HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCB HCA 24-01 Medicaid Supplemental Payment Programs
SPONSOR(S): Health Care Appropriations Subcommittee
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Health Care Appropriations Subcommittee		Smith	Clark

SUMMARY ANALYSIS

PCB HCA 24-01 conforms statute to funding decisions related to supplemental payment programs included in PCB APC 24-01, the House proposed General Appropriations Act for Fiscal Year 2024-2025.

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. Florida delivers medical assistance to most Medicaid recipients using a comprehensive managed care model, the Statewide Medicaid Managed Care program, to provide comprehensive, coordinated benefits coverage to the Medicaid population, leveraging economic incentives to ensure provider participation and quality performance.

Federal Medicaid managed care programs are required to use actuarily sound capitation rates which represent the entirety of the Medicaid expenditures for such services. However, federal law or Florida waiver approvals authorize certain exceptions, allowing additional Medicaid payments to take place outside the managed care relationship for some provider types. These arrangements are called supplemental payment programs. AHCA collects local intergovernmental transfers (IGTs) to fund the state share of the Medicaid match funds from counties, local health care taxing districts, and publicly operated providers. Governmental sources of IGTs sign pledge letters with AHCA specifying their contribution amount.

The bill makes, for certain hospital classes, participation in the Low Income Pool and Indirect Graduate Medical Education supplemental payment programs contingent on the hospital's participation in the Hospital Directed Payment Program. The bill also provides definitions for Hospital Directed Payment Program, Indirect Graduate Medical Program, and Low Income Pool Program.

The bill would have an indeterminate fiscal impact on local government and the private sector. *See* Fiscal Comments.

The bill provides an effective date of July 1, 2024.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Florida 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 Department of Health, 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.[1] 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. The federal government sets the minimum mandatory populations to be included in every state Medicaid program. The federal government also 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.[2] States can add benefits, with federal approval. Florida has added many optional benefits, including prescription drugs, adult dental services, and dialysis.[3]

States have some flexibility in the provision of Medicaid services. Section 1915(b) of the Social Security Act provides authority for the Secretary of the U.S. Department of Health and Human Services (HHS) to waive requirements to the extent that he or she "finds it to be cost-effective and efficient and not inconsistent with the purposes of this title." Section 1115 of the Social Security Act allows states to implement demonstrations of innovative service delivery systems that improve care, increase efficiency, and reduce costs. These laws allow HHS to waive federal requirements to expand populations or services, or to try new ways of service delivery.

Florida operates under a Section 1115 waiver to use a comprehensive managed care delivery model for primary and acute care services, known as the Statewide Medicaid Managed Care (SMMC) Managed Medical Assistance (MMA) program. Florida also has a waiver under Sections 1915(b) and (c) of the Social Security Act to operate the SMMC Long-Term Care (LTC) program.[4]

The Florida Medicaid program covers approximately 4.9 million low-income individuals, including approximately 2.4 million, or 49.6%, of the children in Florida.[5] Medicaid is the second largest single program funded in the state, behind public education, representing approximately one-third of the total FY 2023-2024 state budget.[6] As of September 2023, Florida's program is the 4th largest in the nation by enrollment and, for FY 2021-2022, the program is the 5th largest in terms of expenditures.[7]

Florida delivers medical assistance to most Medicaid recipients – approximately 72% - using a comprehensive managed care model, the SMMC program.[8] The SMMC program was intended to

[1] Title 42 U.S.C. §§ 1396-1396w-5; Title 42 C.F.R. Part 430-456 (§§ 430.0-456.725) (2016).
[2] S. 409.905, F.S.
[3] S. 409.906, F.S.
[4] S. 409.964, F.S.
[5] Agency for Health Care Administration, *Florida Statewide Medicaid Monthly Enrollment Report*, December 2023, available at https://ahca.myflorida.com/medicaid/Finance/data_analytics/enrollment_report/index.shtml (last visited January 17, 2024)..
[6] Chapter 2023-239, Laws of Fla.
[7] The Henry J. Kaiser Family Foundation, *State Health Facts, Total Medicaid Spending FY 2022 and Total Monthly Medicaid and CHIP Enrollment Sep. 2023*, available at http://kff.org/statedata/ (last visited January 17, 2024).
[8] *Supra*, note 6.

provide comprehensive, coordinated benefits coverage to the Medicaid population, leveraging economic incentives to ensure a level of provider participation and quality performance that was impossible under the former, federally prescribed, fee-for-service delivery model.

Supplemental Payment Programs

Federal Medicaid managed care programs are required to use actuarily sound capitation rates which represent the entirety of the Medicaid expenditures for such services. However, federal law or Florida waiver approvals authorize certain exceptions, allowing additional Medicaid payments to take place outside the managed care relationship for some provider types. These arrangements are called supplemental payment programs.

Florida currently has ten supplemental payment programs to fund payments to Medicaid providers that are in addition to reimbursement they receive for services rendered to Medicaid enrollees. They are either authorized by statute or by the General Appropriations Act and are approved by the federal government. Non-General Revenue sources are used for the state share of Medicaid funds, which is used to draw down the federal matching payment. However, some supplemental payments are funded through General Revenue.

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 Hospital Directed Payment Program (DPP) 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.[9] Funds outlined in the letters of agreement must be received by the agency no later than October 31 of each fiscal year in which such funds are pledged, unless an alternative plan is specifically approved by the agency.[10]

Low Income Pool

The terms and conditions of CMS Florida Managed Medical Assistance Waiver Approval Document created a Low Income Pool (LIP) to be used to provide supplemental payments to providers who provide services to Medicaid and uninsured patients. This pool constituted a new method for such supplemental payments, different from the prior program called Upper Payment Limit. 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.

Hospital Directed Payment Program

The Hospital Directed Payment Program (DPP) was authorized in the state fiscal year 2021-22 General Appropriations Act[11], and provides directed payment to hospitals in an amount up to the Medicaid

[9] S. 409.908(26), F.S.
[10] *Id.*
[11] Chapter 2021-36, Laws of Fla.

shortfall, or the difference between the cost of providing care to Medicaid-eligible patients and the payments received for those services.[12]

The payment arrangement directs payments within each Medicaid region, to all hospitals in each class by an equal percentage for hospital services provided by hospitals and paid by Medicaid health plans. The DPP operates regionally. Each region's DPP operates independent of other regions once certain conditions are met.[13]

Participating hospitals must meet the following three criteria:

1. Fall into one of the following three mutually exclusive provider classes:
   - private hospitals
   - public hospitals; or
   - cancer hospitals
2. Operate in one of Florida's 11 SMMC regions; and
3. Provide inpatient and outpatient hospital services to Florida Medicaid managed care enrollees.[14]

For a region to participate in the DPP, all hospitals in at least one of the classes (private, public, cancer hospitals) within that region must agree to participate and be subject to an assessment to fund the state share of the DPP.

The DPP funding is contingent on Local Provider Participation Funds and IGTs. Private hospitals in the State of Florida must be partnered with a governmental entity in order to participate in the DPP. The hospital DPP is a local option that allows local governments to establish a non-ad valorem (non-property tax) special assessment that is charged solely to hospitals.

Indirect Graduate Medical Education

The Indirect Graduate Medical Education (IME) program was authorized in the state fiscal year 2021-22 General Appropriations Act, for the purpose of supporting hospitals with residents in graduate medical education (GME) who are in training to become physicians.[15] IME covers ancillary costs associated with the educational process and the higher case-mix intensity of teaching hospitals with residency programs, that may result in higher patient care costs relative to non-teaching hospitals.[16]

An eligible teaching hospital must have a resident to bed ratio between 0.1% and 100% and meet the criteria for at least one of the following groups:[17]

- Academic Medical Centers Group 1(AMC 1)
  - Statutory teaching hospital with greater than 650 beds per license and
    - Greater than 500 FTEs, or
    - affiliated with the University of Florida Health.
- Public Teaching Hospitals
  - Public hospital with residents in an approved GME program and is not classified as a statutory teaching hospital.
- Academic Medical Centers Group 2(AMC 2)
  - Statutory teaching hospital with greater than 650 beds per license.
- Children's Teaching Hospitals
  - Children's hospital that is excluded from the Medicare prospective payment system, or
  - Reginal Perinatal Intensive Care Center that does not meet the eligibility qualifications of the AMC1, AMC2 or Public Teaching Hospital groups.
- Statutory Teaching Hospitals

[12] Agency for Health Care Administration, Presentation to the House Health Care Appropriations Subcommittee, *Medicaid Reimbursement Rates and Supplemental Payment Programs, available at* https://ahca.myflorida.com/content/download/20776/file/House_HHS_Approps-Medicaid_Supplemental_Programs_Overview.pdf (last visited January 17, 2024).
[13] *Id.*
[14] *Id.*
[15] *Supra*, note 10
[16] Centers for Medicare and Medicaid Services, *Appendix F to Florida Title XIX Inpatient Hospital Reimbursement Plan*, May 4, 2023, On file with the House Healthcare Appropriations Subcommittee.
[17] *Id.*

- Statutory teaching hospital with at least 200 beds per license that does not meet the requirements of AMC1, AMC2, Public Teaching Hospitals, or Children's Teaching Hospital groups.

IME payment amounts are determined by a distribution model, by hospital grouping, calculated using the most recently filed and available Medicare Cost Report[18] extracted from the Healthcare Cost Report. Providers are reimbursed on a quarterly basis, based on the hospital's IME costs for services provided.[19]

Effect of the Bill

PCB HCA 24-01 amends s. 409.908, F.S., requiring a hospital's participation in DPP as a precondition to the hospital's participation in LIP or IME. The bill specifies that the term "hospital" is a health care institution as defined in s. 395.002(12), F.S.[20], but does not include cancer hospitals, public hospitals, Medical School Physician Practices, Federally Qualified Health Centers, Rural Health Clinics or Behavioral Health Providers.

The bill also amends s. 409.901, F.S., codifying into statute definitions for hospital directed payment, indirect graduate medical education, and low income pool programs.

The bill provides an effective date of July 1, 2024.

B. SECTION DIRECTORY:

Section 1: Amends s. 409.901, F.S., relating to definitions.
Section 2: Amends s. 409.908, F.S., relating to reimbursement of Medicaid providers.
Section 3: Amends s. 409.910, F.S., to conform a cross-reference.
Section 4: Provides an effective date of July 1, 2024.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

[18] CMS Form 2552
[19] *Id.*
[20] "Hospital" means any establishment that:
(a) Offers services more intensive than those required for room, board, personal services, and general nursing care, and offers facilities and beds for use beyond 24 hours by individuals requiring diagnosis, treatment, or care for illness, injury, deformity, infirmity, abnormality, disease, or pregnancy; and
(b) Regularly makes available at least clinical laboratory services, diagnostic X-ray services, and treatment facilities for surgery or obstetrical care, or other definitive medical treatment of similar extent, except that a critical access hospital, as defined in s. 408.07, shall not be required to make available treatment facilities for surgery, obstetrical care, or similar services as long as it maintains its critical access hospital designation and shall be required to make such facilities available only if it ceases to be designated as a critical access hospital.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill would have an indeterminate fiscal impact on hospitals that currently participate in LIP and IME but choose not to participate in DPP. The bill's requirement of DPP participation as a precondition to LIP and IME participation would reduce revenue to hospitals related to LIP and IME supplemental payments, if those hospitals choose not to participate in DPP.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

None.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

None.