HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCB HCAS 15-01 Medicaid
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		Clark	Pridgeon

SUMMARY ANALYSIS

The bill conforms statutes to the funding decisions related to the Medicaid Program included in the House proposed General Appropriations Act (GAA) for Fiscal Year 2015-2016. The bill:

- Amends the definition of “rural hospital” to exclude hospitals meeting the qualifications of a federal “sole community hospital” having up to 340 beds.
- Continues the rural designation of certain critical access hospitals beyond June 30, 2015.
- Eliminates Intermediate Care Facilities for the Developmentally Disabled from the statutory rate freeze.
- Revises the years of audited data used in determining Medicaid and charity care days for hospitals in the Disproportionate Share Hospital (DSH) program.
- Continues Medicaid DSH distributions for nonstate, government-owned or operated hospitals eligible for payment on July 1, 2011.
- Clarifies that Achieved Savings Rebates that are refunded to the state will be placed in General Revenue, unallocated.
- Clarifies the Grants and Donations Trust Fund as the designated state trust fund that managed care plans can contribute to for purposes of supporting Medicaid and indigent care.
- Repeals 409.97, F.S., related to the Low Income Pool program.
- Removes reference to supporting the Healthy Start contract with certified public expenditures.
- Clarifies the factors upon which the Agency for Health Care Administration shall reconcile the payments made to Long Term Care Managed Care Plans for changes in Nursing Home rates.
- Prohibits the Agency for Health Care Administration from entering into a contract with any other state or territory for joint fiscal agent operations.

The bill provides an effective date of July 1, 2015, unless expressly provided in the bill, which shall take effect upon becoming a law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Rural Hospitals

Part III of ch. 395, F.S., governs rural hospitals. A rural hospital is defined in s. 395.602(2)(e), F.S., as a licensed, acute care hospital having 100 or fewer licensed beds and an emergency room which is:

- The sole provider in a county with a population density up to 100 persons per square mile;
- An acute care hospital in a county with a population density up to 100 persons per square mile which is at least 30 minutes of travel time from any other acute care hospital in the same county;
- A hospital supported by a tax district or sub-district whose boundaries encompass an area of up to 100 persons per square mile;
- A hospital classified as a sole community hospital under 42 C.F.R., s. 412.92 which has up to 340 licensed beds;
- A hospital with a service area that has a population of up to 100 persons per square mile, with service area being defined as the fewest number of zip codes that account for 75 percent of the hospital's discharges for the most recent five-year period; or
- A hospital designated as a critical access hospital under s. 408.07(15), Florida Statutes. Hospitals under this section that have received funding under the Disproportionate Share Financial Assistance Program for Rural Hospitals beginning no later than July 1, 2002, are deemed rural hospitals through June 30, 2015.

The bill amends s. 395.602(2)(e), F.S., to revise the definition of "rural hospital." The bill deletes the provision regarding a hospital that is classified as a sole community hospital under Title 42, s. 412.92, of the Code of Federal Regulations, having up to 340 licensed beds. Additionally, the bill continues the rural hospital designation for those facilities that received funding under the Disproportionate Share Financial Assistance Program for Rural Hospitals beginning no later than July 1, 2002, from June 30, 2015 to June 30, 2021, after the next United States census.

Intermediate Care Facilities for the Developmentally Disabled (ICF/DD)

Currently, Medicaid reimburses ICF/DD providers through a cost-based reimbursement methodology. Cost-based reimbursement is accomplished through establishing a reimbursement rate based upon each individual ICF/DD's historic cost of providing services, which is then indexed using pre-determined health care inflation indices to provide an inflationary increase. The Agency for Health Care Administration (Agency) collects the cost data from annual cost reports submitted by the ICF/DD providers to use in calculating and setting cost-based reimbursement rates. Other provider types that are reimbursed using a cost-based methodology include nursing homes, hospital outpatient services, rural health clinics, county health departments, hospices, and federally qualified health centers. Additionally, these provider types may be subject to specified reimbursement ceilings and targets.

Chapter 2008-143, L.O.F., directed the Agency to establish provider rates for hospitals, nursing homes, community intermediate care facilities for the developmentally disabled and county health departments in a manner that would result in the elimination of automatic cost-based rate increases for a period of two fiscal years, until July 1, 2011. Chapter 2011-61, L.O.F., revised statute to ensure there would be no rate increases above the July 1, 2011 average unit cost level.

The bill amends s. 409.908(23)(c), F.S., to exclude the community intermediate care facilities for the developmentally disabled Medicaid reimbursement rates from being limited to the July 1, 2011 level.

Disproportionate Share Hospital Program (DSH)

The Medicaid Disproportionate Share Hospital Program (DSH) 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.

The bill updates existing law to provide payments for the 2015-2016 fiscal year related to hospitals in the DSH programs and Medicaid DSH distributions for nonstate, government-owned or operated hospitals that were eligible for payment on July 1, 2011.

Achieved Savings Rebate

Chapter 2011-134, L.O.F., created the Statewide Medicaid Managed Care (SMMC) program, thereby establishing the Medicaid program as a statewide, integrated managed care program for all covered services. Medicaid consists of two managed care programs:

- Medicaid Managed Medical Assistance Program (MMA) – primary and acute care; and
- Long-Term Care Managed Care Program (LTC) – residential and home and community based care, lone or paired with primary acute care for comprehensive coverage.

The Achieved Savings Rebate program is specific to the MMA component of managed care and was created to monitor plan expenditures and impose incentives and disincentives to ensure proper use of state funds.

To calculate whether the plans have achieved a savings for the reporting year and whether they may retain them or must pay a rebate to the state, the plans must submit to the Agency an annual financial audit. Plans regulated by the Office of Insurance Regulation must also submit an annual statement pursuant to s. 624.424, Florida Statutes. In addition, the Agency must audit the plans' financial information. The Agency must contract with independent certified public accountants to conduct the audits, and plans must pay these costs.

The achieved savings rebate will be calculated by determining pre-tax income as a percentage of revenues and applying the following income sharing ratios:

- 100% of the income up to and including 5% of the revenue will be retained by the plan.
- 50% of the income above 5% and up to 10% of the revenue will be retained by the plan with the other 50% refunded to the state.
- 100% of the income above 10% will be refunded to the state.

If the plan meets or exceeds quality measures defined by the Agency, then the plan may retain an additional 1% of revenue.

Plans that are required to pay a rebate to the state, must refund the money to the state; however, current statute does not specify in to which fund it shall be deposited. The bill amends s.409.967(3)(f)(2) and (3), Florida Statutes, to specify that the achieved savings rebates will be deposited into the General Revenue Fund, unallocated, less any applicable federal share to be paid back to the federal government.

Medical Loss Ratio

The SMMC also permitted the Agency to calculate a medical loss ratio for managed care plans. The calculation allows for use of uniform financial data collected from all plans and shall be computed for each plan on a statewide basis. The method of calculating the medical loss ratio is required to meet the following criteria:

- Must be consistent with Title 45 Code of Federal Regulations, part 158;
- Funds provided by the plans to graduate medical education institutions shall be classified as medical expenditures, provided the funding is sufficient to sustain the positions for the number of years necessary to complete the residency requirements and the residency positions funded by the plans are active providers of care to Medicaid and uninsured patients; and
- Prior to final determination of the medical loss ratio for any period, a plan may contribute to a designated state trust fund for the purpose of supporting Medicaid and indigent care and have the contribution counted as a medical expenditure for the period.

Plans that contribute funds for the purpose of supporting Medicaid and indigent care are to deposit funds in a designated state trust fund; however, current statute does not specify in to which fund it shall be deposited. The bill amends s. 409.967(4)(c), F.S., to specify that the funds be deposited into the Grants and Donations Trust Fund within the Agency.

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 only extended the LIP for one year from July 1, 2014 through June 30, 2015. The total computable amount of LIP funding for the year is approximately $2.16 billion. As of the date of this analysis, CMS has not yet approved LIP beyond June 30, 2015. Therefore, the bill repeals statutory provisions related to the LIP

program in its entirety. Upon federal approval of a new LIP program alternative, statute will need to be drafted based on federal parameters.

MomCare Network

Under SMMC, the Agency is directed to contract with an administrative services organization representing all Healthy Start Coalitions in order to continue the MomCare waiver services of care coordination, and other services. All managed care plans must contract with the Healthy Start Coalitions in their regions in order to coordinate services provided to pregnant women and infants. Current statute provides that the Agency will support this contract with certified public expenditures of general revenue appropriated for Healthy Start services and any earned federal matching funds.

Chapter 2014-51, L.O.F., transferred the funding from the Department of Health to the Agency, thereby, no longer relying on certified public expenditures to support the contracts. The bill amends s. 409.975(4)(a), F.S., to remove reference to certified public expenditures.

Nursing Home Pass-through Reconciliation

Under SMMC, the long-term care managed care plans must offer a network contract to nursing homes, hospices, and aging network providers who previously participated in home and community based waivers. Nursing home and hospice providers must participate in all selected plans that offer them contracts. The plans and the providers are required to negotiate mutually acceptable payment terms and rates. However, both nursing home and hospice providers shall receive a “pass-through” rate set by the Agency. This means that nursing home and hospice providers continue to receive a Medicaid reimbursement rate based upon historical data as provided in each facility’s Medicaid cost report.

Current statute provides that the Agency reconcile the long-term care managed care plan rates based on any change in Medicaid reimbursement rate for a nursing home or hospice. However, the statute does not define the parameters upon which the reconciliation shall be based. The bill amends s. 409.983(6), F.S., to clarify that the reconciliation is based on changes in nursing home provider reimbursement rates, and not reconciled based on actual days experienced by the long-term care managed care plans.

Fiscal Agent Operations

The Agency is the single State agency responsible for administering the Medicaid program in Florida. As such, the Agency contracts with an entity to operate as the state’s fiscal agent. Fiscal agent operations consist of distributing Medicaid publications and forms, providing enrollment broker services to Medicaid recipients, enrolling Medicaid providers, maintaining the recipient eligibility system, and processing and paying all Medicaid claims.

Recent Medicaid program changes, including the transition to Statewide Medicaid Managed Care, conversion to Diagnosis Related Groupings for inpatient reimbursements, and other federally mandated requirements, have required expanded operations and required revisions to the Florida Medicaid Management Information System and Decision Support System. Due to these continuing revisions, the bill prohibits the Agency from entering into a contract with any other state or territory to provide additional fiscal agent operations to another state or territory beyond the scope of Florida’s current fiscal agent responsibilities.

B. SECTION DIRECTORY:

Section 1: Amends s. 395.602, F.S., relating to the definition of a rural hospital, and extends the designation of certain critical access hospitals.

Section 2: Amends s. 409.908. F.S., to remove Intermediate Care Facilities for the Developmentally Disabled from a restriction on changes in reimbursement rates.

Section 3: Amends s. 409.911, F.S., to revise the years of audited data used for hospitals in the disproportionate share program and continues Medicaid disproportionate share distributions of nonstate, government-owned or operated hospitals eligible for payment on a specified date.

Section 4: Amends s. 409.967, F.S., to provide that Achieved Savings Rebates refunded to the state will be placed in General Revenue, unallocated. Provides that deposit of contributions by managed care plans to support Medicaid and indigent care be deposited within the Grants and Donations Trust Fund.

Section 5: Amends s. 409.975, F.S., to remove reference to supporting the Healthy Start contract with certified public expenditures.

Section 6: Amends s. 409.983, F.S., to specify the factors upon which the Agency for Health Care Administration shall reconcile the payments made to Long Term Care Managed Care Plans for changes in Nursing Home rates.

Section 7: Repeals s. 409.97, F.S., relating to State and local Medicaid partnerships (Low Income Pool).

Section 8: Creates an undesignated section of law that prohibits the Agency for Health Care Administration from entering into a contract with another state or territory for joint fiscal agent operations.

Section 9: Provides an effective date of July 1, 2015, unless otherwise specified in the bill.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   $213,428,126 in federal Medicaid funds will be generated through the implementation of the DSH programs; however, the State will not earn federal funds of $1,291,241,942 due to the expiration of the Low Income Pool program.

2. Expenditures:

   The House proposed GAA contains the following appropriation:

	FY 2015-16
REGULAR DISPROPORTIONATE SHARE (DSH)	
General Revenue	$ 750,000
Grants and Donations Trust Fund	$ 89,205,900
Medical Care Trust Fund	$ 138,764,925
Total	**$ 228,720,825**
MENTAL HEALTH HOSPITAL DSH	
Medical Care Trust Fund	$ 72,256,892
Total	**$ 72,256,892**
TUBERCULOSIS DSH	
Medical Care Trust Fund	$ 2,406,309
Total	**$ 2,406,309**
DISPRPORTIONATE SHARE HOSPITAL (DSH) SUBTOTAL	
General Revenue	*$ 750,000*
Grants and Donations Trust Fund	*$ 89,205,900*
Medical Care Trust Fund	*$ 213,428,126*
SUBTOTAL	***$ 303,384,026***
INTERMEDIATE CARE FACILITIES / DEVELOPMENTALLY DISABLED	
General Revenue	$ 82,403,570
Grants and Donations Trust Fund	$ 15,147,690
Medical Care Trust Fund	$ 149,476,494
Total	**$ 247,027,754**
TOTAL BUDGETARY IMPACT	
General Revenue	**$ 83,153,570**
Grants and Donations Trust Fund	**$ 89,205,900**
Medical Care Trust Fund	**$ 362,904,620**
GRAND TOTAL	**$ 535,264,090**

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   In order to earn matching federal dollars, local governments and other local political subdivisions would be required to provide $89,205,900 in contributions for the DSH program.

   Local governments and other local political subdivisions that contribute Intergovernmental Transfers (IGTs) under the current Low Income Pool in the amount of $867,606,672 will no longer submit these funds to the state due to the expiration of the program.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Hospitals providing a disproportionate share of Medicaid or charity care services will receive additional reimbursement toward the cost of providing care to uninsured and underinsured individuals.

Hospitals designated as “sole community” were funded with nonrecurring funds during Fiscal Year 2014-15. As a result, the statute must be amended and these hospitals will not receive $7,542,036 in state and federal funds.

Rural hospitals that received funding under the Disproportionate Share Financial Assistance Program for Rural Hospitals beginning no later than July 1, 2002, will continue to receive funds of $1,896,907 (state and federal) through June 30, 2021.

D. FISCAL COMMENTS:

The AHCA will distribute a total of $303,384,026 through federal Disproportionate Share Hospital (DSH) Program to hospitals providing a disproportionate share of Medicaid or charity care services.

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