STORAGE NAME: h1905a.hhs
DATE: April 26, 2000

HOUSE OF REPRESENTATIVES
AS REVISED BY THE COMMITTEE ON
HEALTH AND HUMAN SERVICES APPROPRIATIONS
ANALYSIS

BILL #: HB 1905

RELATING TO: Medicaid

SPONSOR(S): Representative Murman

TIED BILL(S):

ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE:

(1) HEALTH CARE SERVICES YEAS 17 NAYS 0
(2) HEALTH AND HUMAN SERVICES APPROPRIATIONS YEAS 10 NAYS 0
(3)
(4)
(5)

I. SUMMARY:

HB 1905 relates to various Medicaid hospital services reimbursement issues. The bill:

- Increases from $1,000 to $1,500 the annual Medicaid hospital outpatient services cap for adults.

- Authorizes the Agency for Health Care Administration (AHCA) to receive funds from certain entities, including the Board of Regents and local governments, for reimbursement for Medicaid services.

- Revises Medicaid limitations for hospital inpatient services to provide exceptions for raising reimbursement caps, recognition of the costs associated with graduate medical education, and other methodologies provided in the General Appropriations Act; authorizes AHCA to receive funds from certain entities for these reimbursements; and provides an exception from county contribution requirements for such reimbursements.

- Deletes authority for reimbursement of hospitals under the non-existent extraordinary disproportionate share program.

- Authorizes AHCA to retroactively adjust or reclassify disproportionate share program distributions as Medicaid benefits, and provides an exception from county contribution requirements for such reimbursements.

The bill's effective date is July 1, 2000.

The Agency for Health Care Administration estimates that the bill's fiscal impact is $109.95 million, of which $62.3 million is federal funding; $14.5, state; and $33.2, local.

II. SUBSTANTIVE ANALYSIS:

A. DOES THE BILL SUPPORT THE FOLLOWING PRINCIPLES:

1.	Less Government	Yes []	No []	N/A [x]
2.	Lower Taxes	Yes []	No []	N/A [x]
3.	Individual Freedom	Yes []	No []	N/A [x]
4.	Personal Responsibility	Yes []	No []	N/A [x]
5.	Family Empowerment	Yes []	No []	N/A [x]

For any principle that received a "no" above, please explain:

B. PRESENT SITUATION:

Medicaid

Medicaid is a medical assistance program that pays for health care for the poor and disabled. The program is jointly funded by the federal government, the state, and the counties. The federal government, through law and regulations, has established extensive requirements for the Medicaid Program. The Agency for Health Care Administration is the single state agency responsible for administering the Florida Medicaid Program. The statutory provisions for the Medicaid Program appear in ss. 409.901 through 409.9205, F.S. The state budget for the program for the current fiscal year is $7,416,045,061, and the program anticipates serving 1,607,144 clients this year.

Adult Outpatient Hospital Services Cap

Section 409.905(6), F.S., requires AHCA to pay for preventive, diagnostic, therapeutic, or palliative care and other services provided to a Medicaid recipient in the outpatient portion of a hospital. Payment is limited to $1,000 per state fiscal year per adult recipient.

Section 409.908(1)(a), F.S., limits Medicaid reimbursement for hospital outpatient services to $1,000 per fiscal year per adult recipient except for renal dialysis services and for other exceptions made by AHCA. The exceptions are for services that can be safely performed in the hospital outpatient setting and are more cost-effective when done in the outpatient setting rather than in the inpatient setting.

The agency indicated that the last increase in the cap for hospital outpatient services occurred in 1987. Over the past thirteen years, the cost of medical care has risen substantially, while the level of reimbursement cap for hospitals providing outpatient care to adults who are eligible under Medicaid has not changed.

The cap of $1,000 is often inadequate to provide appropriate reimbursement to a hospital serving a Medicaid recipient requiring outpatient care. The average hospital outpatient claim is $164.

Medicaid Reimbursement for Inpatient Hospital Services

In the 1980s and early 1990s, Medicaid expenditures were increasing at double-digit rates. The Legislature authorized the implementation of cost control measures to slow the rate of growth. One measure implemented to control the rate of growth was the establishment of target rate reimbursement limitations on facility-specific Medicaid hospital per diem rates. Medicaid reimburses hospitals for inpatient and outpatient services based on the approved Medicaid reimbursement plan. There are separate plans for inpatient services and outpatient services. The plans guide the Agency for Health Care Administration in the setting of facility specific per diem rates based on each facility's cost report. Hospitals are required to submit annual financial cost reports to the agency. The reports are prepared in accordance with the cost finding of Title XVIII (Medicare) principles of reimbursement, except as modified by the Medicaid hospital reimbursement plans. Per diem rates are prospective or interim, and are based on historical costs adjusted for inflation. Interim rates are based on budgeted costs and subject to an annual cost settlement. Medicaid payment is considered payment in full for covered services.

The Medicaid hospital reimbursement plans limit growth in reimbursement rates based on specific target rates and ceilings. An inpatient variable cost-based reimbursement ceiling is established for each county. General hospitals are subject to the limitation on the variable cost per diem ceiling and will receive a per diem for which the variable cost component will be set at the lower of the variable cost rate for the hospital or the cost-based county ceiling. Statutorily defined teaching hospitals, specialty hospitals, and rural hospitals are exempt from the inpatient variable cost-based ceiling.

The target rate system for hospital inpatient per diem rates was imposed in 1991 and is used to limit the growth in the cost-based county ceiling and facility specific per diem between state fiscal years. The target ceilings are adjusted each July based on the prior January rate semester's ceilings and facility specific per diem multiplied by the allowable rate of increase.

The outpatient cost-based county reimbursement ceiling for variable costs per occasion of service is established for each county. The cost-based county ceilings apply to all hospitals as a limitation on the variable costs per occasion of service that a hospital will be paid. Hospitals will receive the lower of the hospital's occasion of service rate or the cost-based county ceiling. Rural and specialty psychiatric hospitals are exempt from this ceiling.

In 1993 a target rate system for hospital outpatient rates was established. The target ceiling is used to limit the growth in the cost-based county ceiling and facility specific rates between rate semesters. The target ceilings are adjusted each January and July based on the prior rate semester's county ceilings and facility specific rates multiplied by the allowable rate of increase.

Florida's hospitals have undergone major changes in reimbursement policies. Changes in federal Medicare reimbursement policies, limitations on disproportionate share hospital payments, and the trend toward increased managed care have increased the concerns of hospitals over lowered fees and revenues. Florida's high number of uninsured persons also increases hospitals' financial vulnerability.

Federal regulations (42 CFR §447.272) provide that in the aggregate, payments to a group of health care facilities (for example hospitals) by a state’s Medicaid agency may not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles. The upper payment limit (UPL) does not apply

to disproportionate hospital payment adjustments made to hospitals, as DSH payments have separate federal limitations.

The agency has analyzed the Medicaid payments compared to what it estimates would have been paid under Medicare payment principles. The agency estimates that the UPL balance (Medicare payment less Medicaid payment) is $184 million. This is the estimated aggregate maximum increase in hospital reimbursement that the state could make and remain in compliance with the UPL.

Disproportionate Share Programs

In 1987, Congress included in the Omnibus Budget Reconciliation Act provisions pertaining to inpatient hospital reimbursement for hospitals serving a disproportionate share of low-income patients with special needs. Effective July 1, 1988, federal law mandated that each state provide special reimbursement to qualifying "disproportionate share" hospitals provided that the hospitals meet certain conditions.

Currently under the Florida Medicaid program, there are seven separate programs specifically designed to provide enhanced Medicaid reimbursement for certain classes of hospitals rendering services to Medicaid recipients and indigent clients. These programs, their respective authorization, and current total funding (in millions) are as follows:

Statute	Program	Funding
s. 409.911	Regular hospitals	$153.4
s. 409.9112	Regional Perinatal Intensive Care Centers	$6.9
s. 409.9113	Teaching hospitals	$19.8
s. 409.9115	Mental health hospitals	$147.8
s. 409.9116	Rural hospitals	$9.8
s. 409.9117	Primary care hospitals	$6.5
s. 409.9118	Specialty (tuberculosis) hospital	$4.3
	TOTAL	$348.5

The above-referenced provisions in ch. 409, F.S., provide authority, qualifications for participation by hospitals, and reimbursement formulas for DSH payments. The Medicaid Hospital Inpatient Reimbursement Plans which, by reference, are incorporated in administrative rule, also include comprehensive explanations of how the DSH reimbursement is calculated and made for hospitals.

Effective October 1, 1997, the Balanced Budget Act of 1997 provided for state specific limitations on the federal matching funds available each fiscal year. Beginning in federal fiscal year 1998, federal matching funds for DSH payments for Florida are limited to the following:

FFY 1998/SFY 1997-98	$207,000,000
FFY 1999/SFY 1998-99	$203,000,000
FFY 2000/SFY 1999-00	$197,000,000
FFY 2001/SFY 2000-01	$188,000,000
FFY 2002/SFY 2001-02	$160,000,000

FFY 2003 and thereafter: the federal allotment is equal to the DSH allotment for the state for the preceding fiscal year increased by the percentage change in the consumer price

index for all urban consumers (all items; U.S. city average) for the previous fiscal year, except that the DSH allotment shall not exceed the greater of:

- The DSH allotment for the previous year, or
- 12 percent of the total amount of expenditures under the state plan for medical assistance during the year.

Chapter 91-282, Laws of Florida, created the extraordinary DSH program under section 409.9114, F.S. Chapter 93-129, Laws of Florida, repealed this section of statute. However, the reference to the extraordinary DSH program was not deleted from s. 409.908, F.S.

Institutions for Mental Disease Waiver

The 1991 Florida Legislature created subsection (34) of s. 409.905, F.S., which reads in part: "..the department shall apply for a waiver, designed to provide hospitalization services for mental health reasons to children and adults in the most cost-effective and lowest cost setting possible. Such waiver shall include a request for an opportunity to pay for care in hospitals known under federal law as "institutions for mental disease" or IMDs. The waiver proposal shall be conducted in District 6 of the Department of Health and Rehabilitative Services. The waiver may incorporate competitive bidding for hospital services, comprehensive brokering, prepaid capitated arrangements, or other mechanisms…."

A Medicaid/ADM work group developed a 1915(b) federal waiver request to HCFA, which approved the two-year waiver effective July 1, 1993. The waiver was renewed in January 1996 and again in July 1999.

The AHCA Medicaid Office issued a RFP on December 17, 1993, and four entities responded with proposals. A protest was filed, asserting that the RFP favored entities contracting with current community mental health providers. Medicaid issued another RFP on November 23, 1994. The proposal evaluation was completed by May 1995, and AHCA announced a contract award to The Florida Health Partners, Inc. on July 11, 1995. The PMHP contract was executed on February 19, 1996. Services began on March 1, 1996.

The Medicaid Prepaid Mental Health Program (PMHP) is operating as a two-year demonstration project (with the option of two one-year renewals to the current contract) in Hillsborough, Hardee, Highlands, Manatee, and Polk counties.

Recipients in AFDC, Foster Care, SOBRA, and SSI with no Medicare categories are eligible for the program. MediPass recipients in Area 6 are automatically assigned to the PMHP. MediPass provides primary care case management and authorizes physical health services and the PMHP manages and provides mental health services.

In addition to the PMHP, Medicaid HMOs also provide mental health care in Area 6.

Currently, the PMHP serves approximately 43,000 members.

C. EFFECT OF PROPOSED CHANGES:

HB 1905 addresses several Medicaid hospital reimbursement issues, including those relating to calculation of reimbursement amounts for inpatient services and to increasing the annual cap on adult hospital outpatient services. These revisions are primarily an effort

to increase funding related to graduate medical education. See the SECTION-BY-SECTION ANALYSIS which follows for additional details.

D. SECTION-BY-SECTION ANALYSIS:

Section 1. Amends s. 409.905, F.S., relating to mandatory Medicaid services, as follows:

Paragraph (b) of subsection (5), relating to hospital inpatient services and institutions for mental disease, to delete an obsolete provision relating to AHCA's submission of an implementation report to the Legislature by February 1, 1992.

Subsection (6), relating to hospital outpatient services, is amended to increase the annual hospital outpatient services cap for adults from $1,000 to $1,500.

Section 2. Amends s. 409.908, F.S., relating to reimbursement of Medicaid providers, as follows:

The directory language is amended to indicate that nothing in the section is intended to prohibit AHCA from retrospectively adjusting or reclassifying disproportionate share program distributions as program benefits.

Paragraph (a) of subsection (1), relating to reimbursement for inpatient care, is amended to provide exceptions for the limitations on reimbursement for hospital inpatient services specific to the raising of rate reimbursement caps, the recognition of costs of graduate medical education, and other methodologies that are recognized in the General Appropriations Act. Added language goes on to authorize AHCA to receive funds from state entities, including but not limited to the Board of Regents, local governments, and other political subdivisions for the state share of special exception payments, including federal matching funds, through the hospital inpatient reimbursement methodologies. Such funds must be separately accounted for and not commingled with other state and local funds used for these purposes. Counties are exempted from the mandatory contributions imposed under s. 409.915, F.S., for the cost of the special exception reimbursement for hospitals serving a disproportionate share of low-income persons and providing graduate medical education.

The existing provisions of subsection (1) relating to reimbursement for hospital outpatient services is designated as paragraph (b) of that subsection, and the current $1,000 cap on annual hospital outpatient services for adults is increased to $1,500. Added language goes on to authorize AHCA to receive funds from state entities, including but not limited to the Board of Regents, local governments, and other political subdivisions for the state share of making special exception payments, including federal matching funds, through the hospital outpatient reimbursement methodologies. Such funds must be separately accounted for and not commingled with other state and local funds used for these purposes.

Existing paragraph (b) of subsection (1) is redesignated as paragraph (c). This paragraph, relating to disproportionate share reimbursement, is amended to delete reference to the non-existent extraordinary disproportionate share program. Provides that disproportionate share payments may be retrospectively adjusted and reclassified as program benefits, and stipulates that, for any such adjustments, counties be exempted from contributing towards these costs.

Existing paragraph (c) is redesignated as paragraph (d), but is not otherwise amended.

Subsections (2) through (22) of this section are not amended.

Section 3. Provides for a July 1, 2000, effective date.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

Non-Recurring	FY 00-01	FY 01-02
Federal Grants-Title XIX Administration	$75,000	$0
Total Non-Recurring	$75,000	$0
Recurring		
Local Government Funds Transferred to State	$33,209,088	$33,209,088
General Revenue in Board of Regents for GME Hospital Payments and Community Health Education Payments to Hospitals	$14,500,000	$14,500,000
Federal Grants--Title XIX Medical Assistance	$62,245,021	$62,245,021
Total Recurring	$109,954,109	$109,954,109

2. Expenditures:

Non-Recurring	FY 00-01	FY 01-02
Computer System Changes	$150,000	$0
Total Non-Recurring	$150,000	$0
Recurring		
Increase Outpatient Cap to $1,500	$17,361,227	$17,361,227
Eliminate Rate Caps for Inpatient Services	$70,295,100	$70,295,100
Eliminate Rate Caps for Outpatient Services	$22,297,782	$22,297,782
Other Methodologies Recognized in the General Appropriations Act	To be determined by GAA	
Total Recurring	$109,954,109	$109,954,109
Total Revenues	$110,029,109	$109,954,109
Total Expenditures	$110,104,109	$109,954,109

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

The additional federal funds may provide some relief in the growth of expenditures that counties now have to provide in financial assistance to hospitals.

2. Expenditures:

Local governmental entities will be expected to fund the state share of the cost excluding any state funds that can be used as state share. The anticipated cost to local governments is $33.2 million. The $33.2 million contributed by the local entities combined with $14.5 million in state funds identified as potential state match will permit the state to draw down $62.2 million in federal funds for additional payments to hospitals. Additional local contributions will be anticipated for additional exceptional reimbursements if authorized by the General Appropriations Act.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Adult Medicaid recipients will have greater access to outpatient hospital services and hospital providers will be compensated around $17.4 million more for services rendered to Medicaid recipients, providing a small reduction in the uncompensated care burden of hospitals.

If the outpatient and inpatient rate ceilings are increased or eliminated for teaching, specialty, and CHEP hospitals, the qualifying hospitals will see additional Medicaid reimbursement of $92.6 million.

Depending on the provisions, if any, in the General Appropriations Act for additional special exception payments, hospitals could receive additional, substantial Medicaid reimbursement.

D. FISCAL COMMENTS:

N/A

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

This bill does not require counties or municipalities to spend funds or to take action requiring the expenditure of funds.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

The bill does not reduce the authority that counties or municipalities have to raise revenues in the aggregate.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

This bill does not reduce the percentage of a state tax shared with counties or municipalities.

V. COMMENTS:

A. CONSTITUTIONAL ISSUES:

N/A

B. RULE-MAKING AUTHORITY:

N/A

C. OTHER COMMENTS:

In its review of the bill, AHCA commented that the retrospective adjustment or reclassification of disproportionate share distributions as program benefits appears to be contrary to the intent of the federal law. For this reason, AHCA suggests that these provisions, as they appear on page 4, lines 21 and 22 and on page 6, lines 20-24, be deleted.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

When the Committee on Health Care Services heard this bill on April 13, 2000, the committee adopted a “strike-everything” amendment and two amendments to the amendment. As amended, the “strike-everything” amendment:

- Amends s. 381.0403, F.S., relating to the Community Hospital Education Act, to: emphasize primary care training as opposed to family practice program training; provide additional detail as to eligibility for funding based on training slots; provide a means to seek available federal matching funds for graduate medical education purposes; define primary care specialties; provide for a Program for Graduate Medical Education Innovation, to the extent funded; and specify that the Board of Regents certify to the Agency for Health Care Administration those hospitals eligible for certain funds.

- Amends s. 408.07(44), F.S., which defines "teaching hospital," to make the definition specific to *Florida* hospitals and medical schools, specify the accreditation entity, base resident slots on full-time equivalent positions, and specify that AHCA determine the hospitals that meet the definition.

- Deletes reference to the mental health pilot project.

- Deletes reference to any retroactive recalculation of disproportionate share funding amounts, and the recognition of such funds as Medicaid program benefits.

- Ties any increase in certain hospital rate reimbursement caps under Medicaid to certification of eligibility for such increases from the Board of Regents.

- Provides for the Committee on Graduate Medical Education (as a separate section of the bill, rather than as part of the Community Hospital Education Act) with specific study topics and annual report requirements.

On April 26, 2000, the Committee on Health and Human Services Appropriations adopted six amendments to Health Care Services Committee amendment that was traveling with the bill. They are listed as follows:

- **Amendment to Amendment #1** added language to the definition of “Teaching Hospital”.
- **Amendment to Amendment #2** added language allowing Community Health Education Programs five years to attain the requisite number of residents or interns.
- **Amendment to Amendment #3** revised language regarding certification by the Board of Regents.
- **Amendment to Amendment #4** revised language relating to administrative costs associated with the production of the annual report.
- **Amendment to Amendment #5** revised language related to the annual report.

VII. SIGNATURES:

COMMITTEE ON HEALTH CARE SERVICES:

Prepared by:	Staff Director:
Phil E. Williams	Phil E. Williams

AS REVISED BY THE COMMITTEE ON HEALTH AND HUMAN SERVICES APPROPRIATIONS:

Prepared by:	Staff Director:
Lynn Dixon	Lynn Dixon