HOUSE OF REPRESENTATIVES
FINAL BILL ANALYSIS

BILL #:	HB 5201	**FINAL HOUSE FLOOR ACTION:**	
SPONSOR(S):	Health Care Appropriations Subcommittee and Hudson	79 **Y's**	38 **N's**
COMPANION BILLS:	(SB 1520)	**GOVERNOR'S ACTION:**	Approved

SUMMARY ANALYSIS

HB 5201 passed the House on May 3, 2013 as SB 1520. The bill includes portions of CS/SB 1884. The bill conforms to the 2013-14 General Appropriations Act and:

- Repeals s. 381.0403, F.S., relating to the Community Hospital Education Act;
- Amends s. 395.6032, F.S., relating to the timeframe and requirements for the "Rural Hospital" designation as it relates to Medicaid payments;
- Amends s. 409.905, F.S., relating to the methodology for payments for Medicaid hospital inpatient reimbursements through a Diagnosis Related Group (DRG) methodology; establishing cost-based Medicaid hospital outpatient base rates; specifying dates by which the Agency for Health Care Administration (AHCA) may correct hospital outpatient rate calculation errors; and deleting an obsolete requirement to develop a plan to convert Medicaid hospital inpatient rates to a DRG methodology;
- Amends s. 409.908, F.S., providing for exemptions to the DRG methodology for state-owned psychiatric hospitals, newborn hearing screening services, transplant services, and tuberculosis care; specifying that inpatient base rate reimbursement under the DRG methodology will be provided in the General Appropriations Act (GAA); and specifying dates by which local governmental entities must submit executed letters of agreement for intergovernmental transfers;
- Creates s. 409.909, F.S., the Statewide Medicaid Residency Program, and establishes a formula-based distribution for AHCA to make payments to hospitals for inpatient costs associated with Graduate Medical Education (GME);
- Amends s. 409.910, relating to Medicaid third-party liability, to provide AHCA with the right and obligation to recover medical costs from third-parties consistent with U.S. Supreme Court ruling;
- Amends s. 409.911, F.S., to revise the years of audited data used for hospitals in the disproportionate share program (DSH) and continues Medicaid DSH distributions for nonstate government-owned or operated hospitals eligible for payment;
- Amends s. 409.9118, F.S., to revise the disproportionate share program distribution criteria for specialty hospitals related to tuberculosis patient services;
- Amends s. 409.9122, F.S., to remove the sunset provision in the Medicaid managed care selection and assignment statutes so that Medicaid recipients with HIV/AIDS who fail to choose a managed care plan will continue to be assigned to an HIV/AIDS specialty plan;
- Amends s. 409.915, F.S., relating to county contributions to Medicaid; revising the method by which the state charges counties for a portion of Medicaid costs; and
- Repeals and replaces a paragraph of proviso in the General Appropriations Act to correct a scrivener's error.

The bill was approved by the Governor on May 20, 2013, ch. 2013-48, L.O.F., and became effective July 1, 2013.

I. SUBSTANTIVE INFORMATION

A. EFFECT OF CHANGES:

Community Hospital Education Act

The Community Hospital Education Program was created to support primary care residency programs and access to care for communities. The program is funded through a general appropriation by the Legislature each year, which is then used in the Medicaid program to draw down additional federal funding to disperse to hospitals with participating programs. In recent years, the funding has been disbursed through hospital inpatient per diem rates to support graduate medical education.

The bill repeals the Community Hospital Education Program and replaces it with the Statewide Medicaid Residency Program.

Graduate Medical Education

Graduate Medical Education (GME) is the period of training following graduation from a medical school when 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, and can range from three to six years or more in length of time.[1]

Graduate Medical Education has an impact because:[2]

- GME training has a direct impact on the quality and adequacy of the state's physician specialty and sub-specialty workforce and the geographic distribution of physicians.
- The support and expansion of residency programs in critical need areas could result in more primary care practitioners and specialists practicing in Florida.
- Medical residents are more likely to practice in the state where they completed their graduate medical education training than where they went to medical school.
- Quality, prestigious programs will attract the best students, who will stay as practicing physicians.
- Medical residents act as "Safety Nets" to care for indigent, uninsured and underserved patients in the state.
- Supporting residency programs helps ensure Florida's ability to train and retain the caliber of medical doctors the state's citizens and visitors deserve.
- Among the currently practicing physicians in Florida, the top five specialties were:
    - Family Medicine (14.6%),
    - Medical Specialist (14.2%),
    - Surgical Specialist (13.4%),
    - Internal Medicine (12.8%), and
    - Anesthesiology (6.2%).
- 13.2 percent of the physicians from the 2009 survey indicated that they plan to retire in the next 5 years.

Currently, hospitals are reimbursed for their GME costs through their Medicaid Hospital Inpatient reimbursement per diem rates. This is accomplished through a cost-based reimbursement system. The costs directly related to each hospital's residency program are included in the cost reports that the

[1] Florida Department of Health, *Annual Report on Graduate Medical Education in Florida*, January 2010, available at: http://www.doh.state.fl.us/Workforce/GME_Annual_Report_2010.pdf
[2] *Id*

hospitals submit to AHCA. The cost reports are used to set a Hospital Inpatient per diem rate and they receive reimbursement for the GME costs as a percentage of their Medicaid days.

The bill creates a new section of statute entitled "Statewide Medicaid Residency Program." This new program authorizes the AHCA to make payments to hospitals for their costs associated with graduate medical education and for tertiary health care services provided to Medicaid beneficiaries. The bill provides an allocation fraction to be used for distributing funds to participating hospitals and defines the primary factors that will be used in each hospital's factor.

The primary factors of the funding allocation are as follows:

- A resident is defined as a medical intern, fellow, or resident enrolled in a program accredited by the Accreditation Council for Graduate Medical Education, the American Association of Colleges of Osteopathic Medicine, or the American Osteopathic Association.

- Full-time equivalent (FTE) is defined as a resident who is in his or her initial residency period, not to exceed five years. A resident training beyond the initial residency period is counted as one-half of one FTE, unless his or her chosen specialty is in general surgery or primary care, in which case the resident is counted as one FTE. For the SMRP, primary care specialties include:

    - Family medicine;
    - General internal medicine;
    - General pediatrics;
    - Preventive medicine;
    - Geriatric medicine;
    - Osteopathic general practice;
    - Obstetrics and gynecology; and
    - Emergency medicine.

- Medicaid payments are defined as payments made to reimburse a hospital for direct inpatient services, as determined by the AHCA, during the fiscal year preceding the date on which calculations for the program's allocations take place for any fiscal year.

The bill requires AHCA, on or before September 15 of each year, to calculate an allocation fraction for each hospital participating in the program, based on the following formula:

$$HAF = [0.9 \times (HFTE/TFTE)] + [0.1 \times (HMP/TMP)]$$

Where:

HAF = A hospital's total allocation fraction.

HFTE = A hospital's total number of full-time equivalent residents.

TFTE = The total full-time equivalent residents for all participating hospitals.

HMP = A hospital's Medicaid payments.

TMP = The total Medicaid payments for all participating hospitals.

A hospital's annual allocation equals the funds appropriated for the Statewide Medicaid Residency Program in the GAA multiplied by its allocation fraction. If the calculation results in an annual allocation that exceeds $50,000 per FTE resident, the hospital's annual allocation will be reduced to a sum that equals $50,000 per FTE resident. The excess funds will be redistributed to participating hospitals whose annual allocation does not exceed $50,000 per FTE resident.

The AHCA is required to distribute to each participating hospital one-fourth of that hospital's annual allocation on the final business day of each quarter of a state fiscal year. Additionally, the bill authorizes the AHCA to adopt any rules needed to administer the program.

Rural Hospitals

Currently s. 408.07 F.S., defines "rural hospital" as an acute care hospital having 100 or fewer licensed beds and an emergency room, which is:

- The sole provider within a county with a population density of no greater than 100 persons per square mile;
- An acute care hospital, in a county with a population density of no greater than 100 persons per square mile, which is at least 30 minutes of travel time, on normally traveled roads under normal traffic conditions, from any other acute care hospital within the same county;
- A hospital supported by a tax district or subdistrict whose boundaries encompass a population of 100 persons or fewer per square mile;
- A hospital with a service area that has a population of 100 persons or fewer per square mile. The term "service area" means the fewest number of zip codes that account for 75 percent of the hospital's discharges for the most recent 5-year period, based on information available from the hospital inpatient discharge database in the Florida Center for Health Information and Policy Analysis at the AHCA; or
- A critical access hospital.

Rural hospitals are eligible to receive funding through the Disproportionate Share Hospital Program under s. 409.9116, Florida Statutes. A hospital that received funds under this statute for a quarter beginning no later than July 1, 2002, is deemed to have been and shall continue to be a rural hospital from that date through June 30, 2015.

The bill amends s. 395.602, F.S., to include language that specifies if a hospital received Rural Disproportionate Share Hospital Program funding for a quarter beginning no later than July 1, 2002, or was a hospital that was licensed as a rural hospital during the 2010-2011 or 2011-2012 fiscal years, it will continue to receive funding through June 30, 2015, if the hospital continues to have 100 or fewer licensed beds and an emergency room.

Intergovernmental Transfers

Certain exemptions to hospital inpatient and outpatient reimbursement per diem rates 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 are also used to augment hospital payments in other ways, specifically through the Low Income Pool. 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, the 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.

The bill amends statute to require the local governments to submit to the 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.

Hospital Rate-setting

In 2011, the Legislature directed the AHCA to establish a deadline of September 30 which hospital inpatient rates could not be adjusted until the next fiscal year. The following year, the Legislature

extended the statutory deadline for hospital inpatient rate adjustments from September 30 to October 31 and extended the statutory deadline for the reconciliation of errors in cost reporting and rate calculations from September 30 to October 31.

The bill amends statute to include the discovery deadline of source data or rate calculation errors of October 31 to apply to hospital outpatient rates. Errors discovered after October 31 will be reconciled in a subsequent rate period for hospital outpatient rates, identical to the way reconciliations are currently performed for hospital inpatient rates.

Diagnosis Related Group (DRG) System for Hospital Reimbursement

DRG is a type of prospective payment system for reimbursing hospital inpatient services that provides an alternative to cost-based per diem reimbursement. DRGs classify an inpatient stay into a group based on the patient's diagnoses, sex, age, and other factors which can include costs of labor, hospital case mix, and overall wellness or acuity of the population. When demographics and external factors that affect cost are considered, groups of related diagnoses are designed to provide a stable and fairly predictable indication of the resources needed for treating a particular patient. This type of system is used in Medicare and seeks to tailor reimbursement more closely to actual costs of treatment for each individual patient.

There are 38 states that currently use or are considering transitioning to a DRG reimbursement methodology for its Medicaid programs. Among the states that use a DRG reimbursement methodology, the most prevalent DRG reimbursement methodologies are All Patient Refined DRGs (APR-DRGs) and the Medicare DRGs (MS-DRGs). There are differences between these two DRG systems, however the major difference is that MS-DRGs are intended for use on Medicare population (age 65 and older or aged 65 and under with a disability) and the APR-DRGs are more appropriate for all patients (based on Nationwide Inpatient Sample). Additionally, the APR-DRG system has a higher number of DRGs and more relative weights to address the needs on non-Medicare populations, such as pediatric, newborn, and maternity patients.[3]

During the 2012 Session, the Legislature revised the agency's time frame for developing a plan to transition the state's cost-based reimbursement system for hospital inpatient services to a DRG system. During FY 2012-13, the AHCA contracted with a consultant, Navigant Healthcare (Navigant), to develop and plan the transition from cost-based reimbursement to the use of DRGs. The final plan was released on December 21, 2012.

Hospital Provider Types

In its findings, Navigant recommended the use of the APR-DRG system and the following types of providers to be included in the DRG payment methodology:

- General acute care
- Rural hospitals, including critical access hospitals
- Children's hospitals
- Cancer hospitals
- Teaching hospitals
- In-state / out-of-state / border hospitals
- Long term acute care
- Rehabilitation hospitals and distinct part units
- Psychiatric specialty distinct part units

[3] Navigant Healthcare, *DRG Conversion Implementation Plan Final*, December 21, 2012, available at: http://ahca.myflorida.com/Medicaid/cost_reim/index.shtml

The only provider types excluded from Navigant's recommended DRG payment method are the state psychiatric facilities, as these facilities currently bill long-term care claims and have lengths of stay that suggest they are not true acute care admissions.

Hospital Services
Navigant recommended all inpatient services at hospitals included in the DRG payment method be reimbursed via DRGs with two notable exceptions, newborn hearing screening and transplants currently paid via a global fee. Newborn hearing screening is currently reimbursed separately from hospital per diems. Similarly, many transplants are currently paid outside the per diem method using a global fee that covers all related services for a one-year period. Navigant recommended that the AHCA maintain its current reimbursement policy for both of these services.

Provider Base Rates
Navigant recommended a single common base rate to be used for all hospitals. They recommended that the base rate only include the portion of the rate funded from state general revenue and the Public Medical Assistance Trust Fund. Distributions of funds from intergovernmental transfers were recommended to be made outside of the DRG payment methodology and not to be included in the base rate. Additionally, Navigant recommended against applying a wage area adjustment to the base rate.

Policy Adjustors
Policy adjustors are multipliers applied to specific claims for the purpose of increasing or decreasing payment. Generally, policy adjustors are applied for specific types of care, either for all recipients receiving that care or for subsets of recipients. Four types of policy adjustors are commonly used:

- Service adjustors
- Age/service adjustors
- Provider/service adjustors
- Provider adjustors

The adjustors extend beyond DRG relative weights and represent a decision to direct funds to a particular group of patients who are otherwise clinically similar. States that have transitioned to a DRG system, have often provided increased funding to allow for policy adjustors, as the use of policy adjustors can cause hospital base rates to be reduced having the effect of shifting funds from one area to another.

Navigant's recommendations related to policy adjustors are listed below:

- Services adjustor – Recommended for rehabilitation services due to the level of variation in hospital resources needed for these services. DRGs are unable to accurately predict relative hospital cost.
- Age/service adjustors – None recommended.
- Provider/service adjustors – None recommended.
- Provider adjustors – Recommended for three types of providers:
    - Rural Hospitals – due to the historical special consideration given by the Florida Legislature through exemptions from rate cuts and general revenue appropriations to keep per diems for rural hospitals relatively high.
    - Long Term Acute Care Hospitals (LTAC) – to maintain these providers' overall reimbursement compared to historical per diem rates. DRGs are not an accurate predictor of costs for the types of stays common at these facilities.
    - High Medicaid, High Outlier Hospitals – due to the combination of high occurrences of outlier cases with high Medicaid utilization. Recommend an adjustor for any hospital with Medicaid utilization at or above 50 percent and a projected outlier payment percentage at or above 30 percent.

The bill amends current statute to provide that AHCA has the authority to modify the reimbursement for specific types of services or diagnoses, patient ages, and hospital provider types only when authorized by the General Appropriations Act (GAA). The GAA includes an additional $88.3 million ($36.6 million General Revenue) to assist with the transition to DRG system of reimbursement.

The bill amends current statute to allow the AHCA to establish alternative reimbursement methodologies for specific provider types and services, including state-owned psychiatric hospitals, newborn hearing screening services, transplant services for which the AHCA has established a global fee and patients with tuberculosis who are in need of long-term hospital based services. The bill amends statute to authorize the AHCA to modify reimbursement according to methodologies listed specifically in the GAA.

Disproportionate Share Program (DSH)

Each year the Low-Income Pool Council makes recommendations to the Legislature on the Medicaid Disproportionate Share Hospital Program funding distributions to hospitals that provide a disproportionate share of the Medicaid or charity care services to uninsured individuals. However, the Legislature delineates how the funds will be distributed to each eligible facility.

The bill amends several provisions of chapter 409, F.S., to implement the changes in DSH program funding for Fiscal Year 2013-2014. The bill:

- Revises the years of audited data to be used in calculating disproportionate share payments to hospitals for Fiscal Year 2013-2014 to use the 2005, 2006, and 2007 years; and
- Continues disproportionate share payments for any non-state government owned or operated hospital eligible for payment on July 1, 2011 for Fiscal Year 2013-2014.

Disproportionate Share Program (DSH) for Specialty Hospitals

Sections 81 through 83, chapter 2012-184, L.O.F., directed the Department of Health (DOH) to develop and implement a transition plan for the closure of A.G. Holley State Hospital. The department's plan included specific steps to end voluntary admissions, transfer patients to alternate facilities, communicate with families, providers, other affected parties, and the general public, and enter into necessary contracts with providers.

The law directed the DOH to contract for the operation of a treatment program for individuals with active tuberculosis. Prior to the closure of AG Holley, the DOH entered into contracts with two Florida hospitals, Shands Jacksonville and Jackson Health System in Miami to provide care to newly court ordered tuberculosis patients and those patients requiring hospitalization previously treated at AG Holley. AG Holley officially closed on July 2, 2012.

The bill amends current statute to authorize disproportionate share program funding to hospitals that receive inpatient patients who have active tuberculosis or a history of noncompliance with treatment of tuberculosis and who retain a contract with the DOH to accept clients for admission and inpatient treatment.

Medicaid and Third-Party Recovery in Florida

Section 409.910, F.S. is known as the Medicaid Third-Party Liability Act (Act). Pursuant to the Act, third-party benefits for medical services are primary to any medical assistance provided to a recipient by Medicaid. As such, a Medicaid recipient who receives a settlement, award or judgment in a third-

party tort action is required to reimburse the ACHA for any related Medicaid medical costs.[4] The medical costs are calculated as the lesser of 37.5% of the total recovery or the total amount of medical assistance paid by Medicaid.[5] The recipient cannot contest the amount designated by the ACHA as recovered medical expense damages.[6]

Wos v. E.M.A.

The U.S Supreme Court, in Wos v. E.M.A., recently invalidated a North Carolina statute which authorized the recovery of third-party benefits from Medicaid recipients.[7] North Carolina's Medicaid third-party liability statute provides that the state will be paid from a tort settlement or judgment the lesser of the total amount expended on the recipient's behalf by Medicaid or 33% of the total settlement or judgment amount.[8] The Supreme Court held that North Carolina's statute was preempted by the federal anti-lien provision due to the fact that the state statute created an irrebuttable, one-size-fits-all statutory presumption that one-third of a tort recovery is attributable to medical expenses.[9] Such an irrebuttable presumption was found to be incompatible with the Medicaid Act's clear mandate that a state may not demand any portion of a beneficiary's tort recovery except the share that is attributable to medical expenses.[10]

Section 409.910, F.S. creates an irrebuttable presumption that the amount that the AHCA is entitled to from a Medicaid recipient's judgment, award or settlement in a tort action is the lesser of 37.5% of the total recovery or the total amount of medical assistance paid by Medicaid. This provision is similar to the North Carolina provision recently struck down by the Supreme Court in Wos v. E.M.A. To ensure compliance with federal law, the bill amends this section to create a presumption of accuracy as to the AHCA's determination of the reimbursement amount but allows this determination to be rebutted by clear and convincing evidence. The bill establishes the mechanism for these challenges by providing Medicaid recipients with the right to an administrative hearing at DOAH to contest the amount of AHCA's recoupment. The bill establishes Leon County as venue for these hearings and the First District Court of Appeal as venue for any related appeals. The bill also provides that each party is to bear its own attorney fees and costs.

Mandatory Medicaid Managed Care Enrollment

Currently, if a Medicaid recipient is diagnosed with HIV/AIDS, the AHCA assigns the recipient to a managed care plan that is under contract with AHCA on July 1, 2011, which specializes in providing health care services and treatment for individuals diagnosed with HIV/AIDS.[11] Under current law, this requirement will expire on October 1, 2014.

The bill amends statute to remove the sunset provision in the Medicaid managed care selection and assignment process so that Medicaid recipients with HIV/AIDS who fail to choose a managed care plan will continue to be assigned to an HIV/AIDS specialty plan.

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[4] s. 409.910, F.S. As an alternative to this payment, a recipient can place the full amount of the third-party benefits in a trust account for the benefit of the AHCA pending judicial or administrative determination of the AHCA's right to the third-party benefits.
[5] Id.
[6] Id.
[7] *Wos v. E.M.A. ex rel. Johnson*, ___U.S.___, 2013 WL 1131709 (U.S. March 20,2013).
[8] N. C. Gen. Stat. Ann. §108A–57(a).
[9] *Supra* fn 9.
[10] The federal Medicaid Act requires states to have in effect laws pursuant to which states have the right to recover third party benefits for medical assistance provided by the state Medicaid program. *See* 42 U.S.C. § 1396a(a)(25)(H). Federal law also mandates that state Medicaid programs must require recipients to assign to the state any rights the recipient has to benefits from third parties related to medical care. *See* 42 U.S.C. § 1396k(a)(1)(A). Notwithstanding the foregoing provisions, the Medicaid Act's "anti-lien provision" prohibits states from imposing a lien on the property of a recipient prior to his death on account of medical assistance provided by the state's Medicaid program. *See* 42 U.S.C. § 1396p(a)(1).
[11] s. 409.9122(2)(l), F.S.

County Contributions to Medicaid

Chapter 72-225, Laws of Florida, created s. 409.267, F.S., which required county participation in the cost of certain services provided to county residents through Florida's Medicaid program. In 1991, s. 409.267, F.S., was repealed and replaced with s. 409.915, F.S., which provides that the state shall charge counties for certain items of care and service. Counties are required to reimburse the state for:

- 35 percent of the cost of inpatient hospitalization in excess of 10 days, not to exceed 45 days, with the exception of pregnant women and children whose income is in excess of the federal poverty level and who do not participate in the Medicaid medically needy program, and for adult lung transplant services; and
- 35 percent of the cost of nursing home or intermediate facilities in excess of $170 per month, limited to $55 per resident per month, with the exception of skilled nursing care for children under age 21.

The Agency for Health Care Administration (AHCA) provides each county with a monthly bill based on payments made on behalf of the county's residents. The amount collected from the counties is deposited into the General Revenue Fund.

For the period from state Fiscal Year 1994-1995 through Fiscal Year 2006-2007, county contributions to Medicaid collections were approximately 93 percent of total billings in each fiscal year. For Fiscal Year 2007-2008 through Fiscal Year 2011-2012, county contributions to Medicaid collections dropped to less than 90 percent of total billings, with only 64.7 percent of billings billed in Fiscal Year 2010-2011 being paid in that year. The decline in collections was caused mainly by the inability of AHCA and individual counties to reach agreement on whether certain Medicaid recipients were residents of the county. The decline in the amount of billings collected resulted in a large backlog of past due billings.

In 2012, the Legislature reacted to this situation by enacting ch. 2012-33, L.O.F.

Backlog Payments

Chapter 2012-33, L.O.F., amended s. 409.915, F.S., requiring that the amount of each county's billings that remained unpaid as of April 30, 2012, be deducted from the county's monthly revenue sharing distribution over a 5-year period. The amounts by which the distributions are reduced are being transferred to the General Revenue Fund.

By August 2, 2012, AHCA certified to each county the amount of billings that remained unpaid from November 1, 2001 through April 30, 2012. A county could challenge the amount certified by filing a petition with AHCA prior to September 1, 2012.[12] This procedure was the exclusive method to challenge the amount certified. AHCA permitted the counties to make a full or partial payment in the form of a check or wire transfer by September 13, 2012, instead of applying reductions to the revenue sharing distributions. On September 15, 2012, AHCA certified the amount of past billings for each county to the Department of Revenue (DOR). For counties that filed a petition, AHCA certified 100 percent of the past due billings. For counties that did not file a petition, AHCA certified 85 percent of the past due billings. Starting with the October 2012 distribution, DOR deducted the amount of past due billings certified by AHCA from each county's monthly revenue sharing distribution. The deductions will continue for 5 years or until each county has paid the total amount of past due billings.

Prospective Billings

Chapter 2012-33, L.O.F., also provided a new process for collecting counties' future contributions to Medicaid. Beginning May 1, 2012, and each month thereafter, AHCA had to certify to DOR the amount of monthly statements rendered to each county based on each county's Medicaid billings. The law

[12] A county could file a petition under the applicable provisions of Chapter 120, F.S.

provided for DOR to reduce each county's monthly distribution from the Local Half-Cent Sales Tax Trust Fund by the amount certified by AHCA. The amounts by which the distributions were reduced were to be transferred to the General Revenue Fund.

The law also directed AHCA to develop a process allowing counties to submit written requests for refunds. If approved, AHCA would certify to DOR the amount of the refund and DOR would issue the refund from the General Revenue Fund.

Administrative Billing and Refund Process

In order to address the counties' concerns regarding the new law, AHCA developed a process for monthly billings which allows counties to submit both advanced and back end refund requests.[13] Counties must include the reason and provide documentation for the request. Advanced refund requests must be received by AHCA by the end of each billing month. The agency withholds certifying the amount of the advanced refund request to DOR in order to provide time to research and resolve the requests. Advanced refund requests are researched within 60 days by AHCA. Denied refund requests are certified to DOR on a subsequent bill. If a refund request is granted and the bill should have been submitted to another county, the amount will be transferred and certified by AHCA to the appropriate county on a subsequent billing. The ability for a county to make an advanced refund request will expire on April 30, 2013.

In addition to an advanced refund request, a county may submit a back end refund request within 60 days from the date of certification. Counties requesting a back end request have already paid their billing and then subsequently filed their dispute after a monthly payment. AHCA notifies the counties whether the refund request is granted within 90 days after certification. If a back end refund request is granted, the refund will be a credit applied to a future bill and may be transferred to the appropriate county on a subsequent bill.

AHCA also permits each county to submit payment in the form of a check or wire transfer to the agency. The payment must be received by the agency by the 5th day of the month. If the payment is not received by the agency by the 5th day of the month, the agency certifies the amount of the county billing to DOR for withholding from monthly Local Half-Cent Sales Tax distributions.

County Revenue Sharing Program[14]

The Florida Revenue Sharing Act of 1972 was a major attempt by the Legislature to ensure a minimum level of revenue parity across units of local government.[15] Provisions in the enacting legislation created the Revenue Sharing Trust Fund for Counties. Currently, the trust fund receives 2.9 percent of net cigarette tax collections and 2.044 percent of sales and use tax collections.[16] An allocation formula serves as the basis for the distribution of these revenues to each county that meets the strict eligibility requirements. The county revenue sharing program is administered by DOR and monthly distributions are made to the eligible counties.

Local Government Half-Cent Sales Tax Program[17]

[13] *See* Rule 59G-1.025, F.A.C., Medicaid County Billing.
[14] A full description including tables providing estimates of distributions to counties from the county revenue sharing program can be found in the 2012 Local Government Financial Handbook. See Florida Legislature, Office of Economic and Demographic Research, 2012 LOCAL GOVERNMENT FINANCIAL INFORMATION HANDBOOK, available online at <http://edr.state.fl.us/Content/local-government/reports/lgfih12.pdf>, (Last visited April 14, 2013).
[15] Chapter 72-360, L.O.F.
[16] Sections 212.20(6)(d)4. and 210.20(2)(a), F.S.
[17] A full description including tables providing estimates of distributions to local governments from the half-cent sales tax program can be found in the 2012 Local Government Financial Handbook. See Florida Legislature, Office of Economic and Demographic

Authorized in 1982, the local government half-cent sales tax program generates the largest amount of revenue for local governments among the state-shared revenue sources currently authorized by the Legislature.[18] The program distributes a portion of state sales tax revenue via three separate distributions to eligible county or municipal governments. Additionally, the program distributes a portion of communications services tax revenue to eligible local governments. Allocation formulas serve as the basis for these separate distributions.

Changes to Medicaid Program

AHCA is in the process of implementing a new payment method for some Medicaid providers which utilizes diagnosis related groups (DRGs) instead of the current per diem reimbursement method. Also, the use of managed care organizations in the Medicaid program is expected to expand under the Statewide Medicaid Managed Care Program. Both of these changes will affect the current practices used to bill and collect counties' contributions to Medicaid.

The bill amends s. 409.915, F.S., to revise the current process for county Medicaid billings. Instead of the current practice based on expenditures incurred on behalf of a county's residents, the bill provides for an annual contribution for Medicaid. The bill establishes a total contribution of $269.6 million for state Fiscal Year 2013-2014 and $277.0 million for state Fiscal Year 2014-2015. For the 2015-2016 state fiscal year through the 2019-2020 state fiscal year, the total amount of the counties' annual contribution shall be the total contribution for the prior fiscal year adjusted by 50 percent of the percentage change in the state Medicaid expenditures as determined by the Social Services Estimating Conference. For each fiscal year after the 2019-2020 state fiscal year, the total amount of the counties' annual contribution is the total contribution for the prior fiscal year adjusted by the percentage change in the state Medicaid expenditures as determined by the Social Services Estimating Conference.

Each county is responsible for paying a portion of the annual counties' contribution. For state Fiscal Years 2013-14 and 2014-15 the share of the total paid by each county is initially based on actual payments on billings for April 2012 through September 2012. These shares are adjusted when payments on billings for April 2012 through March 2013 are available. Starting in 2015-16 and over the next four years the determination of each county's share transitions to percentages based on county Medicaid enrollees as of March 1 of each year. The AHCA is responsible for calculating this amount for each county and providing the information to the Department of Revenue (DOR) by May 15 of each year.

By June 1 of each year, DOR must notify each county of its annual contribution. Counties must pay, via check or electronic transfer, by the 5th of each month. If a county fails to remit payment by the 5th of the month, DOR is directed to reduce the county's monthly distribution from the Local Government Half-Cent Sales Tax Trust Fund by the amount of the monthly installment. The payments and the amounts by which the distributions are reduced are transferred to the General Revenue Fund.

The bill requires the AHCA to provide a data report that includes information that can be used for a comprehensive evaluation of the new contribution system. The report is due by March 1 each year, and is repealed December 31, 2015.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

Research, 2012 LOCAL GOVERNMENT FINANCIAL INFORMATION HANDBOOK, available online at http://edr.state.fl.us/Content/local-government/reports/lgfih12.pdf. (last visited April 15, 2013).
[18] Chapter 82-154, L.O.F.

1. Revenues:

The Revenue Estimating Conference (REC) has not yet evaluated the impacts of this bill. However, based on REC analysis of previous versions of the bill, staff estimates that, *compared to current official estimates for county contributions to Medicaid*, the bill will have no impact on General Revenue in Fiscal Year 2013-14, will reduce General Revenue by $8.5 million in Fiscal Year 2014-15, and grow to a reduction of $38.7 million in Fiscal Year 2017-18.

2. Expenditures:

The GAA contains the following appropriation:

	FY 2013-14
GRADUATE MEDICAL EDUCATION	
General Revenue	$ 33,056,000
Medical Care Trust Fund	$ 46,924,644
Total	**$ 79,980,644**
DIAGNOSIS RELATED GROUPS (DRG)	
Medical Care Trust Fund	$ 1,000,000
Total	**$ 1,000,000**
INPATIENT HOSPITAL REIMBURSEMENT	
General Revenue	$ 27,036,069
Medical Care Trust Fund	$ 37,893,789
Refugee Assistance Trust Fund	$ 82,539
Total	**$ 65,012,397**
REGULAR DISPROPORTIONATE SHARE (DSH)	
General Revenue	$ 750,000
Grants and Donations Trust Fund	$ 95,243,343
Medical Care Trust Fund	$132,998,411
Total	**$228,991,754**
MENTAL HEALTH HOSPITAL DSH	
Medical Care Trust Fund	$ 70,126,164
Total	**$ 70,126,164**
TUBERCULOSIS DSH	
Medical Care Trust Fund	$ 2,382,533
Total	**$ 2,382,533**
PRIMARY CARE PHYSICIAN SERVICES	
Medical Care Trust Fund	$ 677,722,971
Total	**$ 677,722,971**
TOTAL BUDGETARY IMPACT	
General Revenue	**$ 60,842,069**
Grants and Donations Trust Fund	**$ 95,243,343**
Medical Care Trust Fund	**$ 969,048,512**
Refugee Assistance Trust Fund	**$ 82,539**
GRAND TOTAL	**$1,125,216,463**

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

Local governments and other local political subdivisions may provide $95,242,343 in contributions for the DSH programs.

Each county will pay a portion of the total annual Medicaid county billing contribution for all counties. The Revenue Estimating Conference (REC) has not yet evaluated the impacts of this bill. However, based on REC analysis of previous versions of the bill, staff estimates that, *compared to current official estimates for county contributions to Medicaid*, the bill will have no impact on total contributions in Fiscal Year 2013-14, will reduce total contributions by $8.5 million in Fiscal Year 2014-15, and grow to a reduction of $38.7 million in Fiscal Year 2017-18.

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 individuals.

D. FISCAL COMMENTS:

The AHCA will distribute a total of $239,376,956 through the federal Disproportionate Share Hospital (DSH) program to hospitals providing a disproportionate share of Medicaid or charity care services.