.

12.2 Adjustment for Anticipated Improvement in Documentation and Coding – Recommendation

Even if all claim service lines currently billed without a procedure code are billed with a procedure code in the future, it is difficult to predict the exact effect on overall reimbursement because some of those service lines will receive bundled payment. In addition, there is surprisingly little industry documentation describing the experiences of other Medicaid agencies who have implemented an EAPG-based OPPS.

We are recommending a 5 percent reduction in EAPG base rate for hospitals to account for anticipated improvements in documentation and coding. This amount is consistent with the adjustment made during the first year of APR-DRG pricing for inpatient services by Florida Medicaid. For ASCs we do not recommend any documentation and coding improvement (DCI) adjustment as we do not anticipate any changes in their billing practices.

Because of the uncertainty regarding the effect of DCI on overall reimbursement, we also recommend a mid-year or end-of-year reconciliation. However, because Florida Medicaid has converted most of its program into the Managed Medical Assistance program, a DCI reconciliation for the OPPS may need to be designed differently than the DCI reconciliation used in the first two years of inpatient DRG pricing. In the first two years of inpatient DRG pricing, the DCI reconciliation, when needed, was executed through prospective adjustment to the DRG rates applied to the Medicaid fee-for-service population. Today, the Medicaid fee-for-service population is so small, changes in rates for these recipients may not be sufficient to effect necessary adjustments. Instead, it may be more practical to set aside funds that may be distributed through supplemental payments directly from the Medicaid agencies to hospitals if actual billing does not change as much as anticipated. Unfortunately, if actual billing changes more than anticipated it will be difficult for the Agency to recoup money from hospitals. If needed, credit balances could be defined for individual hospitals that would hold back payment for care to fee-for-service in both the hospital inpatient and outpatient settings until the outpatient overpayments have been recouped.

13 Payment Policy Option – Hospital Outpatient Benefit Limit

Florida Medicaid currently imposes a \$1,500 annual benefit limit on hospital outpatient services. This limit is applied in the fee-for-service (FFS) program, and is optional for the managed care

plans in the Managed Medical Assistance program. According to the Agency, some managed care plans have chosen to implement the \$1,500 annual benefit limit, others have included a limit but increased the dollar threshold, and still others have chosen to do away with the limit.

13.1 Hospital Outpatient Benefit Limit – Discussion

In the FFS program, there are a variety of services for which the benefit limit does not apply, including emergency services, maternity services, and most surgeries. In addition, the benefit limit does not apply to Medicaid recipients under the age of 21.

It is Navigant's understanding that the outpatient benefit limit was installed to help control Medicaid spending, and is unrelated to the method used to calculate individual claim payments. Modeling of the new EAPG-based OPPS has applied the existing \$1,500 benefit limit rules under the assumption that the limit will continue in its current form. Modeling with the benefit limit removed is possible, but the payment rates calculated without the limit will only be accurate to the extent that hospitals bill Medicaid for all services provided, even in cases in which they know the recipient has already exhausted his/her annual benefit.

13.2 Hospital Outpatient Benefit Limit – Recommendation

Given the specific Legislative direction to develop an OPPS that maintains budget neutrality, Navigant and the AHCA Governance Committee are working under the assumption that the \$1,500 hospital outpatient annual benefit limit will continue to be in place when the OPPS is implemented.

14 Payment Policy Option – Charge Cap

Medicaid programs, like most payers traditionally have a charge cap in place which ensures payment on individual claims equals the lesser of the Medicaid allowable payment and the provider's submitted charges. Florida Medicaid currently has a charge cap in place on hospital outpatient claims that limits the allowed amount on individual service lines to be the lesser of the outpatient per diem and the submitted charges on the line.

14.1 Charge Cap – Discussion

The general strategy with EAPG payments is that payments will average out over time to hit Medicaid's desired pay-to-cost ratio even though payments on individual claims may be above or below this ratio. On individual claim service lines payment is calculated using the provider EAPG base rate, the EAPG relative weight, and any applicable policy adjustors. And the EAPG relative weight is based off the average provider resource usage to perform the services grouped within that EAPG category. Given these factors, the EAPG payment on an individual service line may be above or below actual hospital costs, and in rare cases may even be above hospital charges.

Instituting a charge cap on claims paid via EAPGs has the advantage of avoiding large overpayments for individual services. It also has potential to negatively impact providers who are doing a good job of aligning charges with costs. Charge caps have the effect of rewarding hospitals who inflate charges well above costs, which is not necessarily a behavior worthy of reward.

In addition, EAPG payment on an individual service line is often calculated with the intent of covering costs of that line plus other related ancillary services whose payment is bundled in with the payment for the primary service. As a result, a charge cap would more accurately be applied by comparing the EAPG payment to the cost of the service line on which the payment is made plus the cost on all lines whose payment is bundled in with the primary service. Unfortunately, it is not particularly easy to identify which service lines were bundled in with other service lines. Thus, another option would be to apply the charge cap at the claim header level. But applying the charge cap at the claim header level would result in a mixture of payment calculations occurring at both the header and line levels, which adds a significant amount of complexity to a payment method.

In Navigant’s EAPG pricing modeling there are some individual service lines with EAPG payment exceeding submitted charges on claims from both hospitals and ASCs. Total payment above submitted charges at the individual claim service line level is shown in Table 6²⁹.

Table 6. EAPG payment above charges on individual service lines.

Provider Type	Number of Claim Lines	EAPG Payment Above Service Line Charge
Hospital	736,474	\$ 85,316,393
ASC	2,256	\$ 207,983
Total	738,730	\$ 85,524,376

When applying a charge cap at the claim header, there are still occurrences of payments exceeding charges, but, as expected the total payments above charges is lower. Results of the analysis at the claim header level is shown in Table 7.

²⁹ Payment above charges was calculated when considering only the EAPG payment. Supplemental automatic rate enhancements were not included in the payment values. This is consistent with the charge cap policy implemented by AHCA for inpatient DRG pricing. Supplemental automatic rate enhancements are excluded so that we may increase the likelihood of accurately distributing all rate enhancements allocated to individual hospitals over the course of the fiscal year.

Table 7. EAPG payment above charges when calculated at the claim header level.

Provider Type	Number of Claims	EAPG Payment Above Claim Header Level Charge
Hospital	246,707	\$ 38,335,406
ASC	1,504	\$ 137,840
Total	248,211	\$ 38,473,246

If a charge cap policy is implemented, it does not result in savings to the State. Instead, it results in a slightly higher EAPG base rate, thus redistributing the overpayments across other claims in which EAPG payment is less than submitted charges.

14.2 Charge Cap – Recommendation

Although there are some instances in which EAPG payment is greater than provider submitted charges, Navigant does not recommend implementing a charge cap within the OPPS. We feel that a charge cap policy applied at the claim service line level is inaccurate because it would not consider provider cost from all the lines whose payment was bundled in with payment for the primary procedure. Application of a charge cap policy at the claim header level would be more accurate and fair. However, a charge cap at the claim header level would create a mixture of payment calculations at the header and line levels, which adds significant complexity to a payment method. We feel this added complexity is unnecessary when the net result would simply be redistribution of approximately \$38 million, which is approximately 3 percent of total EAPG payments.

15 Impact of OPPS on 340B Drug Pricing Program

15.1 Background

Section 340B of the Public Health Service Act (PHSA), which is referred to as the “340B Drug Pricing Program” or the “340B Program” is a program that allows Medicaid agencies and certain qualified healthcare providers, referred to as “covered entities” to purchase drugs at reduced prices for distribution to their patients. Covered entities are defined in section 340B(a)(4) of the PHSA, and only include healthcare organizations that have certain Federal designations or receive funding from specific Federal programs. These include Federally Qualified Health Centers, Ryan White HIV/AIDS Program grantees, and certain types of hospitals and specialized clinics. The intent of the 340B Program is to permit covered entities “to stretch scarce Federal resources as far as possible, reaching more eligible patients and providing more comprehensive services.”³⁰

³⁰ H.R. Rep. No. 102-384 (Part 2), at 12 (1992) (Conf. Rep.).

Medicaid agencies are allowed to apply for rebates from drug manufacturers for drugs paid for by the Medicaid program that were not purchased at a discounted rate by a covered entity. Drug rebates may be claimed for drugs provided to Medicaid recipients in both fee-for-service and Medicaid managed care programs. However, paying a rebate to a Medicaid agency for a drug that was purchased at a 340B discounted rate by a covered entity is considered duplicate discounting and is prohibited by law.

Also, according to Section 1927(k)(3) (Definitions) of the Social Security Act, Medicaid agencies may not apply for a rebate for drugs, biological products, or insulin if “provided as part of, or as incident to and in the same setting as, any of the following (and for which payment may be made under this title as part of payment for the following and not as direct reimbursement for the drug).”

- (A) Inpatient hospital services;
- (B) Hospice services;
- (C) Dental services, except that drugs for which the State plan authorizes direct reimbursement to the dispensing dentist are covered outpatient drugs;
- (D) Physicians’ services;
- (E) Outpatient hospital services;
- (F) Nursing facility services and services provided by an intermediate care facility for the mentally retarded;
- (G) Other laboratory and x-ray services; and
- (H) Renal dialysis.³¹

HHS published additional guidance on May 13, 1994, which further clarified that, in the settings identified in the limiting definition, “if a covered drug is included in the *per diem* rate (i.e., bundled with other payments in an all-inclusive, a per visit, or an encounter rate), it will not be included in the 340B discount program. However, if a covered drug is billed and paid for instead as a separate line item as an outpatient drug in a cost basis billing system, this drug will be included in the program.”³²

Guidance published in the Federal Register on August 28, 2015 says the following:

“Further, the limiting definition in section 1927(k)(3) to exclude covered outpatient drugs for purposes of the 340B Program only applies when the drug is bundled for payment under Medicaid as part of a service in the settings described in the limiting definition. In contrast, a drug provided as part of a hospital outpatient service which is billed to any other third party or directly billed to Medicaid would still qualify as a covered outpatient drug.”

³¹ The Social Security Act, Section 1927(k)(3).

³² Federal Register, Volume 59, Issue 92, released May 13, 1994.

We find this language to be rather confusing because a drug provided to a recipient in a hospital outpatient setting can be both billed directly to Medicaid and bundled for payment by Medicaid.

15.2 Impact of OPPS on 340B Drug Pricing Program

If drugs are included in the EAPG-based OPPS, many drugs that currently receive specific payment by Florida Medicaid will receive zero payment as their payment will be bundled in with another service deemed more significant by the EAPG categorization scheme. Given the regulations described in the previous section, there is risk that HRSA will consider drugs with EAPG bundled payments to be excluded from the 340B Drug Pricing Program.

For Medicaid drug rebates, we estimated approximately 790,000 drug claim lines annually that were eligible for the rebate in the past, will no longer be eligible for rebate.³³

For hospitals who are covered entities within the 340B Drug Pricing Program, we do not have any way to estimate the impact to their drug purchasing costs if Medicaid implements an EAPG payment method.

16 Timing of Implementation

Development of an EAPG-based OPPS within the Florida Medicaid Management Information System (FMMIS) will require a significant amount of time and utilization of software development resources. In addition, each managed care plan that decides to mimic the Medicaid fee-for-service payment method will need to perform their own conversion to an EAPG-based OPPS. Even if the Florida Legislature decides during the 2016 session to move forward with a change in the outpatient payment method, any payer who waits until completion of the 2016 Legislative session to begin development of an EAPG-based OPPS will almost certainly be unable to implement on July 1, 2016 and will have difficulty implementing by September 1, 2016. (September 1 is the date that annual Medicaid managed care capitation rates are currently updated.) AHCA and the Florida Medicaid Fiscal Agent are currently moving forward with development of an EAPG-based OPPS under the assumption that the Florida Legislature does decide to move forward with this change. Even so, they are estimating an implementation in the fall of 2016 to be the earliest possible timeframe. Assuming this timeframe holds true, AHCA would retroactively adjust outpatient claims with dates of service between July 1, 2016 and the date the OPPS is implemented in FMMIS.

³³ At the time this report was submitted, AHCA and Navigant were still gathering the information needed to estimate the amount of drug rebate AHCA would have collected for these claim lines.

Appendices³⁴

17 Appendix A – Summary of OPPS Payment Method Options

The following table summarizes the payment method options described in this document.

Table 8. Summary of OPPS payment method policy options and recommendations.

Payment Policy Option	Recommendation
Model dataset	<ul style="list-style-type: none"> • SFY 2013/14 data • Including FFS and managed care encounter data • Remove hospitals with more than 33% of their claim lines submitted with blank procedure codes, excluding specific service lines
Outpatient grouping algorithm	<ul style="list-style-type: none"> • Enhanced Ambulatory Patient Groups (EAPGs)
Provider types included and excluded from new OPPS	<ul style="list-style-type: none"> • Include hospitals and Ambulatory Surgical Centers (ASCs) • Exclude free-standing labs and free-standing dialysis centers
Services included and excluded from new OPPS	<ul style="list-style-type: none"> • Include all outpatient services from the included providers • Include pharmaceuticals in the OPPS
Hospital base rate categories	<ul style="list-style-type: none"> • Two, one for hospitals and one for ASCs • No wage area adjustment of base rates
Application of automatic rate enhancements	<ul style="list-style-type: none"> • Distributed as per claim supplemental payments

³⁴ Some information provided in the Appendices was obtained through use of proprietary computer software and data created, owned and licensed by the 3M Company. All copyrights in and to the 3M™ Software are owned by 3M. All rights reserved.

Payment Policy Option	Recommendation
Policy adjustors	<ul style="list-style-type: none"> • Provider policy adjustor for hospitals with 35% or more of their outpatient utilization coming from Medicaid recipients
Outlier payments	<ul style="list-style-type: none"> • No outlier payments
Transition period	<ul style="list-style-type: none"> • None
Documentation and coding improvement adjustment	<ul style="list-style-type: none"> • 5% for hospitals • 0% for ASCs
Charge cap	<ul style="list-style-type: none"> • None
Billing rule changes	<ul style="list-style-type: none"> • Require a procedure code on all outpatient line items effective 7/1/2016, with exceptions if appropriate

18 Appendix B – Hospital Specific Payment Estimates from EAPG Pricing Simulations

The table in this section shows historical (baseline) and simulated outpatient payments for each in-state hospital. Both payment types in this table include distribution of State general revenue, PMATF, and automatic rate enhancements. As mentioned previously, the numbers presented in this table are from SFY 2013/14 FFS and Medicaid managed care claim data re-priced using SFY 2015/16 FFS rates to determine the baseline amounts.

Table 9. Comparison of legacy payment to OPPS payment by hospital - in-state hospitals only.

Provider Medicaid ID	Provider Name	Case Mix	Claim Lines	Cost	Charges	Baseline Payment	Simulated EAPG Payment	Change in Payment	Percent Payment Change	Baseline Pay to Cost Ratio	Simulated Pay to Cost Ratio
010151600	All Children's Hospital	0.656	385,233	\$63,980,754	\$211,187,687	\$64,773,333	\$65,644,674	\$871,341	1%	101%	103%
011648300	Anne Bates Leach Eye Hospital	1.411	41,676	\$12,512,090	\$48,666,419	\$7,571,750	\$7,899,762	\$328,012	4%	61%	63%
012037500	Aventura Hospital and Medical Center	0.790	76,327	\$3,911,907	\$49,739,030	\$1,673,489	\$3,189,578	\$1,516,088	91%	43%	82%
010074900	Baptist Hospital Inc	0.532	170,718	\$10,125,111	\$82,391,470	\$7,891,101	\$9,142,168	\$1,251,067	16%	78%	90%
010035800	Baptist Hospital of Miami	0.502	237,267	\$20,276,506	\$117,335,182	\$15,655,837	\$12,606,648	\$3,049,189	-19%	77%	62%
010232600	Baptist Medical Center - Beaches	0.594	52,388	\$2,942,140	\$18,022,463	\$2,126,047	\$1,849,738	-\$276,308	-13%	72%	63%
010123100	Baptist Medical Center - Nassau	0.514	43,880	\$2,314,698	\$13,869,558	\$2,511,987	\$1,667,743	-\$844,244	-34%	109%	72%
010064100	Baptist Medical Center Jacksonville	0.739	536,198	\$39,806,019	\$220,262,515	\$30,506,206	\$31,324,514	\$818,308	3%	77%	79%
012041300	Bartow Regional Medical Center	0.622	73,001	\$4,715,928	\$47,085,130	\$1,490,722	\$3,638,496	\$2,147,775	144%	32%	77%
010006400	Bay Med Cntr Sacred Heart Hlth Sys	0.713	125,485	\$8,257,187	\$51,823,043	\$6,720,112	\$7,120,456	\$400,344	6%	81%	86%
010156700	Bayfront Health - St Petersburg	0.587	142,114	\$7,335,967	\$70,697,070	\$4,120,284	\$6,209,795	\$2,089,511	51%	56%	85%
010087100	Bayfront Health Brooksville	0.716	161,238	\$8,468,454	\$149,767,622	\$4,838,633	\$7,999,892	\$3,161,259	65%	57%	94%
010959200	Bayfront Health Dade City	0.567	49,810	\$3,300,668	\$42,208,541	\$2,138,718	\$2,471,722	\$333,004	16%	65%	75%
010028500	Bayfront Health Port Charlotte	0.598	76,766	\$4,035,752	\$54,712,016	\$2,901,587	\$3,451,758	\$550,171	19%	72%	86%
010027700	Bayfront Health Punta Gorda	0.633	25,329	\$1,652,646	\$17,889,855	\$863,339	\$1,094,629	\$231,290	27%	52%	66%
010183400	Bert Fish Medical Center	0.592	52,354	\$4,007,142	\$14,628,049	\$2,622,554	\$2,313,504	-\$309,051	-12%	65%	58%
010140100	Bethesda Hospital East	0.693	159,975	\$11,545,097	\$89,726,400	\$7,652,979	\$9,666,851	\$2,013,872	26%	66%	84%
011021300	Blake Medical Center	0.571	46,661	\$4,053,149	\$34,278,893	\$2,295,377	\$3,176,782	\$881,405	38%	57%	78%
010141900	Boca Raton Regional Hospital	0.720	29,551	\$1,946,688	\$11,614,522	\$1,296,405	\$1,562,706	\$266,302	21%	67%	80%
011807900	Brandon Regional Hospital	0.502	229,309	\$14,893,446	\$234,244,434	\$10,830,503	\$9,459,398	-\$1,371,104	-13%	73%	64%
010271700	Brooks Rehab Hosp	0.636	55,435	\$2,549,588	\$7,698,368	\$2,500,467	\$6,964,408	\$4,463,941	179%	98%	273%
012040500	Broward Health Coral Springs	0.899	161,664	\$10,737,143	\$62,287,205	\$9,057,230	\$11,702,277	\$2,645,047	29%	84%	109%

Provider Medicaid ID	Provider Name	Case Mix	Claim Lines	Cost	Charges	Baseline Payment	Simulated EAPG Payment	Change in Payment	Percent Payment Change	Baseline Pay to Cost Ratio	Simulated Pay to Cost Ratio
010821900	Broward Health Imperial Point	1.061	42,913	\$3,539,006	\$18,000,843	\$2,429,389	\$3,103,446	\$674,057	28%	69%	88%
010012900	Broward Health Medical Center	0.767	374,964	\$26,583,376	\$144,161,741	\$22,250,760	\$27,911,079	\$5,660,319	25%	84%	105%
010021800	Broward Health North	1.115	120,353	\$8,353,464	\$49,430,212	\$6,902,109	\$10,067,240	\$3,165,131	46%	83%	121%
010026900	Calhoun Liberty Hospital	0.327	24,814	\$894,260	\$3,330,376	\$680,526	\$715,594	\$35,068	5%	76%	80%
010194000	Campbellton-Graceville Hospital	0.287	4,186	\$247,785	\$538,226	\$265,021	\$147,811	-\$117,209	-44%	107%	60%
010009900	Cape Canaveral Hospital	0.610	37,592	\$2,675,101	\$17,920,237	\$1,983,655	\$1,728,898	-\$254,757	-13%	74%	65%
011971700	Cape Coral Hospital	0.549	143,610	\$7,434,488	\$52,512,473	\$4,816,075	\$5,910,817	\$1,094,742	23%	65%	80%
011980600	Capital Regional Medical Center	0.559	152,070	\$9,944,907	\$95,414,701	\$7,832,024	\$7,345,548	-\$486,476	-6%	79%	74%
010178800	Central Florida Regional Hospital	0.467	108,035	\$8,224,164	\$91,059,150	\$4,891,919	\$3,769,951	-\$1,121,968	-23%	59%	46%
010219900	Citrus Memorial Hospital	0.513	111,121	\$3,590,961	\$26,368,758	\$4,045,110	\$3,755,325	-\$289,785	-7%	113%	105%
010220200	Cleveland Clinic Hospital	0.686	16,524	\$797,348	\$4,935,362	\$664,579	\$552,182	-\$112,397	-17%	83%	69%
010960600	Coral Gables Hospital	1.029	38,489	\$3,530,600	\$31,977,326	\$2,699,304	\$1,849,133	-\$850,171	-31%	76%	52%
012009000	Delray Medical Center	0.826	24,525	\$2,264,193	\$21,370,421	\$1,539,068	\$1,130,098	-\$408,970	-27%	68%	50%
010192300	Desoto Memorial Hospital	0.510	43,036	\$3,099,693	\$11,730,625	\$3,980,263	\$2,276,595	-\$1,703,668	-43%	128%	73%
010354300	Doctors Hospital	0.874	13,120	\$1,749,109	\$9,410,673	\$1,085,227	\$742,996	-\$342,231	-32%	62%	42%
011995400	Doctors Hospital of Sarasota	0.478	15,404	\$1,301,688	\$12,365,073	\$781,080	\$673,662	-\$107,418	-14%	60%	52%
010103600	Doctors Memorial Hospital	0.450	20,635	\$1,651,325	\$3,653,797	\$1,526,764	\$909,329	-\$617,435	-40%	92%	55%
010180000	Doctors' Memorial Hospital	0.562	33,703	\$1,914,688	\$6,684,838	\$2,103,564	\$1,738,437	-\$365,127	-17%	110%	91%
010004800	Ed Fraser Memorial Hospital	0.500	25,332	\$1,751,758	\$6,988,939	\$1,691,775	\$768,488	-\$923,287	-55%	97%	44%
010259800	Edward White Hospital	0.626	14,559	\$1,572,575	\$16,179,898	\$922,677	\$619,637	-\$303,039	-33%	59%	39%
010253900	Englewood Community Hospital	0.481	12,913	\$1,062,148	\$13,478,588	\$413,854	\$546,860	\$133,006	32%	39%	51%
011746300	Fawcett Memorial Hospital	0.629	28,757	\$2,384,379	\$34,264,360	\$1,395,542	\$1,257,430	-\$138,112	-10%	59%	53%
010120600	Fishermen's Hospital	0.560	11,246	\$951,615	\$3,497,210	\$609,551	\$408,108	-\$201,443	-33%	64%	43%
010171100	Flagler Hospital	0.555	102,744	\$7,144,724	\$38,726,385	\$4,213,849	\$3,705,312	-\$508,537	-12%	59%	52%
010129000	Florida Hospital	0.714	1,194,184	\$90,266,298	\$630,589,339	\$78,510,524	\$66,208,484	-\$12,302,039	-16%	87%	73%
010187700	Florida Hospital DeLand	0.479	119,622	\$9,321,014	\$46,231,383	\$4,937,502	\$4,877,434	-\$60,068	-1%	53%	52%
010182600	Florida Hospital Fish Memorial	0.569	110,381	\$7,944,834	\$45,030,334	\$5,067,864	\$4,847,793	-\$220,071	-4%	64%	61%
010189300	Florida Hospital Flagler	0.564	80,644	\$4,734,544	\$28,989,227	\$3,815,006	\$4,768,351	\$953,346	25%	81%	101%
010186900	Florida Hospital Memorial Med Cntr	0.580	91,034	\$6,737,046	\$37,067,727	\$4,568,344	\$4,392,173	-\$176,171	-4%	68%	65%
010357800	Fort Lauderdale Hospital	0.594	46	\$3,417	\$17,665	\$0	\$622	\$622		0%	18%
011132500	Fort Walton Beach Medical Center	0.537	94,457	\$5,990,057	\$97,094,032	\$2,700,316	\$4,161,413	\$1,461,098	54%	45%	69%

Provider Medicaid ID	Provider Name	Case Mix	Claim Lines	Cost	Charges	Baseline Payment	Simulated EAPG Payment	Change in Payment	Percent Payment Change	Baseline Pay to Cost Ratio	Simulated Pay to Cost Ratio
010080300	George E. Weems Memorial Hospital	0.443	9,337	\$773,061	\$1,484,382	\$673,212	\$430,931	-\$242,281	-36%	87%	56%
010152400	Good Samaritan Medical Center	0.810	83,594	\$7,185,613	\$54,142,233	\$5,110,083	\$4,525,871	-\$584,212	-11%	71%	63%
011134100	Gulf Coast Medical Center Lee Memorial Health System	0.801	101,489	\$7,986,365	\$51,073,567	\$5,192,068	\$4,698,706	-\$493,363	-10%	65%	59%
011761700	Gulf Coast Regional Medical Center	0.612	117,563	\$7,429,334	\$92,858,997	\$5,412,873	\$6,800,947	\$1,388,074	26%	73%	92%
012032400	H Lee Moffitt Cancer Center & Research Institute Hospital	1.601	126,693	\$27,723,863	\$118,798,860	\$14,565,359	\$19,316,748	\$4,751,388	33%	53%	70%
010184200	Halifax Health Medical Center	0.664	196,163	\$18,072,178	\$76,191,958	\$10,118,884	\$12,037,692	\$1,918,808	19%	56%	67%
010135400	Health Central	0.664	111,473	\$7,775,437	\$54,712,155	\$5,989,931	\$5,836,822	-\$153,110	-3%	77%	75%
010188500	Healthmark Regional Medical Center	0.406	29,209	\$1,284,855	\$5,072,890	\$1,146,431	\$984,585	-\$161,846	-14%	89%	77%
010275000	HealthSouth Emerald Coast Rehab Hosp	0.847	6	\$361	\$846	\$222	\$986	\$763	343%	62%	273%
010355100	HealthSouth Rehab Hosp of Spring Hill	1.119	125	\$3,455	\$10,376	\$3,768	\$7,267	\$3,499	93%	109%	210%
012033200	HealthSouth Rehab Hosp of Tallahassee	0.736	231	\$26,404	\$68,275	\$14,577	\$35,431	\$20,854	143%	55%	134%
012042100	HealthSouth Sea Pines Rehab Hosp	0.775	29	\$1,868	\$3,960	\$933	\$3,845	\$2,912	312%	50%	206%
012027800	HealthSouth Sunrise Rehab Hosp	1.336	221	\$10,209	\$25,522	\$6,287	\$29,740	\$23,453	373%	62%	291%
010228800	Heart of Florida Regional Medical Center	0.729	143,660	\$8,743,314	\$131,991,098	\$5,599,854	\$6,913,251	\$1,313,398	23%	64%	79%
010086200	Hendry Regional Medical Center	0.575	47,669	\$4,751,887	\$13,263,749	\$3,082,496	\$2,301,094	-\$781,402	-25%	65%	48%
010041200	Hialeah Hospital	0.923	107,309	\$7,021,726	\$76,493,159	\$4,409,765	\$5,502,865	\$1,093,100	25%	63%	78%
010089700	Highlands Regional Medical Center	0.628	56,409	\$3,909,623	\$36,122,676	\$2,427,020	\$2,371,759	-\$55,261	-2%	62%	61%
010008100	Holmes Regional Medical Center	0.545	136,900	\$10,806,622	\$64,418,998	\$6,661,533	\$6,118,181	-\$543,352	-8%	62%	57%
010018800	Holy Cross Hospital	0.644	65,253	\$4,380,342	\$28,930,665	\$3,410,314	\$2,823,351	-\$586,962	-17%	78%	64%
010226100	Homestead Hospital	0.483	245,707	\$23,964,722	\$122,049,561	\$20,396,849	\$9,589,376	-\$10,807,473	-53%	85%	40%
010104400	Indian River Medical Center	0.507	102,345	\$5,817,195	\$20,928,039	\$5,357,025	\$4,417,089	-\$939,935	-18%	92%	76%
010106100	Jackson Hospital	0.502	65,890	\$3,600,036	\$15,226,380	\$3,234,593	\$3,392,457	\$157,864	5%	90%	94%
010042100	Jackson Memorial Hospital	0.659	690,811	\$83,925,927	\$297,267,789	\$77,087,845	\$53,221,994	-\$23,865,851	-31%	92%	63%
010173700	Jay Hospital	0.329	13,716	\$616,217	\$4,096,073	\$776,553	\$515,692	-\$260,860	-34%	126%	84%
010146000	JFK Medical Center	0.936	119,379	\$10,977,733	\$129,166,252	\$8,257,126	\$6,738,283	-\$1,518,843	-18%	75%	61%
012029400	Jupiter Medical Center	0.866	27,225	\$2,550,808	\$13,442,408	\$1,270,873	\$1,497,656	\$226,783	18%	50%	59%
012013800	Kendall Regional Medical Center	0.699	151,419	\$10,943,266	\$159,772,510	\$7,174,631	\$8,445,901	\$1,271,270	18%	66%	77%
010822700	Lake Butler Hospital	0.409	13,496	\$1,183,982	\$3,734,463	\$1,091,184	\$547,516	-\$543,669	-50%	92%	46%
011976800	Lake City Medical Center	0.593	37,512	\$2,624,769	\$28,049,791	\$1,935,503	\$1,806,275	-\$129,228	-7%	74%	69%

Provider Medicaid ID	Provider Name	Case Mix	Claim Lines	Cost	Charges	Baseline Payment	Simulated EAPG Payment	Change in Payment	Percent Payment Change	Baseline Pay to Cost Ratio	Simulated Pay to Cost Ratio
010166400	Lake Wales Medical Center	0.581	51,270	\$3,324,967	\$37,396,582	\$2,275,527	\$2,660,840	\$385,314	17%	68%	80%
010164800	Lakeland Regional Medical Center	0.752	550,188	\$37,547,161	\$287,662,558	\$23,586,245	\$26,469,628	\$2,883,382	12%	63%	70%
010144300	Lakeside Medical Center	0.492	80,576	\$4,858,191	\$20,621,583	\$4,368,671	\$2,887,568	-\$1,481,104	-34%	90%	59%
010342000	Lakewood Ranch Medical Center	0.552	33,519	\$2,293,331	\$20,786,868	\$1,879,988	\$1,494,758	-\$385,230	-20%	82%	65%
011974100	Largo Medical Center	0.645	58,104	\$4,846,912	\$53,341,071	\$2,807,661	\$2,611,393	-\$196,268	-7%	58%	54%
012005700	Larkin Community Hospital	0.733	17,713	\$2,144,668	\$10,971,292	\$1,082,373	\$1,265,867	\$183,494	17%	50%	59%
011969500	Lawnwood Regional Medical Center & Heart Institute	0.781	148,737	\$8,167,870	\$123,110,815	\$7,097,433	\$8,194,400	\$1,096,967	15%	87%	100%
010110900	Lee Memorial Hospital	0.725	305,782	\$25,561,067	\$162,888,187	\$16,395,917	\$25,199,588	\$8,803,671	54%	64%	99%
010107900	Leesburg Regional Medical Center	0.599	95,570	\$6,234,478	\$37,604,971	\$4,930,200	\$4,095,238	-\$834,962	-17%	79%	66%
010111700	Lehigh Regional Medical Center	0.521	88,158	\$4,834,969	\$59,697,810	\$2,389,802	\$3,799,437	\$1,409,635	59%	49%	79%
010119200	Lower Keys Medical Center	0.622	33,579	\$2,134,786	\$17,018,125	\$1,228,427	\$1,671,628	\$443,201	36%	58%	78%
010115000	Madison County Memorial Hospital	0.365	18,656	\$705,476	\$2,154,411	\$452,071	\$645,238	\$193,167	43%	64%	91%
010116800	Manatee Memorial Hospital	0.583	151,117	\$9,072,012	\$84,965,235	\$6,668,298	\$7,286,800	\$618,502	9%	74%	80%
010121400	Mariners Hospital	0.411	11,466	\$1,548,240	\$5,746,212	\$1,427,406	\$461,701	-\$965,705	-68%	92%	30%
010118400	Martin Medical Center	0.655	188,251	\$13,379,507	\$94,712,747	\$10,990,774	\$10,341,725	-\$649,049	-6%	82%	77%
010072200	Mayo Clinic	1.305	10,821	\$1,035,828	\$4,562,925	\$667,860	\$745,130	\$77,270	12%	64%	72%
012008100	Mease Countryside Hospital	0.682	87,315	\$6,014,945	\$42,197,544	\$3,767,560	\$3,942,043	\$174,483	5%	63%	66%
010154100	Mease Dunedin Hospital	0.537	39,029	\$2,450,426	\$17,835,558	\$1,806,068	\$1,421,042	-\$385,027	-21%	74%	58%
010552000	Medical Center of Trinity	0.535	89,649	\$6,561,912	\$96,470,041	\$2,260,066	\$3,642,721	\$1,382,655	61%	34%	56%
010193100	Memorial Hospital Jacksonville	0.529	135,966	\$11,341,495	\$150,842,214	\$7,313,761	\$6,639,530	-\$674,231	-9%	64%	59%
011279800	Memorial Hospital of Tampa	1.151	9,657	\$1,042,141	\$9,268,365	\$817,764	\$788,557	-\$29,207	-4%	78%	76%
010043900	Mercy Hospital	1.432	1,766	\$387,770	\$1,970,434	\$145,006	\$174,267	\$29,261	20%	37%	45%
010054400	Metropolitan Hospital Miami	1.155	28,191	\$1,456,960	\$10,461,528	\$1,156,446	\$1,182,191	\$25,745	2%	79%	81%
010158300	Morton Plant Hospital	0.626	163,034	\$10,803,280	\$69,713,789	\$7,663,448	\$8,270,786	\$607,338	8%	71%	77%
010150800	Morton Plant North Bay Hospital	0.608	73,562	\$4,923,278	\$37,650,293	\$3,584,987	\$2,891,407	-\$693,580	-19%	73%	59%
010046300	Mount Sinai Medical Center	0.907	103,874	\$9,406,128	\$66,353,028	\$8,354,008	\$6,858,785	-\$1,495,223	-18%	89%	73%
010117600	Munroe Regional Medical Center	0.566	192,534	\$11,393,279	\$86,819,142	\$9,110,059	\$12,131,799	\$3,021,740	33%	80%	106%
010031500	Naples Community Hospital	0.615	136,526	\$9,991,530	\$58,538,427	\$6,570,521	\$8,795,165	\$2,224,644	34%	66%	88%
004087600	Nemours Children's Hospital	0.719	92,551	\$42,281,494	\$70,808,913	\$14,960,329	\$11,895,244	-\$3,065,086	-20%	35%	28%
010060900	Nicklaus Children's Hospital	0.648	592,011	\$78,423,750	\$351,278,606	\$88,823,353	\$88,299,410	-\$523,943	-1%	113%	113%
010862600	North Florida Regional Medical Center	0.988	107,612	\$9,744,190	\$126,349,511	\$6,319,650	\$5,382,199	-\$937,451	-15%	65%	55%

Provider Medicaid ID	Provider Name	Case Mix	Claim Lines	Cost	Charges	Baseline Payment	Simulated EAPG Payment	Change in Payment	Percent Payment Change	Baseline Pay to Cost Ratio	Simulated Pay to Cost Ratio
010126500	North Okaloosa Medical Center	1.001	76,548	\$4,548,029	\$76,821,425	\$4,047,548	\$5,780,527	\$1,732,980	43%	89%	127%
010049800	North Shore Medical Center	0.619	233,030	\$16,712,762	\$162,142,388	\$7,203,490	\$9,619,618	\$2,416,128	34%	43%	58%
011519300	Northside Hospital	0.520	39,984	\$3,368,510	\$47,099,054	\$1,770,694	\$1,484,985	-\$285,709	-16%	53%	44%
010459100	Northwest Medical Center	0.693	101,728	\$5,449,400	\$70,933,584	\$3,413,834	\$4,396,853	\$983,019	29%	63%	81%
012007300	Oak Hill Hospital	0.605	70,761	\$4,513,819	\$71,570,185	\$2,687,042	\$2,718,704	\$31,662	1%	60%	60%
010828800	Ocala Behavioral Health, LLC	0.598	1	\$73	\$375	\$0	\$0	\$0		0%	0%
010988600	Ocala Regional Medical Center	0.666	116,463	\$8,015,464	\$89,335,733	\$3,553,401	\$5,533,213	\$1,979,812	56%	44%	69%
011174100	Orange Park Medical Center	0.555	100,709	\$8,179,012	\$123,157,408	\$5,678,737	\$5,266,186	-\$412,551	-7%	69%	64%
010133800	Orlando Health	0.968	602,415	\$55,168,533	\$404,007,866	\$48,154,393	\$60,389,460	\$12,235,066	25%	87%	109%
010138900	Osceola Regional Medical Center	0.525	171,274	\$14,215,557	\$215,632,657	\$9,149,541	\$7,389,484	-\$1,760,056	-19%	64%	52%
003297500	Palm Bay Hospital	0.519	76,045	\$5,321,389	\$36,056,939	\$3,205,891	\$3,071,064	-\$134,827	-4%	60%	58%
010210500	Palm Beach Gardens Medical Center	0.892	31,620	\$2,339,980	\$17,449,170	\$1,636,808	\$1,247,699	-\$389,109	-24%	70%	53%
010053600	Palm Springs General Hospital	1.048	35,600	\$1,755,964	\$11,066,610	\$818,363	\$1,316,350	\$497,987	61%	47%	75%
010460400	Palmetto General Hospital	0.690	162,706	\$13,212,058	\$108,007,430	\$8,339,323	\$8,522,570	\$183,247	2%	63%	65%
012011100	Palms of Pasadena Hospital	0.741	8,253	\$632,868	\$7,513,410	\$488,550	\$355,727	-\$132,823	-27%	77%	56%
012026000	Palms West Hospital	0.730	98,927	\$8,227,147	\$83,847,693	\$5,257,927	\$7,490,155	\$2,232,228	42%	64%	91%
010010200	Parrish Medical Center	0.527	95,060	\$8,589,228	\$41,177,978	\$5,217,271	\$4,774,746	-\$442,525	-8%	61%	56%
010314400	Physicians Regional Medical Center - Pine Ridge	0.667	71,419	\$5,589,096	\$55,062,176	\$2,862,019	\$3,576,135	\$714,116	25%	51%	64%
012000600	Plantation General Hospital	0.937	255,972	\$17,950,796	\$211,364,196	\$11,557,311	\$16,630,581	\$5,073,270	44%	64%	93%
009268300	Poinciana Medical Center	0.410	61,361	\$6,039,772	\$71,440,784	\$5,635,219	\$1,988,646	-\$3,646,573	-65%	93%	33%
004805200	Port St Lucie Hosp, Inc	0.730	5	\$404	\$2,090	\$0	\$232	\$232		0%	57%
011351400	Putnam Community Medical Center	0.606	86,413	\$5,525,245	\$36,230,843	\$5,744,403	\$5,728,779	-\$15,623	0%	104%	104%
011975000	Raulerson Hospital	0.722	67,560	\$4,017,575	\$42,330,341	\$4,069,839	\$3,867,417	-\$202,422	-5%	101%	96%
010114100	Regional General Hospital Williston	0.469	16,494	\$495,051	\$2,493,555	\$459,147	\$503,239	\$44,091	10%	93%	102%
011988100	Regional Med Cntr Bayonet Point	0.566	60,018	\$4,756,482	\$63,966,018	\$2,831,153	\$2,350,369	-\$480,784	-17%	60%	49%
010076500	Sacred Heart Hospital	0.606	338,038	\$36,980,211	\$131,150,317	\$25,618,778	\$18,394,291	-\$7,224,486	-28%	69%	50%
010323300	Sacred Heart Hosp on the Emerald Coast	0.632	44,009	\$3,706,914	\$24,508,655	\$3,625,691	\$2,799,766	-\$825,925	-23%	98%	76%
002012700	Sacred Heart Hospital on the Gulf	0.457	11,065	\$2,060,514	\$4,418,789	\$1,793,376	\$544,440	-\$1,248,936	-70%	87%	26%
010174500	Santa Rosa Medical Center	0.607	88,219	\$5,009,940	\$53,568,733	\$4,018,887	\$3,929,812	-\$89,075	-2%	80%	78%
010176100	Sarasota Memorial Hospital	0.683	165,995	\$14,797,366	\$85,054,209	\$9,499,462	\$10,135,459	\$635,997	7%	64%	68%

Provider Medicaid ID	Provider Name	Case Mix	Claim Lines	Cost	Charges	Baseline Payment	Simulated EAPG Payment	Change in Payment	Percent Payment Change	Baseline Pay to Cost Ratio	Simulated Pay to Cost Ratio
012001400	Sebastian River Medical Center	0.569	26,725	\$2,398,342	\$27,528,135	\$1,041,866	\$1,269,459	\$227,592	22%	43%	53%
011998900	Seven Rivers Regional Med Cntr	0.585	49,689	\$3,088,505	\$35,548,477	\$2,016,386	\$2,059,120	\$42,735	2%	65%	67%
010033100	Shands Lake Shore Rgnl Med Cntr	0.550	110,740	\$5,438,391	\$39,314,660	\$6,455,985	\$4,782,293	-\$1,673,691	-26%	119%	88%
010179600	Shands Live Oak Rgnl Med Cntr	0.461	63,146	\$2,726,914	\$18,443,004	\$2,694,304	\$2,339,364	-\$354,940	-13%	99%	86%
010007200	Shands Starke Rgnl Med Cntr	0.496	59,157	\$3,196,070	\$17,753,886	\$3,042,196	\$2,405,430	-\$636,767	-21%	95%	75%
002576600	Shriners Hospital for Children-Tampa	0.482	7,759	\$883,093	\$4,250,378	\$2,610,092	\$1,174,955	-\$1,435,137	-55%	296%	133%
011994600	South Bay Hospital	0.493	26,460	\$1,709,450	\$25,008,948	\$1,270,600	\$1,039,951	-\$230,648	-18%	74%	61%
010098600	South Florida Baptist Hospital	0.639	92,741	\$7,121,048	\$48,231,254	\$4,007,684	\$5,847,633	\$1,839,949	46%	56%	82%
010108700	South Lake Hospital	0.839	86,327	\$5,198,025	\$42,154,898	\$4,042,547	\$5,538,317	\$1,495,770	37%	78%	107%
010058700	South Miami Hospital	0.603	81,517	\$10,568,032	\$49,323,926	\$4,789,320	\$5,945,715	\$1,156,395	24%	45%	56%
004819100	Springbrook Hosp, Inc	0.763	4	\$1,298	\$6,710	\$0	\$0	\$0		0%	0%
012022700	St Anthonys Hospital	0.901	83,453	\$6,081,622	\$45,698,812	\$5,023,110	\$5,444,137	\$421,027	8%	83%	90%
010346200	St Cloud Regional Medical Center	0.606	59,187	\$4,089,373	\$31,609,583	\$2,482,757	\$2,301,739	-\$181,019	-7%	61%	56%
010148600	St Mary's Medical Center	0.616	194,398	\$16,912,143	\$120,576,900	\$10,873,864	\$11,828,684	\$954,820	9%	64%	70%
010240700	St. Anthony's Rehab Hosp	0.726	44	\$2,140	\$5,103	\$407	\$2,063	\$1,656	407%	19%	96%
010097800	St. Josephs Hospital	0.632	508,632	\$45,545,624	\$266,844,627	\$35,248,028	\$30,524,508	-\$4,723,520	-13%	77%	67%
012010300	St. Petersburg General Hospital	0.650	60,391	\$5,882,152	\$84,267,441	\$3,618,671	\$3,280,264	-\$338,407	-9%	62%	56%
009701300	St. Vincent's Hosp - Clay County	0.542	16,187	\$1,789,661	\$9,074,437	\$1,098,264	\$743,766	-\$354,498	-32%	61%	42%
010073100	St. Vincent's Medical Center Riverside	0.657	120,130	\$9,595,241	\$66,756,206	\$4,591,875	\$6,675,327	\$2,083,452	45%	48%	70%
010373000	St. Vincent's Med Cntr Southside	0.991	43,568	\$3,688,874	\$27,079,286	\$1,807,532	\$2,767,554	\$960,022	53%	49%	75%
012002200	St.Catherine's Rehab Hosp	0.726	32	\$1,524	\$2,889	\$465	\$2,345	\$1,880	404%	31%	154%
011997100	St.Lucie Medical Center	0.694	54,926	\$3,287,394	\$44,230,277	\$2,735,945	\$2,683,308	-\$52,637	-2%	83%	82%
010113300	Tallahassee Memorial Hospital	0.860	148,280	\$15,980,764	\$76,407,688	\$10,476,678	\$10,979,857	\$503,179	5%	66%	69%
011984900	Tampa Community Hospital	0.494	28,942	\$2,440,785	\$24,200,913	\$1,426,494	\$1,259,213	-\$167,281	-12%	58%	52%
010099400	Tampa General Hospital	1.045	325,492	\$27,568,528	\$237,746,528	\$27,545,430	\$24,859,408	-\$2,686,022	-10%	100%	90%
010317900	The Villages Regional Hospital	0.700	30,612	\$2,049,516	\$13,887,686	\$1,119,434	\$1,501,254	\$381,821	34%	55%	73%
010125700	Twin Cities Hospital	0.574	22,129	\$1,581,546	\$19,903,237	\$1,031,707	\$847,536	-\$184,171	-18%	65%	54%
011280100	University Hospital and Med Cntr	0.614	45,008	\$2,676,046	\$35,698,938	\$1,718,086	\$1,736,029	\$17,944	1%	64%	65%
010036600	University of Miami Hospital	1.486	64,126	\$7,738,833	\$61,483,746	\$5,535,678	\$7,865,965	\$2,330,286	42%	72%	102%
010047100	Univ of Miami Hospital and Clinics	1.427	161,519	\$30,631,101	\$166,267,927	\$18,314,781	\$19,935,141	\$1,620,360	9%	60%	65%
011973300	Venice Regional Bayfront Health	0.607	22,560	\$1,632,656	\$16,985,922	\$830,950	\$1,151,311	\$320,360	39%	51%	71%

Provider Medicaid ID	Provider Name	Case Mix	Claim Lines	Cost	Charges	Baseline Payment	Simulated EAPG Payment	Change in Payment	Percent Payment Change	Baseline Pay to Cost Ratio	Simulated Pay to Cost Ratio
003158800	Viera Hospital	0.663	14,041	\$1,589,828	\$7,857,049	\$1,038,480	\$742,471	-\$296,008	-29%	65%	47%
008589300	Wekiva Springs Center LLC	0.598	43	\$4,928	\$25,475	\$0	\$0	\$0		0%	0%
010213000	Wellington Regional Medical Center	0.649	77,549	\$4,396,628	\$40,362,092	\$4,255,029	\$3,645,079	-\$609,950	-14%	97%	83%
012024300	West Boca Medical Center	0.715	69,372	\$5,468,575	\$30,555,401	\$4,282,386	\$3,962,803	-\$319,582	-7%	78%	72%
011321200	West Florida Hospital	0.671	71,787	\$5,252,325	\$52,779,807	\$2,827,182	\$3,748,348	\$921,166	33%	54%	71%
010170200	West Gables Rehab Hosp	0.985	62	\$4,350	\$8,013	\$901	\$2,294	\$1,394	155%	21%	53%
003226500	West Kendall Baptist Hospital	0.587	98,689	\$9,966,612	\$53,360,047	\$8,282,330	\$3,908,718	-\$4,373,612	-53%	83%	39%
012030800	West Palm Hospital	0.862	29,533	\$2,928,551	\$32,108,955	\$1,022,608	\$1,807,835	\$785,227	77%	35%	62%
010062500	Westchester General Hospital	1.376	21,827	\$1,367,479	\$7,740,980	\$1,463,960	\$1,059,672	-\$404,287	-28%	107%	77%
011230500	Westside Regional Medical Center	0.682	42,444	\$2,383,503	\$29,088,452	\$1,210,036	\$1,778,719	\$568,683	47%	51%	75%
010169900	Winter Haven Hospital	0.583	142,257	\$11,576,396	\$76,888,387	\$6,361,737	\$5,748,257	-\$613,481	-10%	55%	50%
010320900	Wuesthoff Medical Center-Melbourne	0.878	57,193	\$4,313,495	\$51,090,764	\$2,367,321	\$3,207,069	\$839,747	35%	55%	74%
010011100	Wuesthoff Medical Center-Rockledge	0.615	130,478	\$8,134,972	\$92,698,261	\$4,725,023	\$5,534,466	\$809,443	17%	58%	68%
Total		0.706	19,277,857	\$1,625,103,346	\$11,546,618,523	\$1,216,297,592	\$1,217,850,024	\$1,552,432	0%	75%	75%

19 Appendix C – ASC Specific Payment Estimates from EAPG Pricing Simulations

The table in this section shows historical and simulated outpatient payments for each Ambulatory Surgical Center, both in and out of state. As mentioned previously, the numbers presented in this table are from SFY 2013/14 FFS and Medicaid managed care claim data re-priced using SFY 2015/16 FFS rates to determine the baseline amounts.

Table 10. Comparison of legacy payment to OPPS payment for each Ambulatory Surgical Center.

Provider Medicaid ID	Provider Name	Provider Type	Case Mix	Claim Lines	Charges	Baseline Payment	Simulated EAPG Payment	Change in Payment	Percent Payment Change
001768100	Advanced Surgery Center of Palm Beach	06	1.358	248	\$857,818	\$64,519	\$72,332	\$7,813	12%
075718700	Aesculapian Surgery Center LLC	06	2.759	195	\$178,640	\$114,024	\$92,322	-\$21,702	-19%
075317300	Aker Kasten Vision & Laser Center	06	2.816	1	\$1,435	\$995	\$785	-\$210	-21%
009386900	Alamarcon Holdings LLC	06	5.303	6	\$23,857	\$3,864	\$4,437	\$573	15%
014293800	Alliance Surgical Center LLC	06	1.139	2	\$12,705	\$666	\$635	-\$31	-5%
079080000	Alpha Ambulatory Surgery	06	1.901	6	\$2,650	\$1,095	\$1,060	-\$35	-3%
079077000	Ambulatory Ankle & Foot Ctr of FL.	06	3.754	277	\$966,768	\$144,990	\$162,285	\$17,295	12%
062927800	Ambulatory Surgery Center Group	06	1.699	318	\$1,487,780	\$119,924	\$126,967	\$7,043	6%
079072900	Ambulatory Surgical Care	06	2.286	43	\$38,746	\$13,583	\$16,575	\$2,992	22%
062936700	American Surgery Center	06	2.962	26	\$53,647	\$20,700	\$18,996	-\$1,704	-8%
079048600	Andre J. Golino, MD & Associates,PA	06	2.816	1	\$3,200	\$995	\$785	-\$210	-21%
076921500	Andrews Institute ASC, LLC	06	3.930	39	\$206,560	\$24,341	\$21,917	-\$2,423	-10%
009285500	Apollo Anesthesia, PA	06	0.075	34	\$29,165	\$0	\$688	\$688	
000934600	Apollo Surgery Center	06	5.065	9	\$27,176	\$4,664	\$5,650	\$986	21%
000875400	Apollo Surgery Center LLC	06	4.946	31	\$74,599	\$18,883	\$23,451	\$4,568	24%
001680900	Armenia Ambulatory Surgery Center, LLC	06	1.906	225	\$469,191	\$51,534	\$79,179	\$27,645	54%
006574700	Atlantic Surgery Center Inc	06	4.176	12	\$9,190	\$8,630	\$12,809	\$4,179	48%
070620500	Baptist Medical Park Surgery Cntr	06	2.200	127	\$312,519	\$48,927	\$48,476	-\$450	-1%
079217900	Baptist Medical Services Corp	06	3.967	136	\$702,024	\$118,496	\$125,010	\$6,514	5%
000788200	Baptist Surgery and Endoscopy Centers LLC	06	1.208	60	\$182,788	\$18,981	\$18,534	-\$447	-2%
003879600	Baptist Surgery and Endoscopy Centers LLC	06	1.777	4	\$8,039	\$1,188	\$1,486	\$299	25%
076159100	Baptist Surgery and Endoscopy Centers, LLC	06	3.714	261	\$1,046,691	\$191,007	\$194,711	\$3,704	2%
009512000	Bardmoor Surgery Center, LLC	06	2.258	7	\$15,467	\$2,043	\$2,519	\$476	23%

Provider Medicaid ID	Provider Name	Provider Type	Case Mix	Claim Lines	Charges	Baseline Payment	Simulated EAPG Payment	Change in Payment	Percent Payment Change
079135100	Barkley Surgicenter	06	1.613	2,528	\$1,536,113	\$327,330	\$371,216	\$43,886	13%
079148200	Bay Area Endoscopy Center	06	1.196	549	\$331,052	\$97,319	\$96,400	-\$919	-1%
076889800	Bay Area Physicians Surgery Center	06	2.115	58	\$146,982	\$22,613	\$20,640	-\$1,973	-9%
010795400	Bay Area Physicians Surgery Center	06	2.503	22	\$63,382	\$11,554	\$9,772	-\$1,782	-15%
062935900	Bay Eye & Surgical Cntr.	06	2.118	50	\$43,216	\$29,769	\$28,942	-\$827	-3%
075404800	Bayfront Same Day Surgery Ctr, LLC	06	2.264	456	\$2,451,444	\$199,074	\$191,977	-\$7,096	-4%
075882500	Bayonet Point Surgery Center Ltd	06	2.496	282	\$1,567,245	\$151,504	\$151,059	-\$445	0%
004613100	Bayside Ambulatory Center, LLC	06	2.278	444	\$2,189,207	\$198,931	\$207,772	\$8,841	4%
079061300	Belleair Surgi-Center	06	2.249	175	\$864,721	\$71,711	\$75,903	\$4,192	6%
079208000	Beraja Healthcare Corporation	06	2.600	420	\$593,157	\$292,207	\$263,904	-\$28,302	-10%
002327900	Bethesda Outpatient Surgery Center, LLC	06	3.153	558	\$2,575,368	\$372,520	\$328,881	-\$43,638	-12%
079215200	Bethesda Outpatient Surgery Ctr LLC	06	3.322	20	\$93,399	\$14,719	\$12,970	-\$1,749	-12%
079097400	Boca Raton Out Pt. Surg & Laser Ctr	06	1.923	45	\$164,746	\$21,467	\$18,773	-\$2,694	-13%
075967800	Bonita Community Health Center, Inc	06	2.222	3	\$12,144	\$1,793	\$1,239	-\$553	-31%
075890600	Boynton Beach ASC LLC	06	2.354	47	\$104,841	\$34,545	\$29,546	-\$4,999	-14%
079233100	Bradenton Endoscopy Center	06	1.156	3	\$895	\$333	\$322	-\$11	-3%
009605300	Brandon Ambulatory Surgery Center	06	2.610	47	\$174,745	\$38,146	\$30,567	-\$7,579	-20%
076015300	Brandon Ambulatory Surgery Center	06	2.899	36	\$126,374	\$27,069	\$23,443	-\$3,626	-13%
076908800	Brandon Ambulatory Surgery Center	06	2.900	30	\$127,070	\$28,604	\$24,266	-\$4,337	-15%
010667300	Brandon Ambulatory Surgery Center	06	2.667	27	\$105,045	\$22,131	\$17,108	-\$5,023	-23%
079085100	Brandon Surgi Center	06	1.992	608	\$3,127,787	\$273,980	\$282,751	\$8,772	3%
010300500	Brevard Surgery Center	06	2.062	8	\$7,543	\$3,529	\$4,026	\$497	14%
079180600	Brevard Surgery Center	06	2.847	7	\$9,735	\$6,414	\$5,557	-\$857	-13%
009012800	BVL Pediatrics	06	0.217	6,256	\$787,462	\$0	\$237,233	\$237,233	
076184200	Cape Coral Ambulatory Surgery, LLC	06	3.912	47	\$290,268	\$36,714	\$29,454	-\$7,260	-20%
079051600	Cape Coral Eye Center, Pa	06	2.512	40	\$50,015	\$29,533	\$23,822	-\$5,710	-19%
076826000	Capital City Surgical Center LLC	06	1.352	231	\$537,000	\$63,609	\$62,580	-\$1,029	-2%
010857300	Capital Surgical Associates	06	0.352	1	\$83	\$0	\$98	\$98	
001037300	Carillon Surgery Center LLC	06	3.064	33	\$92,489	\$25,306	\$21,365	-\$3,941	-16%
014069600	Center For Endoscopy Inc	06	1.765	7	\$4,416	\$833	\$984	\$152	18%
076109500	Central FL Endo & Surg Inst of Ocal	06	1.844	1,419	\$1,572,989	\$315,404	\$418,663	\$103,259	33%

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079143100	Central FL. Eye Assoc Asc	06	2.783	270	\$1,247,247	\$172,550	\$163,761	-\$8,789	-5%
008676300	Central Florida Heart Care	06	0.299	66	\$11,087	\$0	\$4,670	\$4,670	
009238100	Central Florida Internal, Occupational & Environme	06	0.240	17	\$2,056	\$0	\$1,136	\$1,136	
075366100	Charlotte Endoscopic Surgery Ctr	06	1.328	41	\$71,313	\$12,850	\$12,957	\$107	1%
002965700	Childrens Surgery Center LLC	06	3.055	1,381	\$3,497,570	\$782,879	\$684,913	-\$97,966	-13%
079140700	Citrus Regional Surgery Center, LP	06	3.519	266	\$1,305,872	\$184,750	\$174,704	-\$10,046	-5%
079242000	Citrus Urology Center, Inc	06	2.414	31	\$30,175	\$12,071	\$15,486	\$3,415	28%
003516500	Clermont Ambulatory Surgical Center	06	2.590	63	\$128,689	\$30,068	\$26,001	-\$4,068	-14%
010060700	C-Med Ambulatory Surgery Center	06	1.747	34	\$46,166	\$4,388	\$6,822	\$2,434	55%
075218500	Coastal Medical Center LLC	06	2.134	3	\$1,000	\$717	\$595	-\$122	-17%
062949900	Columbia Eye & Spec Surg Ctr, Ltd	06	2.814	48	\$278,068	\$47,760	\$37,666	-\$10,094	-21%
079045100	Columbia Same Day Surgicenter-Orlan	06	3.256	413	\$4,191,946	\$318,429	\$315,989	-\$2,440	-1%
075439100	Coral Gables Surgery Center	06	2.814	145	\$737,421	\$120,457	\$97,298	-\$23,158	-19%
070313300	Coral Springs Ambulatory Surgery Ct	06	1.811	110	\$345,064	\$43,332	\$50,501	\$7,169	17%
079087700	Coral View Surgery Center	06	1.873	867	\$792,655	\$372,870	\$388,159	\$15,289	4%
079046000	Cordova Ambulatory Surgical Center	06	2.412	284	\$253,180	\$56,646	\$100,885	\$44,240	78%
079131800	Countryside Surgery Center, Ltd	06	4.362	64	\$480,833	\$53,782	\$55,963	\$2,181	4%
002230900	David W Nussear	06	0.074	1	\$1,050	\$0	\$21	\$21	
076096000	Delray Ambulatory Surgical & Laser	06	2.816	1	\$12,000	\$995	\$785	-\$210	-21%
001746600	Delray Anesthesia Services, LLC	06	0.074	43	\$31,968	\$0	\$883	\$883	
075230400	Destin Surgery Center Ltd	06	2.215	14	\$73,516	\$8,963	\$7,412	-\$1,551	-17%
075356400	Digestive & Liver Ctr of Melbourne	06	1.266	30	\$66,700	\$8,875	\$8,829	-\$45	-1%
010062100	Doctors Choice Medical Center	06	0.232	669	\$91	\$0	\$40,612	\$40,612	
075479000	Doctors Gi Partnership, Ltd	06	1.484	34	\$109,083	\$9,740	\$10,347	\$607	6%
070793700	Doctors Outpatient Surg. Cntr/Jupit	06	4.324	462	\$942,190	\$298,295	\$267,698	-\$30,597	-10%
076033100	Doctors Outpatient Surgery Center	06	2.223	7	\$14,881	\$4,810	\$4,339	-\$471	-10%
011908000	Doctors Outpatient Surgery Center of Jupiter, LLC	06	3.040	30	\$58,600	\$23,846	\$21,194	-\$2,652	-11%
079212800	Doctors Same Day Surgery Center, Ltd	06	3.106	97	\$498,759	\$58,234	\$58,044	-\$190	0%
079108300	Doctors Surgery Center	06	1.975	414	\$355,267	\$200,726	\$205,974	\$5,248	3%
070375300	Doctor's Surgical Partnership	06	3.450	283	\$692,732	\$177,940	\$179,899	\$1,959	1%
079044300	Dothan Surgery Center, LLC	06	2.951	3	\$3,800	\$2,320	\$2,469	\$149	6%

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002689600	E Street Endoscopy,LLC	06	1.408	159	\$388,253	\$46,447	\$47,103	\$656	1%
079142300	Emerald Coast Surgery Center, LP	06	3.032	163	\$855,436	\$115,195	\$103,149	-\$12,046	-10%
000564100	Endoscopy Center of Ocala, Inc	06	1.437	3	\$1,650	\$833	\$801	-\$31	-4%
070908500	Endosurg Outpatient Center	06	1.688	147	\$90,727	\$42,980	\$48,488	\$5,508	13%
005791600	Endosurg Outpatient Center	06	1.480	32	\$21,426	\$10,650	\$10,733	\$83	1%
004843600	Endo-Surgical Center of Florida, LLC	06	1.224	782	\$873,230	\$243,440	\$242,011	-\$1,429	-1%
004226100	Eye Care and Surgery Center of Ft Lauderdale, LLC	06	2.705	41	\$94,575	\$36,670	\$30,179	-\$6,491	-18%
070413000	Eye Center of North Florida, Pa	06	2.908	48	\$63,798	\$43,923	\$37,298	-\$6,624	-15%
004801300	Eye Physicians of Pinellas, Ph	06	2.950	179	\$252,516	\$137,243	\$128,354	-\$8,889	-6%
003297700	Eye Specialists Laser & Surgery Center Inc.	06	2.600	44	\$95,840	\$38,209	\$31,908	-\$6,301	-16%
001031700	Eye Surgery Center of North Florida, LLC	06	4.217	2	\$3,450	\$1,408	\$1,176	-\$232	-16%
001865700	Feinerman Anesthesia, PA	06	0.081	118	\$94,450	\$0	\$2,632	\$2,632	
079119900	Filutowski Eye Institute	06	0.751	163	\$73,385	\$25,701	\$25,965	\$264	1%
076860000	Filutowski Eye Institute Pa	06	2.792	18	\$32,622	\$17,545	\$14,017	-\$3,528	-20%
009287400	First Priority Anesthesia LLC	06	0.074	12	\$2,088	\$0	\$246	\$246	
076646100	Fleming Island Surgery Center, LLC	06	2.513	161	\$368,321	\$100,836	\$99,518	-\$1,318	-1%
009588500	Florida Endoscopy & Surgery Center LLC	06	0.074	9	\$4,275	\$0	\$185	\$185	
070553500	Florida Endoscopy/Surgery Center,LI	06	1.588	104	\$145,300	\$32,106	\$32,775	\$669	2%
062926000	Florida Eye Clinic	06	0.986	2	\$2,000	\$0	\$550	\$550	
079122900	Florida Eye Institute Surgicenter	06	1.352	5	\$3,080	\$995	\$1,885	\$890	89%
075623700	Florida Medical Clinic-Ambulatory	06	2.816	1	\$1,716	\$995	\$785	-\$210	-21%
075261400	Florida Ortho Inst. Surgery Ctr,LLC	06	2.686	16	\$78,498	\$8,512	\$5,993	-\$2,519	-30%
009622700	Florida Outpatient Surgery Center Ltd	06	1.749	90	\$412,152	\$33,239	\$37,067	\$3,828	12%
079084200	Florida Outpatient Surgery Ctr, Ltd	06	1.139	2	\$7,219	\$666	\$635	-\$31	-5%
372900101	FMC Special Proc.	06	1.709	18	\$13,883	\$5,727	\$4,767	-\$959	-17%
002383900	Ft Myers Endoscopy Center, LLC	06	1.507	142	\$179,390	\$39,099	\$43,277	\$4,179	11%
075183900	Ft. Myers Digestive Health and Pain	06	1.251	1	\$1,300	\$333	\$349	\$16	5%
005493800	Gables Surgical Center	06	3.665	25	\$64,192	\$6,921	\$7,154	\$233	3%
075474900	Grove Place Surgery Center LLC	06	2.151	62	\$78,300	\$20,455	\$30,600	\$10,145	50%
070712100	Gulf Coast Endoscopy Center South	06	1.837	53	\$82,935	\$13,139	\$14,858	\$1,719	13%
075825600	Gulf Coast Surgery Center Inc	06	7.515	4	\$29,924	\$826	\$4,192	\$3,366	407%

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003213900	Hernando Hma, LLC	06	1.465	181	\$250,584	\$58,100	\$58,028	-\$72	0%
003342200	Hillmoor Eye Surgery Center, LLC	06	2.212	88	\$137,269	\$57,658	\$51,806	-\$5,851	-10%
076705100	Hospital Corporation of America	06	3.525	648	\$3,746,257	\$428,024	\$480,733	\$52,709	12%
004259500	Hsc Gamma Partners	06	3.258	17	\$56,242	\$5,727	\$5,452	-\$275	-5%
009288500	Independent Anesthesia Services PA	06	0.074	5	\$3,990	\$0	\$103	\$103	
079172500	Indian River Surgery Center, Ltd	06	2.133	51	\$128,352	\$25,194	\$27,959	\$2,765	11%
076124900	Interventional Therapeutics Institu	06	1.849	115	\$288,127	\$17,588	\$31,457	\$13,869	79%
076593700	Jacksonville Ctr for Endoscopy	06	1.329	281	\$220,508	\$84,059	\$85,591	\$1,532	2%
076592900	Jacksonville Ctr for Endoscopy	06	1.296	277	\$218,365	\$84,435	\$85,655	\$1,220	1%
079187300	Jacksonville Surgery Center	06	3.691	51	\$357,024	\$49,780	\$48,384	-\$1,396	-3%
010092500	James D Davenport MD PA	06	15.910	9	\$4,072	\$655	\$4,437	\$3,782	577%
075208800	Jupiter Outpatient Surg.Ctr.LLC	06	2.971	11	\$37,460	\$7,169	\$8,286	\$1,117	16%
003191300	Key Biscayne Surgery Center	06	2.801	45	\$131,400	\$21,585	\$24,219	\$2,634	12%
079060500	Kissimmee Surgicare, Ltd	06	2.090	271	\$1,751,956	\$130,016	\$133,481	\$3,466	3%
000268900	KZMss Again, LLLP	06	2.853	39	\$138,990	\$34,980	\$30,237	-\$4,743	-14%
010931500	KZMSS Again, LLLP	06	3.313	5	\$28,865	\$4,775	\$4,620	-\$155	-3%
000852900	Lake City Surgery Center	06	1.488	136	\$118,816	\$49,151	\$48,136	-\$1,015	-2%
076874000	Lake Mary Surgery Center LLC	06	2.992	58	\$185,155	\$29,158	\$35,879	\$6,722	23%
005495600	Lake Mary Surgical Center	06	2.418	23	\$30,217	\$18,410	\$15,508	-\$2,902	-16%
079209800	Lake Surgery & Endoscopy Ctr	06	1.003	171	\$85,306	\$38,651	\$43,341	\$4,690	12%
079223300	Lakeland Surgical Diagnostic Ctr	06	4.686	20	\$75,050	\$13,966	\$16,989	\$3,024	22%
076650000	Laser and Outpatient Surgery Center	06	3.044	46	\$134,524	\$24,923	\$21,225	-\$3,698	-15%
062967700	Lee Island Coast Surgery Center	06	3.451	9	\$39,661	\$6,982	\$7,700	\$718	10%
075390400	Live Oak Endoscopy Center, LLC	06	1.156	4	\$4,250	\$1,137	\$967	-\$169	-15%
076167200	Manatee Surgical Center Inc	06	0.534	151	\$366,800	\$69,087	\$22,498	-\$46,589	-67%
062953700	Manatee Surgicare, Ltd.	06	2.776	42	\$223,182	\$34,866	\$27,872	-\$6,994	-20%
009238200	Marinas Medical Center, LLC	06	0.230	1,504	\$179,240	\$0	\$56,734	\$56,734	
002028900	Mayo Clinic	06	0.484	73	\$53,273	\$1,998	\$5,801	\$3,803	190%
079081800	Med Cntr Surgery Assoc., LP	06	5.272	1,150	\$2,039,395	\$721,784	\$676,336	-\$45,448	-6%
079214400	Melbourne Surgery Center LP	06	3.504	165	\$832,676	\$109,190	\$97,731	-\$11,459	-10%
062943000	Memorial Same-Day Surgery	06	2.415	331	\$796,821	\$172,179	\$167,000	-\$5,178	-3%

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076464700	Merritt Island ASC, LLC	06	2.946	26	\$56,430	\$15,363	\$12,323	-\$3,040	-20%
079042700	Miami Eye Center, Inc	06	1.578	3	\$49	\$350	\$440	\$90	26%
079247100	Miami Hand Center, Inc	06	3.225	4	\$11,900	\$2,576	\$2,698	\$122	5%
003044100	Miami Kendall FL Endoscopy ASC,LLC	06	2.373	2	\$3,040	\$500	\$662	\$162	33%
076476100	Miami Lakes Surgery Center, Ltd	06	3.058	165	\$1,077,124	\$106,367	\$107,463	\$1,096	1%
005505000	Miami Lakes Surgery Ctr	06	2.151	122	\$634,499	\$33,763	\$38,987	\$5,224	15%
002837600	Mid Florida Endoscopy and Surgery Center	06	1.267	69	\$41,400	\$22,145	\$22,256	\$111	1%
009131900	Mid-Florida Endoscopy & Surgery Center LLC	06	1.366	70	\$44,100	\$23,798	\$23,239	-\$558	-2%
076884700	Millenia Park Surgery Center LLC	06	1.380	599	\$1,466,486	\$194,690	\$189,307	-\$5,382	-3%
001147200	Mnh Gi Surgical Center, LLC	06	1.257	1,054	\$1,574,213	\$325,042	\$333,615	\$8,573	3%
070519500	Morton Plant Health Services Inc	06	3.535	9	\$30,476	\$4,998	\$6,902	\$1,904	38%
076523600	Murdock Ambulatory Surgery Center	06	3.611	70	\$220,500	\$57,966	\$62,443	\$4,477	8%
005464000	Murdock Ambulatory Surgical Center	06	1.156	2	\$6,400	\$666	\$645	-\$21	-3%
075173100	N Miami Beach Surgical Center Ltd	06	3.426	88	\$709,106	\$71,354	\$64,967	-\$6,387	-9%
079105900	N.Palm Bch Cty Surgery Ctr, Ltd	06	1.831	281	\$1,426,974	\$86,795	\$100,106	\$13,311	15%
070844500	Naples Day Surgery, LLC	06	3.567	433	\$1,567,347	\$286,326	\$263,622	-\$22,703	-8%
070994800	Naples Day Surgery, LLC	06	3.449	44	\$173,289	\$33,098	\$32,703	-\$395	-1%
079039700	New Port Richey Surgery Center	06	2.936	155	\$927,570	\$105,242	\$104,795	-\$447	0%
076773500	New Tampa Surgery Center Ltd	06	3.192	144	\$402,431	\$72,313	\$70,334	-\$1,979	-3%
070711200	North Broward Hospital Distric	06	2.338	515	\$1,760,442	\$278,191	\$247,724	-\$30,467	-11%
079139300	North FL Surgery Center	06	3.609	298	\$918,650	\$199,543	\$199,305	-\$238	0%
070571300	North Florida Endoscopy Center	06	1.619	169	\$387,072	\$43,241	\$46,056	\$2,815	7%
079210100	North Florida Surgery Center	06	1.262	276	\$265,580	\$99,437	\$95,405	-\$4,032	-4%
079112100	North Florida Surgical Pavillion	06	3.323	431	\$3,625,771	\$326,415	\$276,181	-\$50,234	-15%
006979900	North Miami Beach Surgery	06	3.541	8	\$69,440	\$8,319	\$6,913	-\$1,406	-17%
075258400	North Pinellas Surgery Ctr LLC	06	1.522	12	\$18,197	\$3,330	\$3,396	\$66	2%
079136900	Northwest Florida ASC, LP	06	1.599	315	\$428,593	\$84,133	\$90,962	\$6,829	8%
079169500	Northwest Florida Surgery Center	06	2.360	1,194	\$4,661,194	\$326,451	\$379,082	\$52,630	16%
008438800	Nostrum Medical Center Homestead LLC	06	0.227	31	\$4,175	\$0	\$1,962	\$1,962	
002373900	Novamed Surgery Center of Orlando,LLC	06	3.053	388	\$1,924,922	\$249,476	\$236,715	-\$12,761	-5%
075862100	Novamed Surgery Center of Palm Bch	06	1.291	20	\$44,478	\$3,685	\$6,478	\$2,793	76%

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079207100	Ocala Eye Surgery Center Inc	06	2.816	2	\$2,399	\$1,990	\$1,570	-\$420	-21%
013677600	Ocala Specialty Surgery Center LLC	06	5.196	4	\$6,987	\$2,599	\$2,898	\$299	12%
079199700	Ocalasurg, Inc.	06	3.392	86	\$380,061	\$70,122	\$62,438	-\$7,684	-11%
004200000	Orange City Surgery Center, LLC	06	2.195	985	\$1,512,105	\$428,129	\$418,628	-\$9,501	-2%
000133500	Orange City Surgical, LLC	06	3.415	81	\$493,031	\$69,333	\$64,762	-\$4,571	-7%
079109100	Orlando Center For Outpatient Surge	06	1.871	104	\$364,113	\$42,407	\$43,316	\$909	2%
076152400	Orlando FL Endoscopy Acs, LLC	06	1.148	13	\$20,085	\$4,329	\$4,161	-\$168	-4%
000562600	Orlando Mills FL Endoscopy ASC, LLC	06	1.497	30	\$45,000	\$8,159	\$8,350	\$191	2%
075381500	Orlando Ophthalmology Surgery Ctr	06	4.198	7	\$41,650	\$7,576	\$7,024	-\$552	-7%
076188500	Outpatient Surgery Ctr of St August	06	3.972	3	\$11,640	\$1,386	\$2,215	\$829	60%
006804700	Outpatient Surgical Service	06	1.749	77	\$350,241	\$29,997	\$31,220	\$1,223	4%
079161000	Outpatient Surgical Services, Ltd	06	1.899	276	\$1,333,928	\$115,628	\$113,307	-\$2,320	-2%
009238000	Palermo MD PA	06	0.376	354	\$55,359	\$5,638	\$30,925	\$25,287	449%
010210000	Palm Beach Broward Medical Inc	06	0.544	4	\$950	\$0	\$304	\$304	
075618100	Palm Beach Surgery Center, LLC	06	1.542	1,049	\$2,562,395	\$317,605	\$356,000	\$38,395	12%
076116800	Palms West Surgery Center, Ltd.	06	2.444	985	\$4,324,228	\$480,163	\$464,860	-\$15,303	-3%
075701200	Panama City Surgery Center LLC	06	3.234	1,214	\$5,078,334	\$402,275	\$450,051	\$47,776	12%
007839700	Paramount Surgery Center, LLC	06	3.341	30	\$365,773	\$19,210	\$14,906	-\$4,303	-22%
004540200	Park Center For Procedures	06	3.308	44	\$64,063	\$11,496	\$20,296	\$8,800	77%
076718200	Park Creek Surgery Center, LLLP	06	3.529	501	\$1,377,574	\$103,850	\$169,253	\$65,403	63%
076106100	Park Place Surgery Center	06	3.164	81	\$234,956	\$24,164	\$38,829	\$14,665	61%
001394100	Pasadena Surgery Center, LLC	06	2.943	8	\$13,599	\$3,839	\$4,104	\$265	7%
007254600	Pediatric Surgery Center-Odessa, LLC	06	2.920	3,178	\$7,905,775	\$1,793,645	\$1,593,475	-\$200,169	-11%
000486000	Pediatric Surgery Center-Odessa, LLC	06	2.699	1,046	\$2,625,400	\$597,044	\$560,839	-\$36,205	-6%
007250300	Pediatric Surgery Centers LLC	06	2.983	4,827	\$12,107,425	\$2,819,949	\$2,569,826	-\$250,123	-9%
079155500	Physicians Ambulatory Surgery Ctr	06	1.563	331	\$690,050	\$95,969	\$105,478	\$9,509	10%
070466100	Physicians Day Surgery Center	06	4.273	165	\$541,715	\$163,363	\$138,228	-\$25,135	-15%
076177000	Physicians of Winter Haven LLC	06	4.090	6	\$17,758	\$3,233	\$4,563	\$1,330	41%
011143500	Physicians Outpatient Surgery Center, LLC	06	3.321	2	\$9,568	\$973	\$926	-\$47	-5%
079205500	Pinellas Surgery Ctr, Ltd	06	2.683	80	\$410,176	\$42,729	\$46,397	\$3,668	9%
000577800	Premier Endoscopy Center, LLC	06	1.614	59	\$76,300	\$15,789	\$16,657	\$869	6%

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003985800	Premier Surgical Center, LLC	06	1.571	107	\$344,805	\$33,977	\$38,988	\$5,011	15%
079229200	Presidential Surgicenter, Inc	06	2.803	2	\$2,400	\$1,260	\$1,563	\$303	24%
079231400	Prgfl Xiv, Inc	06	2.875	54	\$174,221	\$47,035	\$41,687	-\$5,348	-11%
070572100	Pshs Alpha Parteners, Ltd.	06	3.164	65	\$163,934	\$39,074	\$31,766	-\$7,307	-19%
076877400	Pshs Beta Partners Ltd	06	2.424	18	\$39,294	\$4,508	\$5,407	\$900	20%
004012900	Red Hills Surgical Center, LLC	06	3.325	415	\$1,443,947	\$313,621	\$287,493	-\$26,128	-8%
079102400	Riverside Park Surgi Center	06	3.071	53	\$139,199	\$51,100	\$43,678	-\$7,422	-15%
001577500	Riverside Surgery Center	06	2.572	15	\$18,685	\$13,035	\$10,758	-\$2,277	-17%
005502800	Riverside Surgical Center	06	1.480	119	\$86,198	\$7,109	\$16,097	\$8,988	126%
008139800	Riverwalk Ambulatory Surgery Center	06	1.536	34	\$26,975	\$6,635	\$8,140	\$1,505	23%
076074900	Riverwalk Endoscopy and Surgery Center, LLC	06	1.537	15	\$12,774	\$3,830	\$4,285	\$456	12%
079225000	Riverwalk Surgery Center	06	3.718	33	\$119,773	\$23,251	\$17,628	-\$5,623	-24%
004779700	Sacred Heart Health System, Inc	06	3.133	229	\$573,360	\$160,612	\$140,652	-\$19,960	-12%
003825500	Safety Harbor Surgery Center	06	1.869	133	\$148,549	\$19,428	\$35,972	\$16,544	85%
026267200	Same Day Surgery Centers of Florida LLC	06	2.280	5	\$3,629	\$3,032	\$2,543	-\$489	-16%
000064900	Sand Lake Surgery Center	06	3.944	193	\$1,101,075	\$122,298	\$125,385	\$3,087	3%
007688800	Sand Lake Surgery Center, LP	06	3.723	37	\$201,578	\$20,417	\$17,650	-\$2,767	-14%
004126600	Santa Fe Surgery Center, LLC	06	3.706	7	\$46,933	\$6,110	\$6,201	\$91	1%
007257900	Santa Lucia Surgical Center, LLC	06	2.604	335	\$454,114	\$269,305	\$228,027	-\$41,277	-15%
009289900	Sarasota Physicians Surgical Center LLC	06	3.700	15	\$56,600	\$9,169	\$12,383	\$3,214	35%
070933600	Sarc/Jacksonville	06	3.719	6	\$38,791	\$4,472	\$4,148	-\$324	-7%
076139700	Seven Hills Surgery Center	06	2.801	15	\$22,308	\$9,911	\$9,372	-\$539	-5%
079086900	Seven Springs Surgery	06	2.716	44	\$42,273	\$35,404	\$31,809	-\$3,595	-10%
076062500	South Broward Endoscopy, LLC	06	1.176	3	\$2,161	\$999	\$984	-\$15	-1%
075660100	South FL Ctr For Endoscopy	06	1.500	101	\$186,445	\$27,806	\$29,276	\$1,470	5%
075962700	South Fla Ambulatory Surgical Cntr	06	2.852	125	\$761,143	\$68,812	\$57,264	-\$11,548	-17%
070310900	Southeastern Urological Partners	06	3.113	117	\$241,012	\$84,208	\$89,408	\$5,200	6%
003464500	Southpoint Surgery Center, LLC	06	2.202	38	\$113,318	\$25,695	\$22,104	-\$3,592	-14%
079154700	Space Coast Surgical Center, Ltd.	06	3.350	42	\$335,643	\$35,473	\$34,564	-\$909	-3%
008646400	Specialists In Urology Surgery Center	06	2.502	11	\$17,810	\$4,295	\$5,583	\$1,288	30%
076522800	Specialists In Urology Surgery Cntr	06	3.143	17	\$29,585	\$9,190	\$11,394	\$2,205	24%

Provider Medicaid ID	Provider Name	Provider Type	Case Mix	Claim Lines	Charges	Baseline Payment	Simulated EAPG Payment	Change in Payment	Percent Payment Change
075586900	Specialists In Urology Surgery Ctr	06	3,294	28	\$83,975	\$21,659	\$21,131	-\$528	-2%
076181800	St Anthony's Physicians Surgery Ctr	06	2,253	325	\$796,222	\$131,526	\$128,828	-\$2,697	-2%
076283100	St Augustine Surgery Ctr LLC	06	1,746	39	\$217,849	\$11,447	\$10,710	-\$737	-6%
070735000	St Lucie Surgical Center, Pa	06	1,222	72	\$156,960	\$23,477	\$23,515	\$38	0%
070826700	St Michaels Eye & Laser Institute	06	2,711	6	\$10,519	\$4,589	\$4,537	-\$52	-1%
079055900	St. Augustine Endoscopy	06	1,436	145	\$94,425	\$41,515	\$43,259	\$1,744	4%
079194600	St. Johns Surgery Center, Inc	06	2,816	14	\$16,800	\$13,930	\$10,993	-\$2,937	-21%
079224100	St. Lucie Surgery Center	06	1,619	366	\$1,430,287	\$173,241	\$151,726	-\$21,515	-12%
079068100	St. Lucy's Outpatient Surg. Cntr	06	2,388	32	\$25,408	\$12,284	\$9,991	-\$2,293	-19%
062925100	St. Lukes's Surgical Ctr	06	2,217	186	\$187,012	\$126,393	\$107,597	-\$18,796	-15%
076934700	St. Marks Surgical Center, LLC	06	1,629	33	\$33,930	\$12,848	\$12,721	-\$127	-1%
076202400	St. Petersburg Endoscopy Center	06	1,470	107	\$107,000	\$30,386	\$32,389	\$2,002	7%
010310700	Stuart Outpatient Surgery Ctr-Hca	06	1,155	10	\$17,495	\$3,330	\$3,220	-\$110	-3%
070785600	Summerlin Bend Surgery Center, LLP	06	2,933	725	\$4,612,123	\$391,792	\$321,484	-\$70,308	-18%
079053200	Suncoast Eye Center	06	2,525	32	\$31,850	\$23,773	\$20,422	-\$3,351	-14%
079192000	Suncoast Medical Clinic, LLC	06	0,048	2	\$25	\$0	\$27	\$27	
006679700	Suncoast Specialty Surgery Center, LLLP	06	5,578	6,919	\$21,010,289	\$2,635,683	\$2,517,114	-\$118,569	-4%
000012700	Suncoast Specialty Surgery Center, LLLP	06	4,664	1,133	\$3,390,837	\$572,304	\$518,969	-\$53,335	-9%
070762700	Suncoast Surgery Center, LLC	06	2,204	9	\$17,900	\$6,270	\$5,532	-\$738	-12%
009290200	Sunrise Anesthesia Assoc	06	0,708	183	\$82,051	\$16,025	\$32,996	\$16,971	106%
010840700	Surgcenter Northeast LLC	06	2,062	2	\$12,206	\$1,076	\$575	-\$501	-47%
009742700	Surgcenter Pinellas, LLC	06	1,677	11	\$42,040	\$3,150	\$2,339	-\$811	-26%
079171700	Surgery Center at St. Andrews	06	3,009	9	\$54,195	\$7,278	\$6,713	-\$565	-8%
010410300	Surgery Center at University Park, LLC	06	1,496	193	\$1,136,485	\$71,917	\$68,832	-\$3,085	-4%
000957400	Surgery Center at University Park, LLC	06	1,416	164	\$974,447	\$57,416	\$57,244	-\$172	0%
076770100	Surgery Center of Atlantis, LLC	06	1,440	89	\$324,526	\$24,290	\$26,509	\$2,220	9%
006878100	Surgery Center of Aventura	06	1,320	40	\$149,401	\$11,665	\$11,039	-\$626	-5%
076169900	Surgery Center of Aventura Ltd	06	1,828	146	\$604,215	\$51,791	\$53,010	\$1,219	2%
000899000	Surgery Center of Key West, LLC	06	5,997	1	\$18,243	\$1,500	\$1,673	\$173	12%
009446700	Surgery Center of Okeechobee, LLC	06	2,527	125	\$298,352	\$47,979	\$47,217	-\$762	-2%
007957500	Surgery Center of Pembroke Pines, LLC	06	2,528	20	\$134,535	\$12,310	\$10,575	-\$1,735	-14%

Provider Medicaid ID	Provider Name	Provider Type	Case Mix	Claim Lines	Charges	Baseline Payment	Simulated EAPG Payment	Change in Payment	Percent Payment Change
002184900	Surgery Center of Pembroke Pines, LLC	06	4.178	2	\$18,330	\$1,460	\$1,165	-\$294	-20%
076113300	Surgery Center of Port Charlotte	06	2.960	238	\$1,069,308	\$95,555	\$111,431	\$15,876	17%
075319000	Surgery Center of Southwest Florida	06	3.296	79	\$179,068	\$46,322	\$53,306	\$6,983	15%
002854500	Surgery Center of Volusia, LLC	06	2.157	27	\$112,150	\$14,330	\$12,635	-\$1,694	-12%
079149100	Surgery Ctr at Coral Springs	06	2.672	409	\$2,452,292	\$221,260	\$220,538	-\$722	0%
079246200	Surgery Ctr of Okeechobee, Inc	06	1.680	20	\$41,135	\$5,846	\$6,089	\$243	4%
075971600	Surgical Center For Excellence	06	2.408	2,374	\$3,618,040	\$593,004	\$857,507	\$264,503	45%
007109600	Surgical License Ward	06	3.709	64	\$201,902	\$30,453	\$34,129	\$3,676	12%
079168700	Surgical Licensed Ward	06	3.381	267	\$652,780	\$105,251	\$117,861	\$12,610	12%
079107500	Surgical Park Center	06	3.387	251	\$2,235,560	\$185,072	\$171,897	-\$13,176	-7%
006826900	Surgical Park Center Ltd	06	3.019	118	\$944,309	\$64,639	\$55,571	-\$9,067	-14%
000164800	Surgical Specialists ASC	06	2.673	49	\$97,600	\$22,725	\$22,367	-\$358	-2%
006594000	Surgical Specialists of St. Lucie County, LLC	06	2.752	179	\$1,192,280	\$84,654	\$79,059	-\$5,596	-7%
062937500	Surgicare Center	06	0.496	8,959	\$2,106,247	\$513,689	\$640,097	\$126,408	25%
007954800	Surgicare of Miramar, LLC	06	2.062	2	\$15,653	\$1,076	\$575	-\$501	-47%
079096600	Surgicare of Orange Park	06	2.334	131	\$668,815	\$75,392	\$75,520	\$128	0%
079069900	Tallahassee Endoscopy Center	06	1.478	193	\$188,460	\$55,445	\$58,933	\$3,488	6%
076111700	Tallahassee Neurosurgery Pain Mgmt	06	1.578	82	\$131,200	\$14,325	\$25,087	\$10,762	75%
079092300	Tallahassee Orthopedic Surgery Cntr	06	4.650	170	\$1,350,745	\$149,284	\$160,813	\$11,530	8%
076855300	Tallahassee Orthopedic Surgery Part	06	2.898	31	\$177,815	\$24,811	\$22,630	-\$2,181	-9%
002307300	Tamarac Surgery Center	06	1.460	265	\$1,173,050	\$76,025	\$79,405	\$3,380	4%
001191700	Tamarac Surgery Center	06	1.717	2	\$7,634	\$500	\$479	-\$21	-4%
009290400	Tampa Bay Regional Surgery Center	06	1.156	1	\$1,100	\$333	\$322	-\$11	-3%
075539700	Tampa Bay Specialty Surgery Center	06	1.603	12	\$30,797	\$3,247	\$3,577	\$330	10%
075986400	Tampa Bay Surgery Center	06	3.335	1,993	\$7,005,088	\$1,364,768	\$1,246,426	-\$118,342	-9%
079156300	Tampa Bay Surgery Center	06	2.750	1,448	\$3,273,780	\$314,832	\$417,193	\$102,361	33%
007071100	Tampa Bay Surgery Center Assoc DBA Tampa	06	0.074	555	\$580,271	\$0	\$11,354	\$11,354	
004622700	Tampa Outpatient Surgical Facility	06	1.858	7	\$18,200	\$3,076	\$2,591	-\$485	-16%
002380700	Tampa Surgery Center LLC	06	2.204	35	\$102,000	\$20,450	\$19,665	-\$785	-4%
009001500	Tavares Surgery, LLC	06	1.310	9	\$12,150	\$2,581	\$2,558	-\$23	-1%
076885500	The Altamonte Springs FL Endoscopy	06	1.156	1	\$1,340	\$333	\$322	-\$11	-3%

Provider Medicaid ID	Provider Name	Provider Type	Case Mix	Claim Lines	Charges	Baseline Payment	Simulated EAPG Payment	Change in Payment	Percent Payment Change
001569600	The Brevard Speciality Surgery Center, LLC	06	3.088	328	\$2,279,025	\$184,839	\$160,186	-\$24,653	-13%
079167900	The Crystal River Endoscopy ASC, LP	06	1.248	152	\$114,661	\$46,254	\$45,929	-\$325	-1%
079204700	The Endoscopy Group, LLC	06	1.472	942	\$604,800	\$256,511	\$264,365	\$7,855	3%
079038900	The Eye Associates Surgery Center	06	2.437	19	\$18,064	\$12,083	\$9,513	-\$2,570	-21%
075954600	The Eye Institute Surgery Center	06	2.816	1	\$2,500	\$995	\$785	-\$210	-21%
003931300	The Ft Myers FL Ophthalmology ASC LLC	06	2.089	36	\$77,012	\$23,553	\$19,812	-\$3,741	-16%
079066400	The Gastroentrolgy Cntr of Hialeah	06	1.245	540	\$420,675	\$169,930	\$167,749	-\$2,181	-1%
076847200	The Kissimmee FL Endoscopy ASC, LLC	06	1.199	1,054	\$1,580,600	\$337,995	\$330,607	-\$7,388	-2%
075976700	The Lakeland FL Endoscopy ASC LLC	06	1.261	750	\$1,053,620	\$232,240	\$230,602	-\$1,638	-1%
079230600	The Melbourne Asc, L.P.	06	1.480	84	\$92,168	\$23,477	\$24,345	\$869	4%
006830200	The Miami ASC LP DBA	06	1.524	396	\$557,586	\$108,825	\$114,734	\$5,909	5%
004356600	The Miami ASC, L.P.	06	1.600	1,413	\$2,012,753	\$376,057	\$403,023	\$26,966	7%
079101600	The Mount Dora Ophtalmolgy ASC, LLC	06	2.002	27	\$33,745	\$15,725	\$15,076	-\$649	-4%
079113000	The Ocala Endoscopy ASC, L.P.	06	1.409	63	\$29,342	\$17,899	\$18,467	\$569	3%
079091500	The Ophthalmology Ctr of Brevard	06	2.746	32	\$52,850	\$27,346	\$23,742	-\$3,604	-13%
076151600	The Orlando FL Endoscopy Acs LLC	06	1.269	167	\$251,835	\$48,368	\$48,144	-\$225	0%
079186500	The Outpatient Center of Boynton Bc	06	1.723	284	\$442,011	\$74,892	\$85,544	\$10,652	14%
079232200	The Palmetto Asc LP	06	1.201	1,353	\$1,955,245	\$435,466	\$428,441	-\$7,024	-2%
075984800	The Rockledge FI Endoscopy ASC LLC	06	1.369	50	\$57,054	\$14,402	\$14,894	\$491	3%
070806200	The Sarasota Endoscopy ASC, LLC	06	1.748	3	\$4,338	\$833	\$975	\$142	17%
070950600	The Suncoast Endoscopy ASC, LP	06	1.254	75	\$51,613	\$22,894	\$23,072	\$178	1%
075162600	The Sunrise Ophthalmology, ASC,LLC	06	2.363	30	\$60,707	\$20,693	\$17,789	-\$2,903	-14%
070948400	The Surg. Cntr of Coral Gables,LLC	06	3.036	153	\$262,805	\$137,777	\$121,933	-\$15,844	-11%
075682200	The Surgery & Endoscopy Center	06	1.320	21	\$63,063	\$6,044	\$5,888	-\$156	-3%
009461900	The Surgery Center At Jensen Beach, LLC	06	2.907	9	\$16,000	\$4,983	\$4,053	-\$929	-19%
075675000	The Surgery Center At Sacred Heart	06	1.939	37	\$57,650	\$8,285	\$13,516	\$5,231	63%
076888000	The Surgery Center of Jacksonville	06	3.081	1	\$6,994	\$995	\$859	-\$136	-14%
000620900	The Surgery Center of The Villages, LLC	06	2.894	33	\$55,936	\$29,643	\$25,828	-\$3,815	-13%
000625000	The Surgical Center at Sun N Lake, LLC	06	1.875	260	\$1,249,649	\$112,428	\$113,474	\$1,046	1%
075922800	The Tampa FL Endoscopy ASC LLC	06	1.224	883	\$1,091,398	\$274,485	\$270,286	-\$4,198	-2%
075918000	The Winter Haven/Sebring FL Ophthal	06	2.573	36	\$67,195	\$30,143	\$25,833	-\$4,310	-14%

Provider Medicaid ID	Provider Name	Provider Type	Case Mix	Claim Lines	Charges	Baseline Payment	Simulated EAPG Payment	Change in Payment	Percent Payment Change
075483800	The Winter Haven/Sebring FL Opthalm	06	2.807	29	\$56,989	\$25,566	\$22,701	-\$2,865	-11%
076525200	Tomoka Surgery Center, LLC	06	2.129	8	\$17,240	\$5,075	\$4,751	-\$324	-6%
079222500	Treasure Coast Surgery Center LLC	06	2.315	19	\$57,575	\$9,374	\$9,685	\$311	3%
000895400	Treasure Coast Surgical Center Inc	06	1.237	310	\$759,502	\$97,278	\$97,310	\$32	0%
075510900	Trinity Surgery Center, LLC	06	2.760	166	\$512,868	\$66,705	\$78,509	\$11,805	18%
076653400	Umdc Dept of Ophthalmology	06	3.994	65	\$217,715	\$50,760	\$50,125	-\$636	-1%
000168500	University Medical Service Association Inc	06	3.420	160	\$326,971	\$98,301	\$96,341	-\$1,960	-2%
079153900	University Surgical Center, Inc	06	3.058	446	\$2,427,818	\$339,095	\$314,638	-\$24,457	-7%
009290700	Unlimited Medical Services of FL PL	06	0.221	412	\$42,165	\$0	\$21,966	\$21,966	
000641000	Venture Ambulatory Surgery Center, LLC	06	1.377	238	\$817,550	\$68,681	\$69,487	\$805	1%
079123700	Vesc Inc	06	1.769	16	\$15,873	\$7,080	\$7,402	\$322	5%
000563400	Villages Endoscopy & Surgical Center, LLC	06	1.566	32	\$41,791	\$8,492	\$9,608	\$1,117	13%
075141300	Visual Hlt @ Jupiter Eye Ctr, LLC	06	2.696	49	\$222,800	\$43,085	\$34,589	-\$8,496	-20%
079106700	Waterside Ambulatory Surg Ctr, Inc	06	1.365	29	\$33,669	\$8,325	\$9,136	\$811	10%
075409900	Webster Surgical Ctr of Tall., LLC	06	1.210	61	\$66,300	\$19,148	\$18,555	-\$592	-3%
079184900	West FL Med Cntr Clinic Pa	06	3.901	128	\$265,950	\$110,849	\$93,559	-\$17,290	-16%
076643700	West Florida Surgery Center	06	1.415	27	\$14,155	\$7,326	\$7,892	\$566	8%
076072200	West Palm Beach FL Endoscopy ASC,LI	06	1.175	5	\$9,175	\$1,665	\$1,638	-\$27	-2%
079220900	West Palm Beach Outpt Surg & Laser	06	2.107	115	\$598,859	\$55,145	\$52,885	-\$2,260	-4%
075941400	West Park Surgery Center	06	1.574	745	\$862,280	\$89,738	\$168,126	\$78,388	87%
004259900	Westchase Surity Center	06	3.970	4	\$17,051	\$2,121	\$2,214	\$93	4%
070645100	Weston Outpatient Surgical Ctr, Ltd	06	3.510	231	\$1,710,420	\$138,897	\$148,781	\$9,884	7%
075145600	Westside Outpatient Center LLC	06	1.764	33	\$54,848	\$2,413	\$6,886	\$4,473	185%
079185700	Westside Surgery Center, Ltd.	06	3.191	51	\$310,510	\$42,887	\$41,828	-\$1,059	-2%
007987800	Winter Haven Ambulatory Surgical Center, LLC	06	2.799	422	\$1,223,938	\$274,436	\$274,003	-\$433	0%
079145800	Winter Park Surgery LP	06	2.768	283	\$867,552	\$159,948	\$164,437	\$4,490	3%
Total			2.045	98,786	\$226,180,498	\$35,657,540	\$35,657,877	\$337	0%

20 Appendix D – Budget Calculations

The table in this section shows the budget or total payment goals for the EAPG pricing simulation. The payment goals were set in order to reach budget neutrality – that is the total payment under the EAPG pricing simulations is intended to be as close as possible to the total historical payment for the claims in the dataset. The budget goal for hospitals in the “High Medicaid Outpatient Utilization” category was set to 90 percent of cost, which is slightly lower than what they receive under the legacy payment method. The reduction in payment to these hospitals was shifted to the hospitals in the “All Other” category.

Table 11. Calculation of budget goals for determination of EAPG base rates and provider policy adjustors.

Simulation 08									
A	B	C	D	E	F	G	H	I	J
Provider Classification	Outpatient Claim Lines	Baseline Payment From GR and PMATF	Automatic Rate Enhancements	Total Baseline Payment	Estimated Cost (Mcr CCRs)	Ninety Percent of Cost	Adjustment to Funds for Base Rate	Funds Available for EAPG Rates	Funds Available for EAPG Rates
1 All Other Hospitals	18,295,764	\$ 974,785,660	\$ 75,485,288	\$ 1,050,270,947	\$ 1,447,139,290	n/a	\$ 4,154,927	\$ 978,940,586	\$ 1,054,425,874
2 Hi Mcaid OP Util Hosps	1,077,554	\$ 150,759,934	\$ 20,407,173	\$ 171,167,108	\$ 185,569,090	\$ 167,012,181	\$ (4,154,927)	\$ 146,605,008	\$ 167,012,181
3 ASCs	98,786	\$ 35,657,540	\$ -	\$ 35,657,540	n/a	n/a	\$ -	\$ 35,657,540	\$ 35,657,540
4									
5 Totals:	19,472,104	\$ 1,161,203,134	\$ 95,892,461	\$ 1,257,095,595	\$ 1,632,708,380	\$ 167,012,181	\$ -	\$ 1,161,203,134	\$ 1,257,095,595
6									
7								Total Budgeted EAPG Claim Payments:	\$ 1,257,095,595
Notes:									
1) Stays in dataset are FFS and managed care outpatient claims from state fiscal year (SFY) 2013/2014 with 19 hospitals removed.									
2) Baseline Payment from GR and PMATF was calculated by applying SFY 2015/2016 legacy pricing rates and rules to claims in the dataset.									
3) Automatic Rate Enhancements are the annual amounts allocated for SFY 2015/16 to the hospitals included in the modeling dataset.									
4) Outpatient payment goal for hospitals in the "High Medicaid Outpatient Utilization" category is 90% of cost.									

21 Appendix E – OPSS Payment Simulation Parameter Summary

The following table shows historical and simulated payments by the categories of providers given their own base rate or provider policy adjustor. EAPG base rate and policy adjustors are also listed.

Table 12. Summary of OPPS simulated payments and payment parameters.

OPPS Payment Simulation					
Simulation 08					
Simulation Parameters	Overall	All Other Hospitals	High Medicaid Outpatient Utilization Hospitals	ASCs	Comment
Baseline payment - GR/PMATF	\$1,161,203,134	\$974,785,660	\$150,759,934	\$35,657,540	Equals sum of allowed amounts on FFS claims and re-priced MC claims
Baseline payment automatic rate enhancements	\$95,892,461	\$75,671,878	\$20,220,583	\$0	
Baseline payment - Total	\$1,257,095,595	\$1,050,457,538	\$170,980,518	\$35,657,540	
Simulation payment goal - GR/PMATF	\$1,161,203,134	\$978,940,586	\$146,605,008	\$35,657,540	Intention is budget neutrality in aggregate, with small shift of funds from High Medicaid OP Utilization hospitals to All Other hospitals.
Simulation payment goal - automatic rate enhancements	\$95,892,461	\$75,485,288	\$20,407,173	\$0	Intention is budget neutrality
Simulation payment goal - Total	\$1,257,095,595	\$1,054,425,874	\$167,012,181	\$35,657,540	
Simulation payment result - GR and PMATF	\$1,161,201,617	\$978,938,145	\$146,605,595	\$35,657,877	
Difference	-\$1,517	-\$2,441	\$587	\$337	
Simulation payment result - automatic rate enhancements	\$95,894,189	\$75,485,502	\$20,408,687	\$0	
Difference	\$1,728	\$214	\$1,514	\$0	
Simulation payment result - total	\$1,257,095,806	\$1,054,423,647	\$167,014,282	\$35,657,877	
Difference	\$211	-\$2,227	\$2,101	\$337	
EAPG Base Rate	N/A	\$388.07	\$388.07	\$278.88	
Claim Lines in Simulation	19,472,104	18,295,764	1,077,554	98,786	
Wage index adjustment of base price	None				
Cost outlier parameters	None				
Policy adjustor - Provider	N/A	None	1.4182	None	
Policy adjustor - EAPG (service)	None				
Policy adjustor - Age	None				
Documentation & coding adjustment	None				
Relative weights	EAPG v3.10 national				
Notes:					
1) Simulation 08 includes two base rates, one for hospitals and another for ASCs.					
2) Simulation 08 has a policy adjustor for High Medicaid Outpatient Utilization Hospitals. These are the four free-standing children's hospitals in Florida - All Childrens Hospital, Nemours Childrens Hospital, Nicklaus Childrens Hospital, and Shriners Hospital for Children.					
3) Simulation 08 spreads the nearly \$96 million in automatic rate enhancements as per-claim supplemental payments to specific hospitals. This total is less than the \$133 million overall budget because some hospitals that receive automatic rate enhancements are not included in the EAPG claims dataset.					

22 Appendix F – Payment to Cost Comparisons by Service Line

The table on the following page summarizes estimates of outpatient reimbursement change by service line. Although the payment change is budget neutral overall, changes in payment are expected for individual types of services because the legacy payment method and the new OPPS payment method are significantly different. Outside of laboratory services, the legacy payment method makes no attempt to adjust payment for individual services based on the level of effort or resource requirements needed to perform the service. The EAPG-based OPPS, in contrast, uses relative weights to increase payments for higher cost services and decrease payments for lower cost services. In addition, the legacy payment method provides a reimbursement on nearly every service line, whereas the EAPG-based OPPS bundles payment for some services in with payment for other services.

Also in the table below, services provided by ASCs are grouped into their own category, and estimated cost for these services is intentionally left blank because we have no practical way to measure cost at ASCs. ASCs are not required to submit Medicare cost reports as are hospitals.

Table 13. Comparison of legacy payment to simulated OPPS payment by service line.

Simulation 08						
Summary of Simulation by Service Line						
Service Line	Claim Lines	Charges	Baseline Payment - GR/PMATF	Simulated EAPG Payment - GR/PMATF	Payment Change	Percent Payment Change
Laboratory	7,451,195	\$1,716,475,458	\$46,681,778	\$27,368,644	-\$19,313,134	-41%
Pharmacy	3,858,775	\$956,506,336	\$342,189,398	\$229,784,026	-\$112,405,372	-33%
Emergency room	2,888,826	\$2,864,797,433	\$244,704,498	\$259,808,611	\$15,104,113	6%
Diagnostic and testing	2,121,946	\$3,044,343,274	\$191,778,031	\$121,761,466	-\$70,016,565	-37%
Therapies	922,465	\$263,334,379	\$97,805,021	\$160,854,466	\$63,049,444	64%
Supplies	725,066	\$368,524,841	\$63,410,371	\$0	-\$63,410,371	-100%
OR-Anesthesia-Recovery	381,264	\$1,352,901,266	\$40,546,096	\$160,329,991	\$119,783,895	295%
Observation	343,666	\$283,800,580	\$27,928,305	\$42,061,861	\$14,133,556	51%
Care Delivery	217,178	\$344,788,596	\$22,133,414	\$38,035,068	\$15,901,653	72%
Radiology and Nuclear Medicine	210,583	\$259,380,462	\$20,485,301	\$58,994,421	\$38,509,120	188%
Clinic	135,158	\$41,951,570	\$17,369,785	\$10,968,658	-\$6,401,127	-37%
ASC	98,786	\$226,180,498	\$35,657,540	\$35,657,877	\$337	0%
Labor-Delivery	59,055	\$43,749,432	\$5,113,243	\$5,475,689	\$362,446	7%
Blood	42,247	\$25,178,995	\$4,195,771	\$5,377,485	\$1,181,714	28%
Dialysis	10,043	\$13,015,812	\$996,699	\$4,430,899	\$3,434,199	345%
Behavioral Health	1,905	\$1,099,637	\$159,369	\$291,562	\$132,193	83%
Error	1,651	\$425,146	\$14,028	\$0	-\$14,028	-100%
Non-Payable	926	\$32,497	\$0	\$0	\$0	
Trauma Response	545	\$5,650,451	\$28,942	\$892	-\$28,051	-97%
Professional Fees	467	\$131,529	\$0	\$0	\$0	
DME	104	\$10,429	\$0	\$0	\$0	
Transportation	101	\$170,137	\$0	\$0	\$0	
Organ acquisition	80	\$351,780	\$5,474	\$0	-\$5,474	-100%
Room and board	45	\$140,719	\$0	\$0	\$0	
Nursing	9	\$1,119	\$0	\$0	\$0	
Telemedicine	7	\$3,691	\$0	\$0	\$0	
Oncology	7	\$3,074	\$0	\$0	\$0	
Hospice	2	\$829	\$67	\$0	-\$67	-100%
Home Health	2	\$297	\$0	\$0	\$0	
Total	19,472,104	\$ 11,812,950,267	\$ 1,161,203,134	\$ 1,161,201,617	\$ (1,517)	0%
<i>Note(s):</i>						
1) Service lines assigned based on the revenue codes.						
2) Baseline and simulated payments in this table include only distribution of GR and PMATF funds. Automatic rate enhancements are not included.						

23 Appendix G – Payment to Cost Comparisons by Provider Category

The table on the following page summarizes estimates of outpatient reimbursement change by category of provider. In this table, providers may be included in more than one category.

Also in the table below, estimated cost for services provided by ASCs is intentionally left blank because we have no practical way to measure cost at ASCs. ASCs are not required to submit Medicare cost reports as are hospitals.

Table 14. Comparison of legacy payment to simulated OPPS payment by provider category.

Simulation 08										
Summary of Simulation by Provider Category										
Provider Category	Claim Lines	Case Mix	Estimated Cost	Charges	Baseline Payment	Simulated Payment	Change in Payment	Percent Change	Baseline Pay / Cost	Simulated Pay / Cost
Hospital	19,373,318	0.686	\$ 1,632,708,380	\$ 11,586,769,769	\$ 1,221,438,055	\$ 1,221,437,929	\$ (126)	0%	75%	75%
General Acute	7,259,653	0.652	\$ 533,908,978	\$ 4,508,505,345	\$ 355,874,460	\$ 364,472,740	\$ 8,598,281	2%	67%	68%
Trauma	7,163,913	0.711	\$ 672,172,067	\$ 4,143,148,442	\$ 554,803,171	\$ 559,085,611	\$ 4,282,440	1%	83%	83%
Safety Net	6,995,709	0.722	\$ 620,469,546	\$ 3,684,926,231	\$ 528,539,224	\$ 512,053,115	\$ (16,486,109)	-3%	85%	83%
For Profit	6,438,884	0.677	\$ 470,331,076	\$ 5,089,596,461	\$ 309,451,555	\$ 330,882,452	\$ 21,430,897	7%	66%	70%
High Charity	4,199,035	0.670	\$ 321,558,801	\$ 2,866,569,242	\$ 223,631,094	\$ 235,003,012	\$ 11,371,918	5%	70%	73%
Statutory Teaching	3,273,913	0.850	\$ 330,573,118	\$ 1,978,935,333	\$ 276,007,861	\$ 254,146,542	\$ (21,861,319)	-8%	83%	77%
Public	2,759,233	0.705	\$ 201,416,231	\$ 1,213,877,176	\$ 142,567,308	\$ 170,351,160	\$ 27,783,852	19%	71%	85%
Children	1,077,554	0.655	\$ 185,569,090	\$ 637,525,583	\$ 171,167,108	\$ 167,014,282	\$ (4,152,825)	-2%	92%	90%
Rural	1,036,075	0.529	\$ 64,048,983	\$ 336,176,671	\$ 61,322,012	\$ 48,537,965	\$ (12,784,048)	-21%	96%	76%
ASC	98,786	2.045	\$ -	\$ 226,180,498	\$ 35,657,540	\$ 35,657,877	\$ 337	0%	0%	0%
Out of state	95,461	0.523	\$ 7,605,034	\$ 40,151,246	\$ 5,140,463	\$ 3,587,905	\$ (1,552,558)	-30%	68%	47%
Rehabilitation	56,185	0.640	\$ 2,599,899	\$ 7,823,352	\$ 2,528,027	\$ 7,048,379	\$ 4,520,352	179%	97%	271%

Note(s):
 1) Hospitals may be included in more than one category.
 2) Costs using Medicare cost-to-charge ratios are unavailable for the Ambulatory Surgical Centers.

24 Appendix H – Manual Adjustments to Improve EAPG Assignment

As mentioned in Section 3.4, manual adjustments were made to specific types of services to enable assignment of an EAPG on claim lines submitted without a procedure code. This was done only for specific revenue codes that are generally billed with one of a small number of procedure codes that map to a small number of EAPG codes. In these scenarios, manual manipulation could be performed for the purpose of assigning EAPG codes, with a reasonable level of accuracy. For some revenue codes, the manual manipulation involved assigning a procedure code to claim service lines with blank procedure codes. This was done prior to processing through the EAPG grouping software so that EAPG codes and discounting logic could be applied based on these procedure codes. A summary of the procedure code assignments is shown in Table 15. In other cases, the manual adjustment involved assignment of an EAPG code directly to the claim line without populating the procedure code. Details of when manual assignment of an EAPG code was performed is included in Table 16.

Table 15. Manual assignment of procedure codes on select lines with blank procedure codes.

Type of Service	Revenue Code	Manually Assigned Procedure Code	Resulting EAPG Code	EAPG Rel Wt
Physical Therapy	0420, 0421, 0424	97110, 97001, 97035, 97112, 97116, 97002, 97140, 97530	271 - Physical Therapy	0.7257
Occupational Therapy	0430, 0431, 0434	97532, 97003, 97535	270 - Occupational Therapy	0.9767
Speech Therapy	0440, 0441, 0444	92507, 92506, 92522	272 - Speech Therapy and Evaluation	0.3224
Dialysis	0800 – 0809 0820, 0822 – 0829 0880 - 0889	90935	168 - Hemodialysis	1.5279
	0821	Assign procedure code 90935 to 1 in every 3 lines with this revenue code	168 - Hemodialysis	1.5279
	0830 - 0859	90945	169 - Peritoneal Dialysis	1.6323
	0330	96521; Chrgs < \$1,000 77293; Chrgs >= \$1,000	489 - Level II Other Miscellaneous Ancillary Procedures 481 - Therapeutic Radiology Simulation Field Setting	0.1828 0.9624
Radiology	0331, 0335	96413; Chrgs < \$1,275 96415; Chrgs >= \$1,275	111 - Pharmacotherapy Except by Extended Infusion 110 - Pharmacotherapy by Extended Infusion	0.7535 1.4448
	0333	77417; Chrgs < \$350	471 - Plain Film	0.1106
		77300; Chrgs Btwn \$350 and \$590 77014; Chrgs Btwn \$590 and \$638	480 - Teletherapy/Brachytherapy Calculation 473 - CT Guidance	0.1703 0.1859

Type of Service	Revenue Code	Manually Assigned Procedure Code	Resulting EAPG Code	EAPG Rel Wt
Nuclear Medicine	0340, 0341	77336; Chrgs Btwn \$638 and \$860	478 - Medical Radiation Physics	0.2149
		77334; Chrgs Btwn \$860 and \$1,085	479 - Treatment Device Design and Construction	0.3547
		77421; Chrgs Btwn \$1,085 and \$1,615	474 - Radiological Guidance for Therapeutic or Diagnostic Procedures	0.5431
		77315; Chrgs Btwn \$1,615 and \$1,671	484 - Therapeutic Radiology Treatment Planning	0.6564
		77290; Chrgs Btwn \$1,671 and \$1,680	481 - Therapeutic Radiology Simulation Field Setting	0.9624
		77418; Chrgs >= \$1,680	343 - Radiation Treatment Delivery	2.0324
		A9503; Chrgs < \$500	490 - Incidental to Medical, Significant Procedure or Therapy Visit	0.0000
		78306; Chrgs Btwn \$500 and \$1,990	330 - Level I Diagnostic Nuclear Medicine	0.6347
		78582; Chrgs Btwn \$1,990 and \$3,550	331 - Level II Diagnostic Nuclear Medicine	0.7456
		78452; Chrgs >= \$3,550	332 - Level III Diagnostic Nuclear Medicine	1.7284
		0342	79005	340 - Therapeutic Nuclear Medicine

Table 16. Manual assignment of EAPG codes to select claims billed with blank procedure codes.

Type of Service	Revenue Code	Submitted Charges	Manually Assigned EAPG Code	EAPG Rel Wt	Packing Indicator
Pharmacy	0250 – 0259 0630 – 0639 0343 - 0344	Charges < \$10	496 - Minor Pharmacotherapy	0.0000	Y
		Charges between \$10 and \$63	435 - Class I Pharmacotherapy	0.0271	Y
		Charges between \$63 and \$124	436 - Class II Pharmacotherapy	0.2492	N
		Charges between \$124 and \$212	437 - Class III Pharmacotherapy	0.4632	N
		Charges between \$212 and \$350	438 - Class IV Pharmacotherapy	0.4741	N
		Charges between \$350 and \$558	439 - Class V Pharmacotherapy	1.1952	N
		Charges between \$558 and \$855	440 - Class VI Pharmacotherapy	1.2863	N
		Charges between \$855 and \$1,260	444 - Class VII Pharmacotherapy	1.6068	N
		Charges between \$1,260 and \$1,782	460 - Class VIII Combined Chemotherapy and Pharmacotherapy	2.1573	N
		Charges between \$1,782 and \$2,415	461 - Class IX Combined Chemotherapy and Pharmacotherapy	3.8809	N
		Charges between \$2,415 and \$4,251	462 - Class X Combined Chemotherapy and Pharmacotherapy	4.4917	N
		Charges between \$4,251 and \$6,501	463 - Class XI Combined Chemotherapy and Pharmacotherapy	7.4539	N
		Charges between \$6,501 and \$10,001	464 - Class XII Combined Chemotherapy and Pharmacotherapy	14.2305	N
		Charges >= \$10,001	465 - Class XIII Combined Chemotherapy and Pharmacotherapy	30.5443	N
Supplies	0264 0170 – 0279 0621 - 0624	n/a	490 - Incidental to Medical, Significant Procedure, or Therapy Visit	0.0000	Y

The final manual data manipulation involved claims for observation. Claims for observation services only is a unique scenario within the EAPG grouping/pricing algorithm, in that the algorithm looks for the occurrence of two different procedure codes from two different service lines before assigning an EAPG code to each line. One line item affecting another line item's payment amount is very common in an EAPG-based OPSS. However, one line item affecting the assignment of an EAPG code on another line item is rare and occurs when a claim is submitted for observation services only. Specifically, when procedure code G0378 – hospital observation per hour – is included on a claim and there is no significant procedure included on the claim, the EAPG grouping logic looks for a second line item with a procedure code in one of two small lists. One of those lists includes evaluation and management codes, 99201 – 99205; 99211 – 99214, 99281 – 99285, and G0463, and the other list includes observation codes, 99217 – 99220, 99224 –

99226, 99234 – 99236, and G0379. If a procedure code from the evaluation and management list is present on the claim, then a medical visit EAPG gets assigned. If a procedure code from the observation list is present on the claim, then an observation EAPG gets assigned. But if procedure code G0378 is present on the claim, no significant procedure is present on the claim, and no procedure from either of these two small lists is present on the claim, then the observation services receive an error EAPG and no payment.

This somewhat complex billing requirement does not exist in the current legacy payment method, so some claims for observation services only were billed without a combination of codes required by EAPG grouping. For these claims, Navigant added a new claim service line with an evaluation and management procedure code equal to 99281, so that a valid EAPG and a non-zero payment could be determined for the observation services.

NAVIGANT

PROPOSED OUTPATIENT
PROSPECTIVE PAYMENT SYSTEM
FOR FLORIDA MEDICAID

Presentation to:

Florida House Health Care Appropriations Subcommittee

January 12, 2016

Presenters



Malcolm Ferguson

Associate Director
Navigant Consulting

James Pettersson

Managing Director
Navigant Consulting

Direction to AHCA to Consider an OPSS



SFY 2015/16 General Appropriations Act ...

“... the Agency for Health Care Administration to contract with an independent consultant to develop a plan to **convert Medicaid payments for outpatient services from a cost based reimbursement methodology to a prospective payment system**. The study shall identify steps necessary for the transition to be completed in a budget neutral manner. The report shall be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than November 30, 2015.”

Activity Performed by AHCA and Consultant



- » 5 meetings held with an internal AHCA “Governance Committee” comprised of executives from AHCA and representatives from Navigant Healthcare
- » 4 public stakeholder meetings with phone and webinar external access were held to review and solicit feedback from the provider community for recommendations defined by the Governance Committee
- » Minutes from the AHCA “Governance Committee” meetings and recordings of the public meetings were published on the AHCA website
- » EAPG pricing modeling performed using historical Medicaid fee-for-service and managed care outpatient claims

Acronyms and Vocabulary



- » APCs – Ambulatory Patient Classifications
- » ASCs – Ambulatory Surgical Centers
- » EAPGs – Enhanced Ambulatory Patient Groups
- » OPSS – Outpatient Prospective Payment System
- » Bundling – Combining the payments for individual components related to an outpatient service visit into a single outpatient payment amount
- » Discounting – Paying less than 100% for a service when provided in conjunction with another similar or more expensive service
- » Outpatient services – a.k.a. ambulatory care – patient is not admitted – examples include Emerg Dept, chemo, lab, MRI, therapy
- » Outpatient payment – payment for use of the facility, nursing staff, drugs, materials, and administration (separate payment is made for physician services)

Current Versus Proposed New Payment Method



Current Method - Hospitals

- » Hospital-specific cost-based rates
- » The same, “flat” rate is paid for all non-lab services, independent of complexity
- » Lab services paid via a fee schedule
- » Payments are retroactively cost-settled
- » More services equates to more payment

Current Method - ASCs

- » ASCs are paid based on a limited fee schedule which groups each procedure into one of 14 different rates
- » Secondary procedures are generally discounted

Proposed OPPS

- » Payment is visit-based and considers full range of services performed in an outpatient setting
- » Payment is better aligned with cost of care for different types of services
- » Creates incentives to avoid performing unnecessary services
- » Provides the same payment for the same service across all facilities with similar characteristics
- » Hospitals and ASCs paid under the same method (but amounts may vary)
- » Payment is prospective – cost settlements are no longer necessary

OPPS Classification Systems



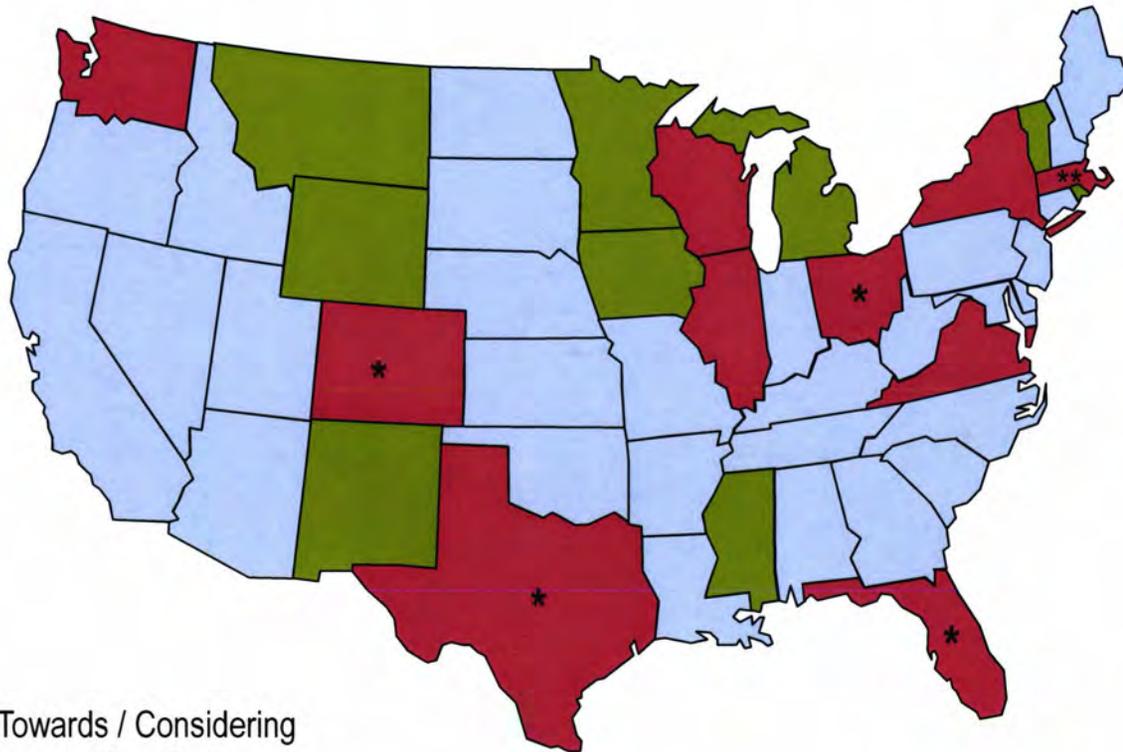
- » Most OPPS payment methods utilize one of two service classification systems to calculate payment:
 - › Enhanced Ambulatory Patient Groups – EAPGs – proprietary product of 3M HIS
 - › Ambulatory Patient Classifications – APCs – used by Medicare
- » Both methods attempt to balance fair payment with incentives to control cost of care and avoid providing unnecessary services
- » Both methods determine payment for individual services performed with some consideration given to the set of services included in the outpatient visit
- » EAPGs are less familiar to the healthcare provider community, but are becoming more commonplace for Medicaid payment across the country

Survey of Other Medicaid Agencies



Outpatient Payment Method - Other Medicaid Agencies

- EAPGs
- APC or APC-based fee schedule
- Primarily fee schedule or cost based



* Indicates Moving Towards / Considering
** Using EAPGs for case mix adjustment

Recommending Use of EAPGs



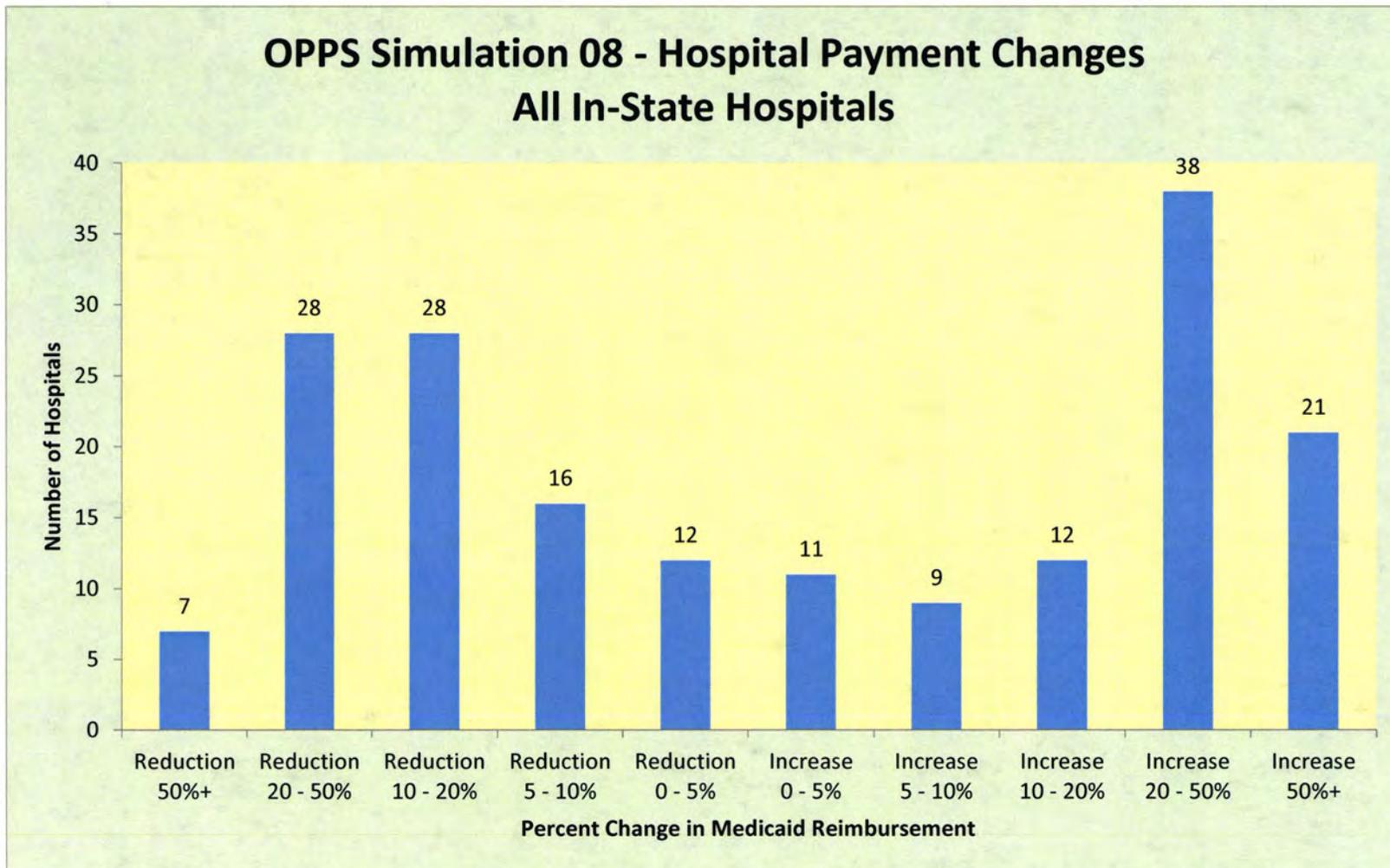
- » EAPGs provide enhanced incentives to better manage the cost of care through bundling and discounting of secondary services
- » EAPGs support calculation of payment for the full range of services offered in an outpatient setting, whereas the APC classification system has to be supplemented with fee schedules for some services, most notably laboratory, physical therapy, and durable medical equipment
- » EAPGs are designed for use with any population, whereas APCs are specifically designed for the Medicare population

Recommendations Included in the OPPS Study

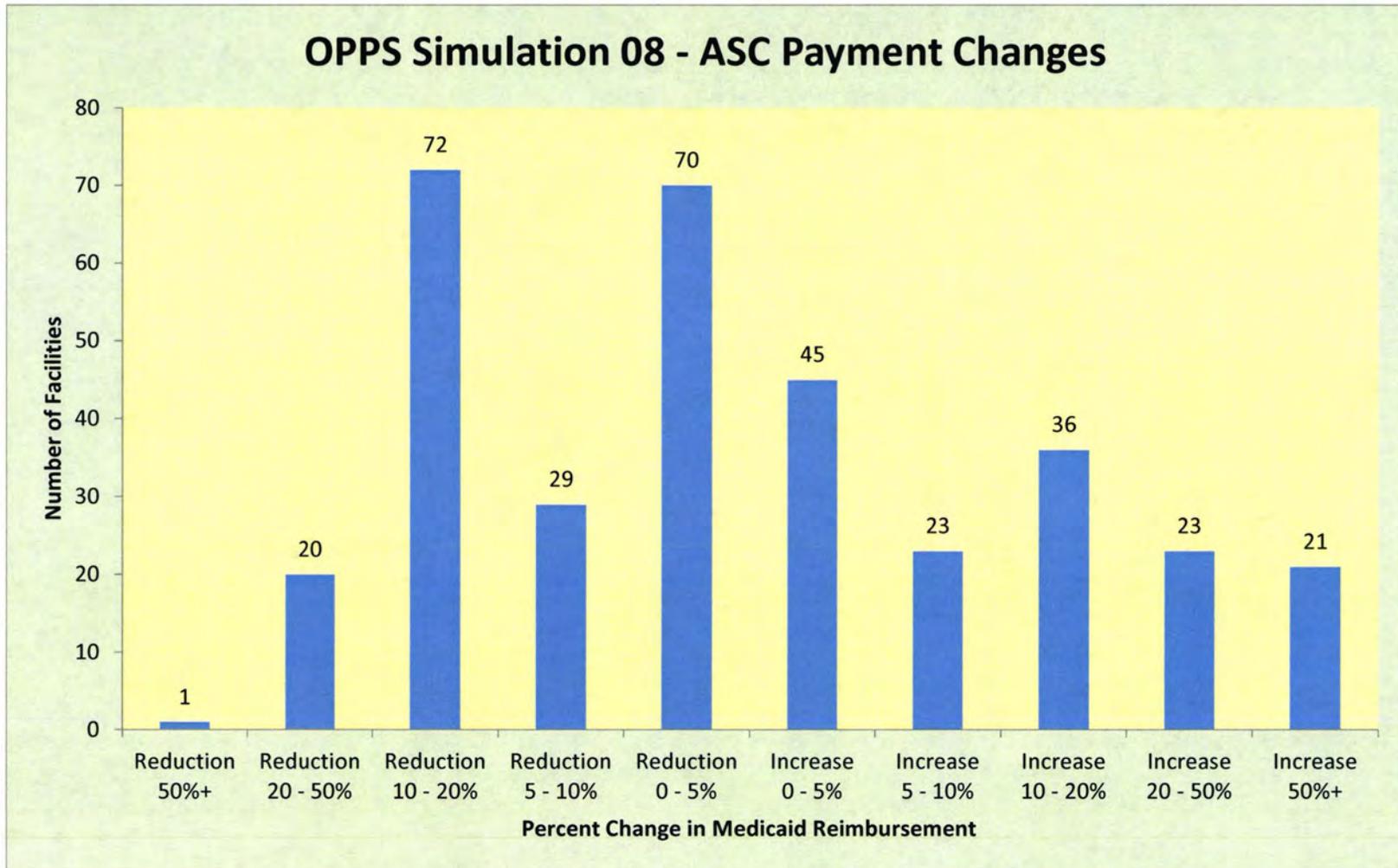


- » Implement an OPPS using Enhanced Ambulatory Patient Groups (EAPGs)
- » Apply the OPPS for calculation of payment for hospital outpatient services and services provided by Ambulatory Surgical Centers (ASCs)
- » Apply EAPG pricing to all outpatient services at hospitals and ASCs
- » Utilize two EAPG base rates – one for hospitals and one for ASCs
- » Apply a provider policy adjustor for hospitals with an unusually high percentage of their outpatient utilization coming from Medicaid recipients
- » Apply automatic rate enhancements through supplemental payments (outside the base rate) similar to the method used for hospital inpatient payments
- » Implement a 5% documentation and coding improvement adjustment for hospitals; no adjustment for ASCs

Summary of Impact to Hospitals



Summary of Impact to ASCs



Payment Modeling Challenges – Hospitals Removed



"Base" Provider Medicaid ID	Provider Name	Claim Lines Excluding Specific Services ¹			Overall Outpatient Totals		
		Blank Claim Lines	Total Claim Lines	Percent of Claims with Blank Procedure Codes	Claim Lines	Submitted Charges	Baseline Payment
000949600	Florida Hospital at Connerton - LTAC	28	28	100%	68	\$45,353	\$668
008135900	University Behavioral Center	2	2	100%	2	\$3,000	\$0
008135300	Emerald Coast Behavioral Hospital, LLC	154	154	100%	154	\$9,555	\$0
010102800	Florida Hospital Tampa	18,271	52,903	35%	173,105	\$115,882,262	\$7,633,814
010345400	Memorial Hospital Miramar	24,111	30,829	78%	101,409	\$60,200,676	\$2,991,886
010020000	Memorial Regional Hospital	105,348	137,570	77%	419,733	\$335,944,853	\$26,409,856
010252100	Memorial Hospital West	40,381	53,903	75%	191,714	\$144,551,040	\$9,229,487
010222900	Memorial Hospital Pembroke	22,706	31,917	71%	94,442	\$52,790,777	\$2,912,238
010260100	Florida Hospital Wauchula	6,895	10,392	66%	35,962	\$16,621,964	\$2,045,480
010003000	UF Health Shands Hospital	60,494	93,064	65%	397,145	\$180,094,812	\$19,525,367
010090100	Florida Hospital Heartland Med Cntr	14,336	26,776	54%	95,693	\$46,143,550	\$4,485,171
010190700	Northwest Florida Cmnty Hospital	3,863	7,694	50%	32,071	\$10,017,686	\$1,790,768
010823300	Windmoor Healthcare, Inc.	14	28	50%	28	\$29,100	\$0
010067600	UF Health Jacksonville	44,781	92,479	48%	398,500	\$230,451,128	\$20,048,730
010109500	Florida Hospital Waterman	17,142	36,647	47%	139,059	\$70,530,246	\$6,867,582
005456800	Florida Hospital Wesley Chapel	6,325	15,385	41%	55,227	\$33,596,727	\$3,973,165
010094300	Florida Hospital Carrollwood	8,827	22,390	39%	76,348	\$49,583,510	\$4,193,585
010161300	Florida Hospital North Pinellas	4,779	12,812	37%	42,694	\$24,151,233	\$2,393,240
010149400	Florida Hospital Zephyrhills	7,091	21,235	33%	72,044	\$42,469,113	\$2,861,300
Total		385,548	646,208	60%	2,325,398	\$1,413,116,586	\$117,362,335

Note(s):

1) Amounts in these columns exclude the following service lines: Pharmacy, Laboratory, Supplies, Therapies, Dialysis, Radiology and Nuclear Medicine.

Timing of Implementation



- » Inpatient DRG implementation required,
 - › 6 months of payment policy design
 - › 6 months of software development
- » Outpatient OPSS implementation is more complicated and will require
 - › 6 months of payment policy design (already complete)
 - › At least 9 months of software development
 - › Earliest implementation would be fall of 2016, potentially with OPSS pricing applied retroactively back to July, 1, 2016

Questions



Questions?

OPPAGA Update



The Maintenance Adoption Subsidy Program and Methodology for Projecting Annual Budget Needs

January 6, 2016

Summary

At the request of the Legislature, OPPAGA reviewed the Maintenance Adoption Subsidy Program to answer three questions.

1. What are the federal and state requirements for determining the amount of monthly adoption subsidy payments?
2. What factors may influence monthly adoption subsidy payment amounts, the number of adoption subsidy recipients, and overall expenditures over the next few years?
3. What methodology does the Department of Children and Families use to project the annual budget needed for adoption subsidy payments, and what improvements have or need to be made to these projections?

Background

The Adoption Assistance and Child Welfare Act of 1980 created a joint federal-state program to support children in foster care and adoptive families.¹ The act established the Adoption Assistance Program, which provides financial assistance to families that adopt children with special needs.² Financial assistance includes non-recurring payments, pre-adoptive subsidies, and monthly maintenance adoption subsidies. Non-recurring payments are intended to pay for the expenses associated with an adoption, such as attorney fees.³ Pre-adoptive subsidies are intended to assist prospective adoptive parents with the cost of caring for a child pending the finalization of the adoption.⁴ Monthly subsidy payments are intended to assist adoptive parents with the extra costs associated with adopting a special needs child. The family receives monthly subsidy payments until child's 18th birthday when he or she is no longer eligible for the program.

Families receive adoption subsidies funded by one of three sources: (1) federal Title IV-E funds, (2) federal Temporary Assistance for Needy Families (TANF), or (3) state general revenue

¹ The Adoption Assistance and Child Welfare Act of 1980 (Public Law 96-272) is also known as Title IV-E of the Social Security Act.

² Special needs children are those in the custody of the Department of Children and Families or a licensed, private child-placing agency who have established significant emotional ties with their foster parents or are not likely to be adopted because they are at least eight years old, developmentally disabled, physically or emotionally handicapped, of black or racially mixed heritage, or a member of a sibling group being placed for adoption together.

³ The Title IV-E Adoption Assistance Program allows states to offer non-recurring adoption payments to cover an adoptive family's adoption-related expenses. Adoption expenses are defined as the reasonable and necessary adoption fees, court costs, attorney fees and other expenses that are directly related to the legal adoption of a child with special needs and that have not been reimbursed from other sources or funds. Federal guidelines set the maximum non-recurring adoption payment amount a state may provide an adoptive family at \$2,000. In Florida, the maximum amount for non-recurring adoption payments is \$1,000. If families receive non-recurring payments, they cannot claim these payments for federal income tax purposes because IRS regulations prohibit adoptive families from claiming adoption expenses for which they received funds under any local, state, or federal program.

⁴ Pre-adoptive subsidies begin after the adoption subsidy amount is agreed upon, the adoption agreement is signed, and the child is placed with the prospective adoptive parents. These subsidies are intended to be paid for 90 days or less.

funds.⁵ The department's screening process determines financial eligibility for a subsidy from federal Title IV-E or TANF funds. If the child is not eligible for either federal funding source, the subsidy is funded with state general revenue funds.^{6,7} While federal laws and rules for adoption assistance apply only to Title IV-E funds, Florida also applies federal guidelines for state-only funded subsidies. The Department of Children and Families (DCF) administers Florida's Adoption Assistance Program; the amount of a maintenance adoption subsidy is determined at the local level by the department's 17 community-based care lead agencies.

Due to increases in annual adoption assistance expenditures, the Legislature previously directed OPPAGA to examine factors associated with these increases. In December 2013, OPPAGA made the following observations.

- From Fiscal Year 2007-08 to Fiscal Year 2012-13, the number of adoption assistance recipients increased 31% due to historical growth in adoptions. Most children are young when they are adopted and do not stop receiving subsidies until they turn 18 years of age. Therefore, when adoptions grew by over 50% in the early 2000s, the number of subsidy recipients grew for at least a decade because the number of children entering the program exceeded the number of children who were exiting the program on their 18th birthday.
- During the same period, the average monthly adoption subsidy amount increased from approximately \$343 to approximately \$376. This growth is primarily due to the difference in cost of children exiting the program at age 18 whose families received lower historical subsidy rates as compared to children entering the program whose families receive current higher rates.

The department reports that adoption subsidy expenditures increased by 53% from \$111 million in Fiscal Year 2008-09 to \$171 million in Fiscal Year 2014-15, representing an average annual increase of \$9.9 million per year. The department's Fiscal Year 2016-17 Legislative Budget Request (LBR) requested \$191 million. In Fiscal Year 2014-15, DCF finalized 3,219 adoptions. The department reported that 35,697 children received maintenance adoption subsidies in June 2015, which represents a 68% increase over the number of children who received the subsidies 10 years ago.

What are the federal and state requirements for determining the amount of monthly adoption subsidy payments?

Federal and state laws and rules establish criteria for determining subsidy amounts. Federal policies stipulate that Title IV-E-funded adoption assistance be based on the specific needs of each child and the circumstances of his or her adoptive family, as determined through negotiations between the parents and a representative of the state IV-E agency. The payment that is agreed upon should combine with the parents' resources to cover the ordinary and special

⁵ Florida funds its Adoption Assistance Program primarily with federal Title IV-E adoption funds; the majority of children adopted are eligible for this funding source.

⁶ The 2008 federal Fostering Connections to Success and Increasing Adoptions Act revised Title IV-E adoption assistance eligibility criteria by gradually increasing the share of children eligible for Title IV-E adoption assistance payments and reducing the need for TANF or general revenue funding. Phasing in of this change began during federal Fiscal Year 2010 and will be complete at the start of federal Fiscal Year 2018. As a result, nearly all special needs children newly adopted from foster care after 2018 will be eligible for Title IV-E-funded adoption assistance. A small number of adoptive children may not be eligible because federal eligibility criteria for Title IV-E will remain in effect for areas such as citizenship and immigration status requirements.

⁷ States may establish state-funded adoption assistance programs for children who are not eligible under the federal Title IV-E adoption assistance program and have the flexibility under federal law and rules to set eligibility criteria for such programs, which vary by state.

needs of the child projected over an extended period of time and should cover anticipated needs, such as child care.⁸

Federal law and state policies link adoption assistance payments to foster care payments. Prior to 2007, state rules established the adoption subsidy amount at 80% of the foster care board rate, including the medical foster care board rate.^{9, 10} In 2007, the Legislature raised Florida's adoption subsidy amount to \$5,000 annually (\$417 per month) or an amount other than \$5,000 annually as determined by the adoptive parents and the department.^{11, 12, 13} While this action decoupled adoption subsidy payments from foster care payments, the range of allowable payments is still affected by foster care board rates.

Federal law and policies specify that Title IV-E-funded adoption assistance payments cannot exceed the foster care payment the child would have received if he or she had been in a foster family home.^{14, 15, 16} However, these policies allow for higher, specialized rates for children who have more significant needs. For example, children adopted from Medical or Therapeutic Foster Care, with foster care board payments higher than the minimum, may have needs that require larger subsidies. Lead agencies approve subsidy amounts up to 100% of the statewide foster care board rate; agency adoption program specialists, the lead agency director, and the DCF regional director must approve higher subsidy amounts.^{17, 18} State statute establishes the monthly foster care board rates shown in Exhibit 1.

⁸ Federal law prohibits states from considering the income and other assets of adoptive families in determining the child's eligibility for the Title IV-E adoption assistance program.

⁹ Rule 65C-16.013(7), *F.A.C.*, stated that the initial monthly basic subsidy payment will be based on the department's published standard foster care board rates and that the basic subsidy will be 80% of these rates, including medical foster care rates. This section was amended in 2008.

¹⁰ During our study period, the medical foster care board rate increased from \$504 to \$527 per month. The Department of Health's Medical Foster Care Operational Plan states that medical foster parents receive the same foster care board rate received by regular foster parents for children 13 to 21 years of age regardless of the medical foster care child's age. In addition, beginning in January 2015, the medical foster care board rate will receive the same annual percentage cost of living increases as regular foster care.

¹¹ Section 409.166, *F.S.*

¹² In 2013, the majority of lead agencies reported either establishing the adoption subsidy amount at \$417 or beginning the negotiation process at this amount. The department reported that it appeared that lead agencies have varying interpretations of whether \$417 is the standard rate for subsidies or the maximum subsidy amount.

¹³ In 2013, some lead agencies reported encouraging adoptive families to sign an adoption agreement with a zero subsidy amount if they do not request financial assistance. This allows the family to request a subsidy later should physical or psychological problems, not diagnosed at the time of the adoption, appear that require care or services beyond what the parents or Medicaid can provide.

¹⁴ Section 473(a)(3) of the Social Security Act and Chapter 8.2D.4 of the federal Child Welfare Policy Manual.

¹⁵ Federal law and regulations do not prohibit states from having a law or policy that limits the maximum adoption assistance payments to a level lower than the maintenance payment a child would have received in a foster family home. The law only prescribes that the adoption assistance payment can be no more than the foster care maintenance payment that the child would have received in a foster family home during the same time period (Section 473(a)(3) of the Social Security Act).

¹⁶ Section 409.166(4)(b), *F.S.*, mirrors the federal requirement, stating that the monthly adoption subsidy payment shall not exceed the foster care maintenance payment that would have been paid during the same period if the child had been in a foster family home.

¹⁷ The department reports that there are no criteria for regional directors to follow; however, they must examine all the documentation justifying the higher adoption subsidy request.

¹⁸ Rule 65C-16.013(7), *F.A.C.*

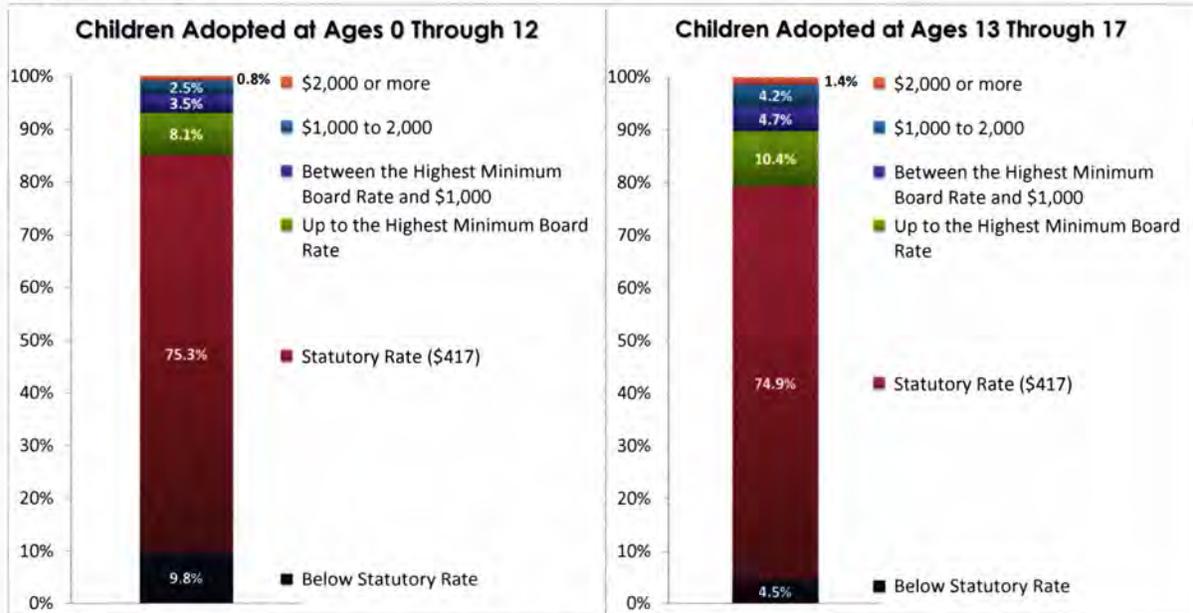
Exhibit 1
The Minimum Monthly Foster Care Maintenance Payment Has Increased Over the Last 15 Fiscal Years

Child's Age	Monthly Foster Care Maintenance Payment			
	Before FY 2000-01	FY 2000-01	FY 2006-07	FY 2014-15
Birth to 5 Years Old	\$350	\$369	\$429	\$439
6 Years Old to 12 Years Old	\$361	\$380	\$440	\$451
13 Years and Older	\$432	\$455	\$515	\$527

Source: Department of Children and Families

As shown in Exhibit 2, 75% of children adopted over the past three fiscal years received the statutory rate of \$417. Eight percent of children ages 0 through 12 and 10% of children ages 13 through 17 received subsidies at or below the highest minimum foster care board rate but above the statutory rate of \$417.¹⁹ Of those, approximately 5% received adoption subsidies equal to the minimum medical foster care rate at the time of \$504 and 1% to 2% received adoption subsidy amounts at 100% of the statewide established foster care board rate.²⁰

Exhibit 2
Seventy-five Percent of Children Adopted Received the Statutory Monthly Rate of \$417 as Their Adoption Subsidy



Source: OPPAGA analysis of Department of Children and Families data.

¹⁹ The highest minimum foster care board rate is the higher of the minimum medical and minimum non-medical foster care board rates. For children ages 0 through 12 the higher rate is the minimum medical foster care rate at the time (\$504). For children ages 13 through 17, the higher rate is the minimum non-medical foster care board rate.

²⁰ Less than 0.1% of children received payments of \$3,000 or more per month.

Adoptive families must be informed that they may request an increase in the subsidy amount after approval of the initial subsidy agreement.²¹ Adoptive parents may renegotiate their adoption assistance agreement under three conditions

- 1) the family's circumstances change;
- 2) the child needs additional medical, mental health, or special services; or
- 3) periodic across-the-board increases to the state's foster care board rates.

In addition, subsidy agreements can only be modified with the concurrence of the adoptive family and can only be terminated under certain circumstances.²²

What factors may influence adoption subsidy payment amounts, the number of adoption subsidy recipients, and overall expenditures over the next few years?

According to department staff, two factors may have caused adoption subsidy amounts to increase. In 2013, the Florida Legislature enacted s. 409.145(4), *Florida Statutes*, which requires foster parents to receive an annual cost of living increase equal to the percentage change in Consumer Price Index.²³ Since lead agencies may approve up to 100% of the foster care board rate without department approval, department staff reported that this increase may result in higher adoption subsidy amounts as the board rate increases. Department staff also reported that foster parents and adoptive parents are requesting higher foster care maintenance and adoption subsidy rates. Because they are more informed about the policies and practices governing these rates, foster parents who adopt may request an adoption subsidy equal to the higher foster care board rate they were receiving prior to adoption. Staff attributed membership in local foster and adoptive parent associations and the exchange of information among foster and adoptive parents for the higher rate requests.

Federal and state policy changes led to an increase in private adoptions, making more children eligible for adoption assistance. Department staff reported an increase in the number of children adopted through a private adoption process as a result of federal and state statutory changes in recent years.^{24, 25} Private adoptions occur under two scenarios: (1) children who are not in the child welfare system are adopted through private, child-placement or child-caring agencies; and (2) children who are in the child welfare system but whose parents choose to place the child with a private adoption entity before termination of parental rights is finalized. However, these children must still meet the federal eligibility criteria for Title IV-E-funded adoption assistance, e.g., a child with special needs. Staff noted that it is difficult to predict accurately the number of children who become eligible for adoption assistance each year through private adoptions.

²¹ In 2013, lead agency officials reported that most adoptive families do not renegotiate their subsidy rate after the child is adopted, even if the standard adoption subsidy amounts increase. Our analysis of payment data shows that, over one to two years, about 2% of children's rates were increased through renegotiation by an average of \$210 per month.

²² When there is a statewide across-the-board reduction or increase in the foster care maintenance payment rate, the state may adjust the adoption assistance payment without the adoptive parent's concurrence. Adoption agreements terminate when the child dies, reaches 18 years of age, is emancipated, is no longer receiving support from the adoptive parents, or is no longer the legal responsibility of the adoptive parents.

²³ This change became effective on January 1, 2015.

²⁴ Fostering Connections to Success and Increasing Adoptions Act of 2008 (Public Law 110-351). Modifications to the federal adoption assistance eligibility criteria made children in the care of private child welfare agencies eligible for Title IV-E-funded adoption assistance.

²⁵ Chapter 2012-81, *Laws of Florida*, expanded the definition of an adoption entity to include a licensed Florida child-placing agency (s. 63.032(3), *F.S.*) and required the parents of the child to be informed of the availability of a private placement with an adoption entity before the petition for termination of parental rights is filed (s. 39.802(4)(d), *F.S.*).

Some recent state policy changes may increase the number of children adopted, others may result in a decrease. In 2015, the Legislature made two changes to the state's adoption laws. Department staff reported that these changes may increase the number of children adopted and thereby increase the number of children receiving adoption assistance and related state expenditures. However, the effect of these policies cannot be determined since they were only recently implemented.

- Chapter 2015-130, *Laws of Florida*, created an adoption incentive program to award incentive payments to community-based care lead agencies and their subcontracted adoption providers who achieve specific and measurable adoption performance standards. These incentives may redouble the efforts of lead agencies and their subcontract adoption providers to recruit adoptive families and thus, increase the number of children adopted.
- Chapter 2015-130, *Laws of Florida*, also reinstated state employee adoption benefits. State employees who adopt a child from the child welfare system are eligible for a lump sum monetary benefit of \$10,000 in addition to receiving adoption assistance. Department staff reported that the state employee adoption incentive program previously resulted in 400-500 adoptions each year.

In addition, the number of children in out-of-home care increased by approximately 4,320 (24%) between November 2013 and November 2015. Increases in the out-of-home care population may also lead to increased adoptions if these children are not reunited with their families and become available for adoption.

Department staff also reported that the extension of foster care to 21 years of age has decreased the number of older adolescents adopted. In 2013, the Legislature extended the age of children eligible to remain in foster care from 18 to 21 years of age.²⁶ Beginning January 1, 2014, current or former youth in foster care between the ages of 18 to 21 years of age may continue to reside in licensed foster care (or approved supervised living environments). Young adults may continue to reside with their current foster family, if both the young adult and the foster family agree. Monthly room and board is paid directly to the foster family and extended foster care benefits, including Medicaid, are available to young adults until age 21 (and up to their 22nd birthday for those with a diagnosed and documented disability).^{27,28} Adoption subsidies and Medicaid coverage end when adopted children turn 18 years of age potentially creating a financial incentive for youth and foster families to pursue extended foster care, delay adoption until the young adult turns 21 years of age, and then pursue a private adoption.

What methodology does the Department of Children and Families use to project the annual budget needed for adoption subsidy payments, and what improvements have or need to be made to these projections?

In previous years, the department's Legislative Budget Request (LBR) methodology used a generally defensible approach but had some problems implementing the details. The department used essentially the same model for its LBRs for Fiscal Years 2012-13 through

²⁶ Chapter 2013-178, *Laws of Florida*.

²⁷ A young adult may be in extended foster care and also receive financial and academic support services for postsecondary educational pursuits.

²⁸ Young adults adopted from foster care after the age of 16 are eligible for tuition and fee waivers from Florida universities and colleges (s. 1009.25(1)(d)). These young adults may also be eligible for the Postsecondary Education Services and Support education monthly stipend of \$1,256 (which is available until the young adult's 23rd birthday) or the federal Educational Training Voucher educational stipend of \$6,250 annually.

2014-15.²⁹ To forecast the number of children who would receive a subsidy payment and the amount that would be paid during the budget year, the department started with the baseline population of children who received subsidies in June, 13 months before the beginning of the fiscal year for which the budget request was prepared.³⁰ Then, the department subtracted payments for children turning 18 years of age before or during the budget year and added payments for the number of children it projected would be adopted before or during the budget year. For children projected to be adopted during this period, the department assumed children would receive the monthly subsidy amount specified in statute of \$417 per month. Additional dollars were added for projected rate renegotiations for a small percentage of children. Finally, the department added expenditures for non-recurring payments for expenses associated with the adoption process for children adopted during the budget year.

Although this basic approach is reasonable, it had several shortcomings, including the following.

- The department underestimated expenditures by including children who would turn 18 before the budget year in the calculation of the average rate. Many of the children turning 18 years of age were adopted longer ago when adoption subsidies tended to be lower. As a result, including them in the calculation inaccurately reduced the average rate. The department corrected this starting with its Fiscal Year 2015-16 initial LBR.³¹
- The department underestimated expenditures by assuming newly adopted children would receive the statutory rate of \$417 per month. Although the majority of children adopted in recent years received the statutory rate, some children received more than the statutory rate, as is permitted by statute for children with more significant needs. As a result, the average rate for children adopted between the baseline month and end of the budget year was higher than the assumed \$417. The department corrected this starting with its Fiscal Year 2015-16 final LBR.³²
- The department also overestimated expenditures because children receiving pre-adoptive payments were not excluded from the June baseline population. Instead, these children were counted twice as a subsidy recipient—once as on-going subsidy recipients from the baseline population and again as recipients when they were projected to be adopted after the baseline month. This issue has not been corrected in the department's current method.^{33, 34}

²⁹ The most important change DCF made during this period was that in Fiscal Year 2013-14, the department correctly started deducting expenditures for children aging out during the baseline month.

³⁰ For example, June 2013 is the baseline month for the Fiscal Year 2014-15 budget request.

³¹ Starting with its Fiscal Year 2015-16 initial LBR, the department appropriately excluded children who turn 18 before the budget year from the average rate calculation and calculated the average rate separately for children who aged out during the budget year. In addition, the department began correctly treating children aging out of the subsidy during the budget year as getting paid for the full month in which they aged out.

³² The department's current method uses payments to children in the June baseline month for children adopted during the prior year to calculate the average rate for new adoptees. Then, it applies an inflation factor, assuming the rates for new adoptees will grow at the rate of inflation, to estimate the rates that will be paid to children adopted during the budget year.

³³ An additional related complication is that children adopted in the baseline month are often counted twice. The department is required to give the children a new ID in its case management information system, FSFN, when the child is adopted. In the month in which the child is adopted, the child often receives a pre-adoptive payment for part of the month under the pre-adoptive ID and a post-adoptive payment for the remainder of the month under the post-adoptive ID. Since children are primarily identified in the data by their ID, this appears to be two payments to two different children who are treated as receiving monthly payments at the full monthly rate until they turn 18.

³⁴ If the department directly excludes pre-adoptive payments in the future, it should continue to treat children as receiving full-month payments.

- The department used an outdated analysis to project rate renegotiations, which slightly underestimated expenditures. Our analysis of the department’s data shows that for approximately 2% of children in the baseline population, their renegotiated monthly rate is, on average, \$210 higher. While the department’s rate renegotiation factor yielded net increases that are only slightly lower than our estimates, the department should periodically update its analysis to reflect current practices.³⁵

Some of these shortcomings underestimated spending while others overestimated spending. As shown in Exhibit 3, the net result of these errors was that, in four of the past five fiscal years, DCF’s initial budget requests were approximately \$2 to \$3 million (1.4% to 1.9%) below actual adoption subsidy expenditures, resulting in budget shortfalls.³⁶ In these shortfall years, the department received additional funding ranging from \$1.6 million to \$4.3 million. According to department data, in three of the four years, the additional funds resulted in an end of the fiscal year surplus of \$1 million to \$1.3 million.

Exhibit 3
DCF Underestimated Spending in Four of the Past Five Fiscal Years

Fiscal Year ¹	Initial LBR	Final Appropriation ²	Final Expenditures	Initial LBR Over/Under Expenditures	Percentage Over/Under Expenditures
2010-11	\$129.0	\$130.6	\$131.4	(\$2.4)	(1.9%)
2011-12	\$138.7	\$141.7	\$140.7	(\$2.0)	(1.4%)
2012-13	\$154.1	\$149.5	\$150.4	\$3.7	2.4%
2013-14	\$158.6	\$162.2	\$161.2	(\$2.6)	(1.6%)
2014-15	\$168.0	\$172.3	\$171.0	(\$3.0)	(1.8%)

¹ Numbers are in millions.

² Final appropriation includes the original appropriations through the General Appropriations Act and subsequent appropriations through Back of Bill additions.

Source: Department of Children and Families and the Florida Fiscal Portal.

Although the department corrected some of these issues, the current method still has some limitations and likely overestimates expenditures. The department appropriately addressed two of the prior methodology’s issues—improving how children turning 18 years of age and leaving the program were counted and improving estimates of the subsidy amounts paid for newly adopted children. However, by correcting the two most important factors that underestimated spending and not addressing the factor that overestimates spending, the department’s current method likely overestimates spending. In addition, starting with the Fiscal Year 2015-16 amended LBR, the department began using higher adoptions estimates, which further increased projected spending. (See Exhibit 4.) There are some factors that could contribute to an increase in adoptions over the next few years. However, three observations from the data suggest these

³⁵ In addition, the department’s current LBR approach: (1) does not deduct payments for children adopted after the June baseline month who turn 18 before or during the budget year, (2) does not add pre-adoptive payments paid in the LBR year, and (3) has not always consistently rolled up payments for children in the baseline population across all accounting categories for recurring payments. The department’s current approach also excludes partial-month payments when calculating average rates, which would be appropriate except that they do not exclude pre-adoptive payments—an error that is inflated when partial-month payments are excluded. In addition, when updating its LBR projections later on in the year, it would be appropriate to discount the inflation factor since some of the rate renegotiations would already be reflected in the more recent baseline population data.

³⁶ Over the past five Fiscal Years, Fiscal Year 2012-13 is the only year where the department’s initial LBR exceeded expenditures. This is likely the result of inaccuracies in the data from the department changing data systems used to process payments. The department did a phased transition to the new system starting in 2010 and concluding in August 2011, just two months after the June 2011 baseline month for its Fiscal Year 2012-13 LBR.

new adoptions estimates are likely too high: (1) the projection for Fiscal Year 2014-15 exceeded actual adoptions by approximately 350 children; (2) its projections for Fiscal Years 2015-16 and 2016-17 were higher than the number of children adopted in any of the last six years; and (3) for the Fiscal Years 2015-16 and 2016-17 projections to be correct, there would have to be 292 more adoptions each year than in Fiscal Year 2014-15.

**Exhibit 4
Adoptions Projections in LBRs Exceed Recent Trends**

Fiscal Year	Actual Adoptions	Adoptions Projections ¹
2009-10	3,368	
2010-11	3,009	
2011-12	3,252	
2012-13	3,354	
2013-14	3,248	
2014-15 ²	3,219	3,568
2015-16		3,511
2016-17		3,511

¹ Adoptions projections are from the Fiscal Year 2015-16 final LBR and Fiscal Year 2016-17 LBR.

² The Fiscal Year 2014-15 adoptions projection shown is an estimate based on the half-year adoptions projection shown in the department’s mid-Fiscal Year 2015-16 LBR. Since the department’s LBR assumes adoptions are evenly split between the first and last halves of the year, we doubled DCF’s mid-year adoptions projection.

Source: Department of Children and Families’ official adoptions counts and *Department of Children and Families’ Legislative Budget Requests* from the Florida Fiscal Portal.

The department’s Fiscal Year 2015-16 final LBR was \$8.5 million higher than its initial LBR. The implementation of two changes explains 74% of the increase. First, with the final Fiscal Year 2015-16 LBR, the department more accurately calculated subsidy amounts paid for newly adopted children, which increased the final LBR by approximately \$3.9 million over the initial LBR. Second, the department’s higher adoptions estimates increased the final LBR by approximately \$2.4 million more.³⁷

Based on our analysis of the department’s methodology, we estimate that there will be a budget surplus in Fiscal Year 2015-16 of approximately \$4 million and that the Fiscal Year 2016-17 budget request, if funded at the requested amount of \$191.1 million, may result in a surplus of approximately \$4 million to \$5 million. Our simulated validation, which corrects all known deficiencies with the department’s current method, projects that actual expenditures will be below the department’s LBR by approximately \$4.4 million for Fiscal Year 2015-16 and \$4.6 million for Fiscal Year 2016-17 if there is no growth in adoptions.³⁸ (See Exhibit 5.) If the number of adoptions over the next two years exceeds the number over the past two years, then the discrepancy will likely be smaller.

³⁷ The remaining 26% of the increase between the initial and final Fiscal Year 2015-16 LBRs appear to be due to the department switching to only using full-month payments in calculating average rates and a few other smaller factors.

³⁸ To further corroborate that the department’s current method overestimates spending, we also projected what the department would have requested if it had used its prior method rather than the current method for the Fiscal Years 2015-16 and 2016-17 LBRs. Since the prior method was too low by \$2 million to \$3 million, if the current method produced estimates that exceed the old method by more than \$2 million to \$3 million, the current method would likely overestimate spending. Our analysis showed that the department’s requests using the current method are about \$5 million to \$9 million above what the prior method would have projected.

Exhibit 5
The Department's Requests Exceed Our Best Estimates of Expenditures

Projection Method ¹	Fiscal Year 2015-16	Fiscal Year 2016-17 LBR
Department's LBR	\$184.3 ²	\$191.1
Old model with current LBR adoptions projections	\$179.1	\$184.8
Old model with no growth in adoptions	\$177.3	\$182.5
Validated through simulation with no growth in adoptions	\$180.0	\$186.5
Recommended approach with no growth in adoptions	\$178.9	\$185.9

¹ The expenditures projections are in millions. Models assuming no growth in adoptions use the number of adoptions from Fiscal Years 2013-14 (3,248) and 2014-15 (3,219). The Department's LBR and old model with current LBR adoptions projections use the department's higher adoptions forecast of approximately 3,568 for Fiscal Years 2014-15 and 3,511 for 2015-16 and 2016-17.

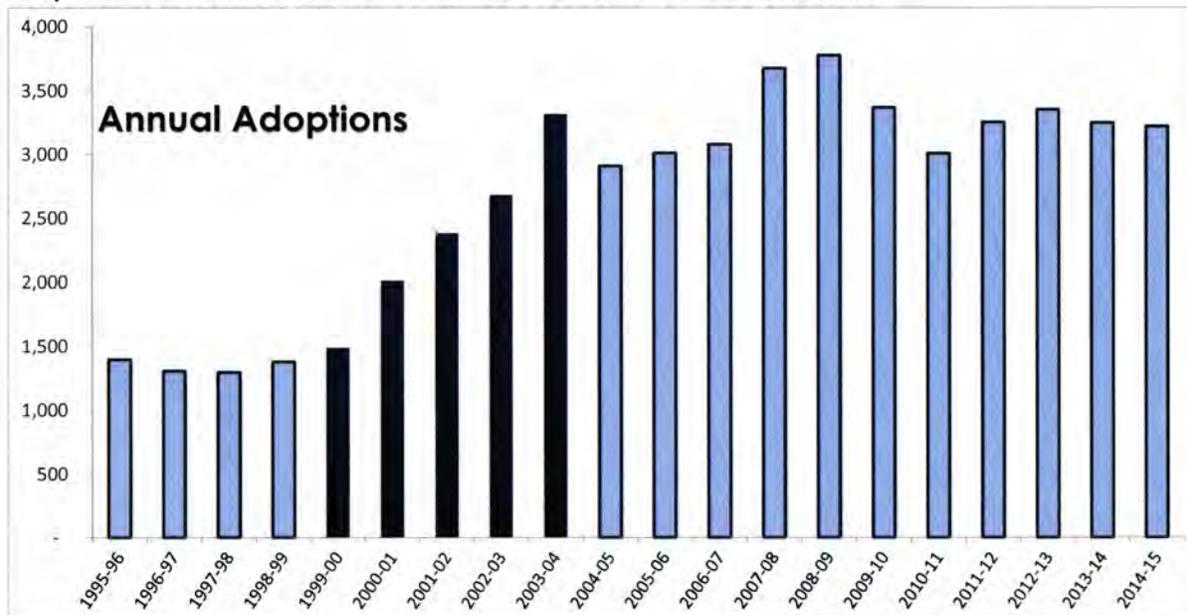
² The department's final LBR for Fiscal Year 2015-16 requested \$184.3 million.

Source: OPPAGA analysis of Department of Children and Families' data and *Department of Children and Families' Legislative Budget Requests* from the Florida Fiscal Portal.

The Fiscal Year 2016-17 budget request does not reflect the fact that adoptions subsidy growth is slowing. The department's Fiscal Year 2016-17 LBR requests \$191.1 million, which is an average annual increase of \$10 million over total expenditures from Fiscal Year 2014-15. This is consistent with the average annual increase in spending of \$9.9 million per year over the past six fiscal years. However, this likely overestimates spending because growth in adoption subsidy expenditures is likely slowing due to slower growth in the number of subsidy recipients. Although the number of children starting to receive adoption subsidies has been relatively consistent, the number of children turning 18 years of age and leaving the program has increased over the past few years. Since more than half of children adopted are less than six year of age when adopted, approximately 12 years after rapid growth in adoptions, the number of children turning 18 years of age and leaving the program will increase. As shown in Exhibit 6, about 13 to 15 years ago, the number of children adopted grew rapidly, resulting in the recent increase in the number of children turning 18 and leaving the program.³⁹ Despite the slowing net inflow of children into the adoption subsidy program, expenditures will likely continue to grow, but at a slower rate because children aging out of the adoption program have lower average subsidy payment amounts than newly adopted children.

³⁹ If one were to assume that the factors noted above were to result in higher than normal adoptions over the next two years and used the department's higher adoption numbers in its recent LBRs, these budget requests show that the two-year growth in adoption subsidy recipients declined from a projected 2,661 in Fiscal Year 2013-14 to 1,878 in Fiscal Year 2016-17—a decrease of 783 recipients.

**Exhibit 6
Adoptions More than Doubled Between Fiscal Years 1999-2000 and 2003-04**



Source: Department of Children and Families data.

There are several critical areas that the department has not addressed that could further improve its adoption subsidy budget request. The department could improve the accuracy of its budget projection by addressing the following issues in order of priority. The recommended approach in Exhibit 5 estimates the amount the department would have requested if they had used the following recommendations and assumed no growth in adoptions over the next two years.

- Reduce the baseline population by the number of children receiving pre-adoptive payments. This would improve the expenditures projections by not counting a child once in the baseline population and a second time in the adoptions projections.⁴⁰
- Return to using slightly lower adoption forecasts for the budget request. While it is difficult to predict the number of children who will be adopted during the budget year, the department’s current method likely overestimates adoptions.
- Update the analysis of subsidy renegotiations periodically to reflect current practices. The department’s LBR uses an outdated adjustment to reflect the extent to which expenditures are affected by rate renegotiations. Based on our calculations, approximately 2% of the baseline population negotiated a subsidy increase of approximately \$210 per month. This should be applied only to children in the baseline population, not newly adopted children, since most rate renegotiations are for older children receiving older, lower subsidy amounts.

⁴⁰ There are a number of challenges with the adoption subsidy data, such as changing child IDs and missing historical data from legacy systems, which may make distinguishing between pre-adoptive and post-adoptive payments challenging. If the department cannot reasonably make this distinction, a reasonable approximation may be to reduce the baseline population by approximately 1 child per 5 to 5.5 children projected to be adopted in the year before the budget year. If this change is made, then excluding children with a partial-month payment, as the department did in the Fiscal Years 2015-16 and 2016-17 LBRs, will likely improve the accuracy of the estimates. This is because the majority of children with a partial-month payment are children receiving pre-adoptive payments and children receiving pre-adoptive payments typically receive higher payment amounts than the overall population of subsidy recipients.

Maintenance Adoption Subsidy Program and Methodology for Projecting Annual Budget Needs

A Presentation to the House Health Care
Appropriations Subcommittee

Justin Graham
Chief Legislative Analyst

January 12, 2016



Maintenance Adoption Subsidy Program

- ▶ What are the federal and state requirements for determining the amount of monthly adoption subsidy payments?
- ▶ What factors may influence monthly adoption subsidy amounts, the number of adoption subsidy recipients, and overall expenditures over the next few years?
- ▶ What methodology does DCF use to project the annual budget needed for adoption subsidy payments, and what improvements have or need to be made to these projections?

Maintenance Adoption Subsidy Program

The federal Adoption Assistance and Child Welfare Act of 1980 established the Adoption Assistance Program

- ▶ Provides financial assistance to families that adopt children with special needs from foster care
- ▶ Financial assistance includes monthly adoption subsidies and non-recurring adoption expenses

Maintenance Adoption Subsidy Program

- ▶ Department of Children and Families administers the program
- ▶ Community-based care lead agencies (CBCs) determine the subsidy amount
- ▶ Program funding
 - Primary source of funding for adoption subsidies, Federal Title IV-E adoption funds
 - Temporary Assistance for Needy Families (TANF)
 - State General Revenue

Determining the Adoption Subsidy

- ▶ Federal and state laws and rules establish criteria
 - Based on specific needs of the child and circumstances of adoptive family
 - Cannot exceed foster care board rate child would have received in foster care
- ▶ Florida Statute establishes subsidy at \$5,000 annually (\$417 per month) or a different amount as determined by the adoptive parents and the department

Factors That May Influence Adoption Subsidy Expenditures

- ▶ The number of adoptions may increase due to
 - Increases in private adoptions
 - CBC adoption incentive program and state employee adoption benefits
 - Increases in the number of children in out-of-home care
- ▶ Adoptions may also be reduced due to extending foster care to age 21
- ▶ Payment amounts may also increase due to cost of living adjustments to foster care board rates

DCF Annual Budget Projections for Adoption Subsidy Expenditures

Methodology for Fiscal Years 2012-13 through 2014-15

- ▶ DCF started with baseline of children receiving subsidies at the time the budget request was developed
 - Subtracted payments for children turning 18 before or during the budget year
 - Added payments for children projected to be adopted before or during the budget year
 - Added projected funding for subsidy rate renegotiations and non-recurring adoption expenses

Shortcomings in DCF Projection Methodology

- ▶ Factors in underestimating expenditures
 - Including the lower subsidy rate for children turning 18 before the beginning of the budget year in the calculation of the overall average rate
 - Assuming newly adopted children receive the statutory subsidy rate of \$417
 - Using an outdated analysis to project subsidy rate renegotiations
- ▶ Factors in overestimating expenditures
 - Counting children receiving pre-adoptive payments twice—in baseline and as newly adopted children

Methodology Shortcomings Resulted in Underestimates

DCF underestimated spending in 4 of the past 5 years

Fiscal Year ¹	Initial LBR	Final Appropriation ²	Final Expenditures	Initial LBR Over/ Under Expenditures	Percentage Over/ Under Expenditures
2010-11	\$129.0	\$130.6	\$131.4	(\$2.4)	(1.9%)
2011-12	\$138.7	\$141.7	\$140.7	(\$2.0)	(1.4%)
2012-13	\$154.1	\$149.5	\$150.4	\$3.7	2.4%
2013-14	\$158.6	\$162.2	\$161.2	(\$2.6)	(1.6%)
2014-15	\$168.0	\$172.3	\$171.0	(\$3.0)	(1.8%)

¹ Numbers are in millions.

² Final appropriation includes the original appropriations through the General Appropriations Act and subsequent appropriations through Back of Bill additions.

Source: Department of Children and Families and the Florida Fiscal Portal.

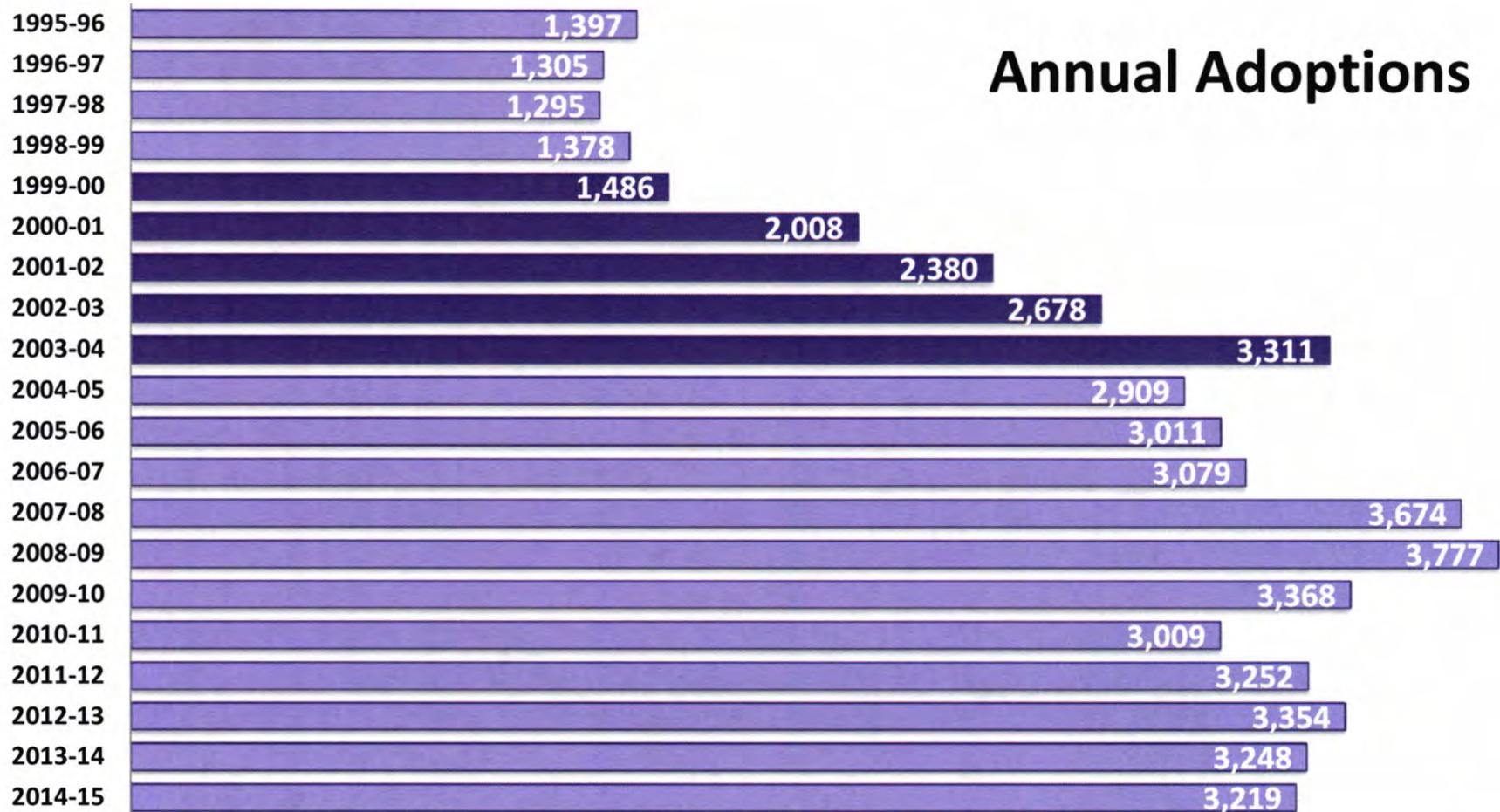
Recent Changes to Projection Methodology

- ▶ DCF corrected 2 problems for its Fiscal Year 2015-16 budget request
 - Excluded the lower subsidy rate for children turning 18 before beginning of the budget year in the calculation of the overall average rate
 - Estimated the actual average subsidy amount paid for newly adopted children
- ▶ DCF began using higher adoptions projections

Current Methodology Contains Limitations

- ▶ Revised methodology
 - Does not correct error that overestimates expenditures and new adoptions projections are likely too high
- ▶ Estimates likely too high
 - Approximately \$4 million for Fiscal Year 2015-16, \$4 million to \$5 million for Fiscal Year 2016-17
- ▶ Does not reflect slowing growth in the number of adoption subsidy recipients
 - More children aging-out of program due to rapid growth in adoptions from Fiscal Years 1999-2000 through 2003-04

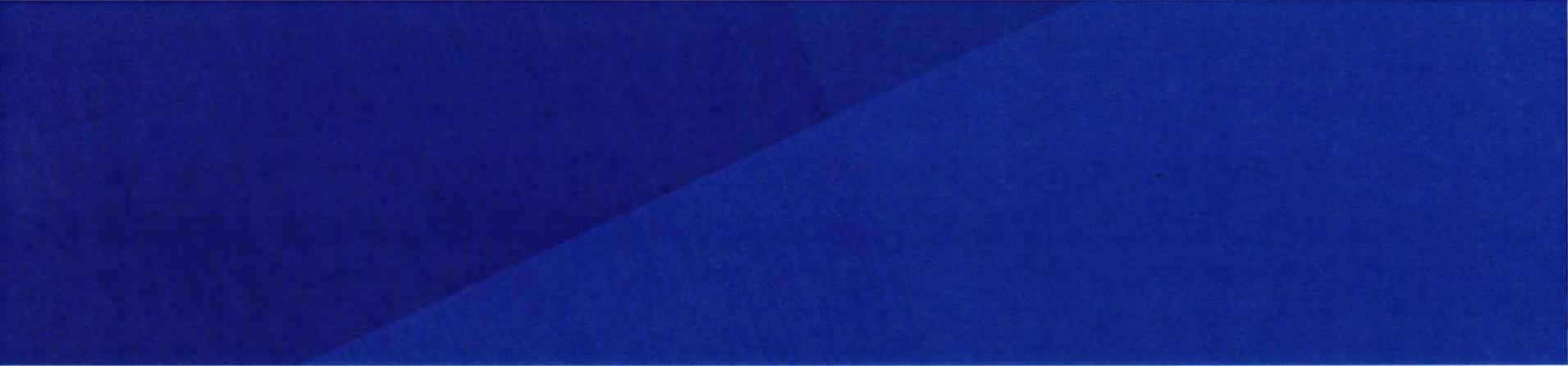
Adoptions Doubled Between Fiscal Years 1999-2000 and 2003-04



Source: Department of Children and Families data.

Areas to Improve Adoption Subsidy Request

- ▶ Exclude children receiving pre-adoptive payments from the baseline population
- ▶ Use slightly lower adoptions projections
- ▶ Periodically adjust analysis of subsidy rate renegotiations to reflect current practices



Questions?

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OPPAGA supports the Florida Legislature by providing data, evaluative research, and objective analyses that assist legislative budget and policy deliberations.

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