HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 5201 (PCB HCAS 13-01) Medicaid
SPONSOR(S): Health Care Appropriations Subcommittee; Hudson
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Health Care Appropriations Subcommittee	10 Y, 3 N	Clark	Pridgeon
1) Appropriations Committee	22 Y, 0 N	Clark	Leznoff

SUMMARY ANALYSIS

The bill conforms statutes to the funding decisions included in the proposed General Appropriations Act (GAA) for Fiscal Year 2013-2014. The bill:

- Repeals the Community Hospital Education Act.
- Establishes a new statute to provide a methodology to distribute Graduate Medical Education funding through the new Statewide Medicaid Graduate Medical Education Program.
- Modifies definition of rural hospital for reimbursement purposes.
- Defines how hospital inpatient rates will be calculated under a prospective payment system.
- Modifies current statute to provide deadlines related to intergovernmental transfer (IGT) letters of agreement and for source data and rate calculation corrections related to hospital inpatient and outpatient reimbursements.
- Modifies current statute to eliminate language related to the diagnosis-related group (DRG) study.
- Defines how hospital outpatient base rates will be set under a cost-reimbursement system and provides statutory deadlines for rate adjustments.
- Modifies statutes to convert hospital inpatient rates to a DRG payment system.
- 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.
- Revises the Medicaid DSH distribution criteria for Specialty Hospitals related to Tuberculosis patient services.

The bill provides an effective date of July 1, 2013.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED 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 Graduate Medical Education 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 is important 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 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.

[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*

The bill creates a new section of statute entitled “Statewide Medicaid Graduate Medical Education 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:

- The number of full-time residents enrolled in a hospital’s graduate medical education program as reported in the hospital’s most recently filed Medicare/Medicaid cost report to the AHCA.
- The direct medical education costs divided by total facility costs as reported in the hospital’s most recently filed Medicare/Medicaid cost report to the AHCA multiplied by the sum of the hospital’s total Medicaid inpatient reimbursements.

The bill requires AHCA, on or before October 1 of each year, to calculate each hospital’s funding allocation by applying the following allocation fraction:

$$THAF = [(HFTE/TFTE) \times 0.5] + [(HGMP/TGMP) \times 0.5]$$

Where:

THAF = A hospital's total allocation fraction.

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

TFTE = The sum of all participating hospitals' full-time equivalent residents.

HGMP = A hospital's total Graduate Medical Education Medicaid payments.

TGMP = The sum of all participating hospitals' total Graduate Medical Education Medicaid payments.

The result of this fraction produces each hospital’s total allocation factor that is multiplied by the total amount of Graduate Medical Education funding available to determine each hospital’s funding amount.

The bill also 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 15 of each year.

Hospital Rate-setting

In 2011, the Legislature directed the AHCA to establish a deadline of September 30 which hospital rates could not be adjusted until the next fiscal year. The following year, the Legislature extended the statutory deadline for 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 extend the discovery deadline of source data or rate calculation errors from October 31 to November 7. Errors discovered by November 7 will be corrected by the AHCA by November 15; however, errors discovered after November 7 will be corrected in the next fiscal year.

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, 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

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

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

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 $76.6 million to assist with the transition to DRG system of reimbursement.

The AHCA does not have the authority to modify reimbursement for any individual hospital providing specialized services if those services are already reflected in the existing DRGs used to set the 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. Additionally, the bill excludes payment of Graduate Medical Education through the DRG payment system, as reimbursement of these costs will be made through the Statewide Medicaid Graduate Medical Education Program.

Finally, 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.

B. SECTION DIRECTORY:

Section 1: Repeals s. 381.0403 F.S., relating to the Community Hospital Education Program.
Section 2: Amends s. 395.602, F.S., relating to the timeframe for the designation of rural hospitals.
Section 3: Amends s. 409.905, F.S., relating to the methodology for establishing prospective payment hospital inpatient rates and cost-based outpatient base rates; specifying dates by which local governmental entities must submit letters of agreement for intergovernmental transfers; specifying dates by which AHCA may correct errors in rate calculations; and deletes a requirement to develop a plan to convert Medicaid hospital inpatient rates into a DRG methodology.
Section 4: Amends s. 409.908, F.S., to convert current Medicaid hospital inpatient reimbursement to a DRG methodology.
Section 5: 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 for nonstate government-owned or operated hospitals eligible for payment on a specified date.
Section 6: Creates s. 409.9111, F.S., the Statewide Medicaid Graduate Medical Education Program.
Section 7: Amends s. 409.9118, F.S., to revise the disproportionate share program distribution criteria for specialty hospitals related to tuberculosis patient services.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

$205,507,108 in federal Medicaid funds will be generated through the implementation of the DSH programs.

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	$ 31,835,516
Medical Care Trust Fund	$ 44,706,842
Refugee Assistance Trust Fund	$ 97,301
Total	**$ 76,639,659**
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**
TOTAL BUDGETARY IMPACT	
General Revenue	**$ 65,641,516**
Grants and Donations Trust Fund	**$ 95,243,343**
Medical Care Trust Fund	**$298,138,594**
Refugee Assistance Trust Fund	**$ 97,301**
GRAND TOTAL	**$459,120,754**

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None

2. Expenditures:

   Local governments and other local political subdivisions may provide $95,243,343 in contributions for the DSH programs.

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 $301,500,451 through the 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:

B. RULE-MAKING AUTHORITY:

The bill authorizes the AHCA to adopt any rules needed to administer the Statewide Medicaid Graduate Medical Education Program.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES