HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCB APC 17-10 Medicaid Services
SPONSOR(S): Appropriations Committee
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Appropriations Committee	17 Y, 10 N	Clark	Leznoff

SUMMARY ANALYSIS

The bill conforms statutes to the funding decisions related to the Medicaid Program included PCB APB 17-06, the House proposed General Appropriations Act (GAA), for Fiscal Year 2017-2018. The bill:

- Amends the definition of a "rural hospital" to eliminate sole community hospitals with up to 175 beds;
- Removes obsolete language related to ambulatory surgical center reimbursements due to the implementation of a prospective payment system;
- Removes Hospital Outpatient services reimbursements from the statutory rate freeze due to the implementation of a prospective payment system;
- Requires local governments that submit Intergovernmental Transfers to AHCA to submit the total amount of the funds as agreed upon in the executed letter of agreement, no later than October 31 of the year the funds are pledged unless an alternative plan is specifically approved by AHCA;
- Revises "Medicaid Payments" within the Statewide Medicaid Residency Program to include Hospital Outpatient Medicaid rates due to the implementation of a prospective payment system;
- Revises the years of audited data used in determining Disproportionate Share Hospital payments;
- Provides a nonrecurring appropriation for a Low Income Pool Program contingent upon federal approval; and
- Provides conforming cross-references.

The bill provides for an effective date of July 1, 2017.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Medicaid

Medicaid is the health care safety net for low-income Floridians. Medicaid is a federal and state partnership 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 Department of Health (DOH), the Agency for Persons with Disabilities, and the Department of Elderly Affairs (DOEA).

The Florida Medicaid program covers approximately 4 million low-income individuals, including approximately 2.3 million, or 58.7%, of the children in Florida.[1] Medicaid is the second largest single program in the state, behind public education, representing 31 percent of the total FY 2016-2017 budget. Medicaid expenditures represent over 19 percent of the total state funds appropriated in FY 2016-2017.

Sole Community Hospitals

The federal Medicare program classifies a hospital as a "sole community hospital" based on criteria specified in title 42, s. 412.92, of the Code of Federal Regulations, including whether the hospital is situated in a federally-designated rural area, the hospital's capacity, and the hospital's distance from other hospitals. A sole community hospital is given special treatment and is eligible for payment adjustments from the Medicare program due to the federal government's consideration of the hospital's accessibility to residents of rural areas who have limited options for hospital services.

In 2016, the Legislature amended the definition of a rural hospital to include hospitals classified as sole community hospitals having up to 175 licensed beds, beginning in the 2016-2017 fiscal year.[2] Chapter 2016-66, Laws of Florida provided non-recurring funding for the increased cost associated with amending the definition to include hospitals classified as sole community hospitals.

Outpatient Reimbursement

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. The hospital outpatient rates are based on unaudited, historical cost reports submitted prior to services being rendered. The reimbursement rates are adjusted post-payment for some facilities each year based on audited cost reports. The cost report audit and rate adjustment processes can take several years for full reconciliation and finalization of payment.

During the 2015 Legislative Session, the Legislature authorized the study and design of an Outpatient Prospective Payment System (OPPS) for Florida Medicaid[3]. The Legislature required that the Agency for Health Care Administration develop a plan to convert Medicaid payments for outpatient services, including hospital outpatient services and ambulatory surgery centers, to a prospective payment system and identify steps necessary for the transition to be completed in a budget neutral manner.

[1] Agency for Health Care Administration, *Florida Statewide Medicaid Monthly Enrollment Report*, February 2017, available at http://www.fdhc.state.fl.us/medicaid/Finance/data_analytics/enrollment_report/index.shtml (last accessed March 17, 2017).
[2] Chapter 2016-65, Laws of Florida
[3] Chapter 2015-232, Laws of Florida

During the 2016 Legislative Session, the Legislature amended s. 409.905, F.S., replacing AHCA's existing per diem and retroactive adjustment fee methodology for Medicaid outpatient care, with a prospective payment system. Under the new system, AHCA will calculate reimbursement rates annually for Hospital Outpatient Services. Additionally, s. 409.908(5), F.S., was amended to reflect the transition to prospective payment system for ambulatory surgical centers. The new rates are required to go into effect on July 1, 2017, and on July 1 every year thereafter. The new methodology must function like an outpatient prospective payment system by categorizing the amount and type of services used in outpatient visits, and group together procedures that share similar characteristics and costs.

Intergovernmental Transfers

Certain programs, including but not limited to the Statewide Medicaid Residency Program, the Graduate Medical Education Startup Bonus Program, the Disproportionate Share Hospital (DSH), and certain hospital reimbursement exemptions are funded through county and other local tax dollars that are transferred to the state and used to draw federal match. Local dollars transferred to the state and used in this way are known as "intergovernmental transfers" or IGTs. IGTs may be used to augment hospital payments in other ways, specifically through direct payment programs authorized by the federal Centers for Medicare and Medicaid Services (CMS) through waivers or state plan amendments. Examples include the Upper Payment Limit (UPL) and Low Income Pool (LIP) programs. All IGTs are contingent upon the willingness of counties and other local taxing authorities to transfer funds to the state in order to draw down federal match. The local taxing authorities commit to sending these funds to the state in the form of an executed Letter of Agreement with the AHCA. In order for AHCA to make timely payments to hospitals, AHCA must know which local governments will be submitting IGTs and the amount of the funds prior to using the funds to draw the federal match. Current law requires local governments who will be submitting IGTs to submit to AHCA the final executed letter of agreement containing the total amount of the IGTs authorized by the entity, no later than October 1 of each year. Currently, there is no date requirement for the local governments to transfer the actual IGTs to AHCA.

Statewide Medicaid Residency Program

In 2013, the Legislature created the Statewide Medicaid Residency Program (SMRP) to fund graduate medical education (GME).[4] GME is the education and training of physicians following graduation from a medical school in which physicians refine the clinical skills necessary to practice in a specific medical field (surgery, dermatology, family practice, etc.). GME or "residency" programs for allopathic and osteopathic physicians include internships, residency training, and fellowships. These residency programs vary in length from three to seven years. Previously, graduate medical education was reimbursed through hospital inpatient and outpatient reimbursements.

The SMRP defines "Medicaid payment" as payments made to reimburse a hospital for direct inpatient services, as determined by AHCA. Consequently, AHCA must calculate an allocation fraction in accordance with statutory formula on or before September 15 of each year. A hospital's annual allocation equals the funds appropriated for the SMRP in the GAA multiplied by its allocation fraction. Regardless of the formula, a hospital's annual allocation may not exceed two-times the average per resident amount for all hospitals. Any funds beyond this amount must be redistributed to participating hospitals whose annual allocation does not exceed this limit. AHCA must distribute each participating hospital's annual allocation in four installments on the final business day of each quarter of the state fiscal year.[5]

[4] Chapter 2013-48, Laws of Florida
[5] S. 409.909, F.S.

Disproportionate Share Hospital Program

The Medicaid Disproportionate Share Hospital (DSH) Program funding distributions are provided to hospitals that provide a disproportionate share of the Medicaid or charity care services to uninsured individuals. Each year, the Legislature delineates how the funds will be distributed to each eligible facility either through statutory formulas or other direction in the implementing bill or proviso.

Low Income Pool

The Low Income Pool (LIP) was originally created as a result of the original 1115 Waiver that established the Managed Medicaid Pilot program. Pursuant to s. 409.91211(1)(b), F.S., the Managed Medicaid Pilot waiver was "contingent upon federal approval to preserve the upper-payment-limit funding mechanism for hospitals, including a guarantee of a reasonable growth factor, a methodology to allow the use of a portion of these funds to serve as a risk pool for demonstration sites, provisions to preserve the state's ability to use intergovernmental transfers, and provisions to protect the disproportionate share program." The LIP was to be used to provide supplemental payments to hospitals that provide services to Medicaid recipients, the uninsured and underinsured individuals. The LIP program also authorized supplemental Medicaid payments to provider access systems, such as federally qualified health centers, county health departments, and hospital primary care programs, to cover the cost of providing services to Medicaid recipients, the uninsured and the underinsured. Florida law provides that distribution of the Low-Income Pool funds should:

- Assure a broad and fair distribution of available funds based on the access provided by Medicaid participating hospitals, regardless of their ownership status, through their delivery of inpatient or outpatient care for Medicaid beneficiaries and uninsured and underinsured individuals;
- Assure accessible emergency inpatient and outpatient care for Medicaid beneficiaries and uninsured and underinsured individuals;
- Enhance primary, preventive, and other ambulatory care coverages for uninsured individuals;
- Promote teaching and specialty hospital programs;
- Promote the stability and viability of statutorily defined rural hospitals and hospitals that serve as sole community hospitals;
- Recognize the extent of hospital uncompensated care costs;
- Maintain and enhance essential community hospital care;
- Maintain incentives for local governmental entities to contribute to the cost of uncompensated care;
- Promote measures to avoid preventable hospitalizations;
- Account for hospital efficiency; and
- Contribute to a community's overall health system.

On April 11, 2014, the Centers for Medicaid and Medicare Services (CMS) extended the 1115 demonstration waiver, titled Managed Medical Assistance, for three years; however, they extended the LIP for only one year from July 1, 2014 through June 30, 2015. The total computable amount of LIP funding for the 2014-15 fiscal year was approximately $2.16 billion.

On May 21, 2015, the CMS outlined an approach to the LIP that allowed for a two-year transition of the LIP by reducing the size of the pool from $2.16 billion in the 2014-15 fiscal year to $1.0 billion in the 2015-16 fiscal year. Additionally, during the 2016-17 fiscal year, the LIP pool was further reduced to $607,825,452 until June 2017, when Florida's current LIP is scheduled to end.

On April 12, 2017, the CMS notified AHCA and provided a preliminary outline that would continue LIP in the amount of $1,508,385,773 annually for an additional five years. The state is required to submit a draft Reimbursement and Funding Methodology Document (RFMD) to CMS prior to November 1, 2017. CMS and the state will work together to obtain final approval of the LIP by January 31, 2018. The state may not claim federal financial participation for LIP payments until after a revised RFMD is approved by CMS.

Effect of Proposed Bill

Sole Community Hospitals

The bill amends s. 395.602, F.S., to revise the definition of "rural hospital" by deleting the provision allowing a hospital to qualify as a rural hospital by being classified as a sole community hospital having up to 175 licensed beds since the increased costs associated with this change was funding with non-recurring appropriations.

Outpatient Reimbursement

During the 2016 Legislative Session, the Legislature required that the Agency for Health Care Administration implement prospective payments for outpatient services, including hospital outpatient services and ambulatory surgery centers.[6] The bill deletes obsolete language in s. 409.908(5), F.S., due to the statutorily required implementation of a prospective payment system effective July 1, 2017. The new rates go into effect on July 1, 2017, and on July 1 every year thereafter. Additionally, the bill eliminates hospital outpatient services from the statutory rate freeze that ensures no increase in statewide expenditures resulting from a change in unit costs effective July 1, 2011.

Intergovernmental Transfers

The bill amends s. 409.908, F.S., to require the local governments to submit to AHCA the total amount of the IGTs as agreed upon in the executed letter of agreement, no later than October 31 of the year the IGTs are pledged unless an alternative plan is specifically approved by AHCA.

Statewide Medicaid Residency Program

This legislation amends s. 409.909, F.S., to modify the definition of "Medicaid payments" under the SMRP to include outpatient services. This change is necessitated by the statutory transition to a prospective outpatient payment system. This is similar to the transition that occurred when Florida moved to inpatient Diagnosis Related Groups.

Disproportionate Share Hospital Program

The bill amends s. 409.911, F.S., to update existing law to provide payments for the 2017-2018 fiscal year related to hospitals in the Disproportionate Share Hospital (DSH) Programs and Medicaid DSH based upon the average of the 2009, 2010, and 2011 audited disproportionate share data to determine each hospital's Medicaid days and charity care.

Low Income Pool

The bill provides a nonrecurring appropriation of $1,508,385,773 ($578,918,460 in Grants and Donations Trust Fund and $929,467,313 in Medical Care Trust Fund) for the continuation of the LIP program. The bill appropriates the LIP funds in a qualified expenditure category. Subject to federal approval of the final terms and conditions of the LIP, the AHCA is required to submit a budget amendment to request release of the LIP funds. The Legislative Budget Commission must approve the release of funds. The bill requires the budget amendment to include the RFMD, which documents permissible LIP expenditures, a proposed distribution model by entity, and a proposed listing of entities contributing IGTs to support the state match. The bill requires that LIP payments to providers are contingent upon the nonfederal share being provided through IGTs and if IGTs are not available, the state is not obligated to make LIP payments.

[6] Chapter 2016-65, Laws of Florida

The bill provides for an effective date of July 1, 2017.

B. SECTION DIRECTORY:

Section 1: Amends s. 395.602, F.S., relating to rural hospitals.
Section 2: Amends s. 409.908, F.S., relating to reimbursement of Medicaid providers.
Section 3: Amends s. 409.909, F.S., relating to Statewide Medicaid Residency Program.
Section 4: Amends s. 409.911, F.S., relating to Disproportionate Share Program.
Section 5: Amends s. 391.055, F.S., conforming cross-references.
Section 6: Amends s. 427.0135, F.S., conforming cross-references.
Section 7: Amends s. 1011.70, F.S., conforming cross-references.
Section 8: Provides a nonrecurring appropriation for a Low Income Pool, contingent upon federal approval.
Section 9: Provides an effective date of July 1, 2017.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

$476,864,450 in federal Medicaid funds will be generated through the implementation of the Hospital Outpatient Prospective Payment System, the GME program, and the DSH programs:

- Hospital Outpatient Services = $146,635,622
- Graduate Medical Education = $110,916,000
- Disproportionate Share Hospital Program = $219,313,128

Upon federal approval of the LIP program, $929,467,313 in federal Medicaid funds will be generated through the LIP program.

2. Expenditures:

The bill does not increase the Medicaid outpatient reimbursements as the transition from a cost-based reimbursement system to a prospective payment system is required to be budget neutral.

The bill will require AHCA to make payments to eligible DSH providers, based on the statutory formulas, a total amount of $310,541,853 ($6.5 million General Revenue).

The bill will require AHCA to make LIP payments to eligible entities in the amount of $1,508,385,773 upon federal approval of the LIP program and upon approval of budget amendment request by the Legislative Budget Commission.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

In order to earn matching federal dollars for IGT funded programs, including LIP, the local governments and other local political subdivisions would be required to provide $828,747,355 in contributions, no later than October 31, 2017, unless an alternative plan is specifically approved by AHCA.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

D. FISCAL COMMENTS:

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

2. Other:

B. RULE-MAKING AUTHORITY:

C. DRAFTING ISSUES OR OTHER COMMENTS:

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES