The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Appropriations

BILL: SPB 7058

INTRODUCER: For consideration by the Appropriations Committee

SUBJECT: Medicaid

DATE: April 3, 2013 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Brown	Hansen		**Submitted as committee bill**
2.				
3.				
4.				
5.				
6.				

I. Summary:

SPB 7058 amends statutes relating to the Medicaid program and Medicaid funding relating to:

- Rural hospitals;
- Medicaid hospital reimbursement;
- Graduate medical education; and
- Disproportionate share hospital (DSH) programs.

The bill conforms the statutes relating to Medicaid to the Senate proposed General Appropriations Bill, SPB 7040.

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

The bill substantially amends the following sections of the Florida Statutes: 395.602, 409.905, 409.908, 409.911, and 409.9118.

The bill creates section 409.909, Florida Statutes.

II. Present Situation:

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 no greater than 100 persons per square mile;
- An acute care hospital in a county with a population density no greater than 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 100 persons or fewer per square mile;
- A hospital in a constitutional charter county with a population of over one million persons that has imposed a local option health service tax and in an area that was directly impacted by a catastrophic event on August 24, 1992, for which the Governor of Florida declared a state of emergency and which has 120 or fewer beds and which serves an agricultural community with an emergency room utilization of no less than 20,000 visits and a Medicaid inpatient utilization rate greater than 15 percent;
- A hospital with a service area of fewer than 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).[1]

Population densities must be based upon the most recently completed United States census.

The definition also provides that a hospital that received funds from the disproportionate share/financial assistance program for rural hospitals[2] for a quarter beginning no later than July 1, 2002, is deemed to have been and will continue to be a rural hospital from that date through June 30, 2015, if the hospital continues to have 100 or fewer beds and an emergency room.

An acute care hospital that has not previously been designated as a rural hospital and meets the definition's criteria will be granted rural designation upon making application, with supporting documentation, to the Agency for Health Care Administration (AHCA).

Currently 28 hospitals are designated as rural hospitals:

Rural Hospital	County	City	Beds
Baptist Medical Center - Nassau	Nassau	Fernandina Beach	54
Calhoun-Liberty Hospital	Calhoun	Blountstown	25
Campbellton-Graceville Hospital	Jackson	Graceville	25
Desoto Memorial Hospital	Desoto	Arcadia	49
Doctors Memorial Hospital	Holmes	Bonifay	20
Doctors Memorial Hospital Inc	Taylor	Perry	48
Ed Fraser Memorial Hospital	Baker	Macclenny	25
Fishermen's Hospital	Monroe	Marathon	25
Florida Hospital Flagler	Flagler	Palm Coast	99
Florida Hospital Wauchula	Hardee	Wauchula	25

[1] Section 408.07(15), F.S., defines a critical access hospital as "a hospital that meets the definition of 'critical access hospital' in s. 1861(mm)(1) of the Social Security Act and that is certified by the Secretary of Health and Human Services as a critical access hospital."
[2] *See* s. 409.9116, F.S.

Rural Hospital	County	City	Beds
George E Weems Memorial Hospital	Franklin	Apalachicola	25
Healthmark Regional Medical Center	Walton	Defuniak Springs	50
Hendry Regional Medical Center	Hendry	Clewiston	25
Jackson Hospital	Jackson	Marianna	100
Jay Hospital	Santa Rosa	Jay	55
Lake Butler Hospital Hand Surgery Center	Union	Lake Butler	25
Lakeside Medical Center	Palm Beach	Belle Glade	70
Madison County Memorial Hospital	Madison	Madison	25
Mariners Hospital	Monroe	Tavernier	25
Northwest Florida Community Hospital	Washington	Chipley	59
Putnam Community Medical Center	Putnam	Palatka	99
Raulerson Hospital	Okeechobee	Okeechobee	100
Sacred Heart Hospital On The Emerald Coast	Walton	Miramar Beach	58
Sacred Heart Hospital On The Gulf	Gulf Port	Saint Joe	19
Shands Lake Shore Regional Medical Center	Columbia	Lake City	99
Shands Live Oak Regional Medical Center	Suwannee	Live Oak	15
Shands Starke Regional Medical Center	Bradford	Starke	25
Tri County Hospital - Williston	Levy	Williston	40

Rural hospitals are eligible to participate in the rural hospital Medicaid disproportionate share (DSH) and financial assistance programs under s. 409.9116, F.S. Rural hospitals may also receive a special Medicaid payment for their rural status, and inpatient and outpatient per diem rates for rural hospitals are exempt from reimbursement ceilings.

Medicaid Hospital Reimbursement

Under current law, Florida pays hospitals for Medicaid services using cost-based reimbursement methodologies, one for inpatient rates and one for outpatient rates. The methodologies are approved by the federal Centers for Medicare & Medicaid Services (CMS) and documented in official state Medicaid Hospital Reimbursement Plans. The plans are amended as necessary to follow policy and budgetary guidance passed by the Florida Legislature. The reimbursement process is complex and a number of far-reaching alterations have been applied over the years. The main elements are outlined below.

Cost Reports

Hospitals submit audited cost reports for Medicaid services annually. For each hospital, the most recently available cost reports are analyzed for allowable costs and put through a methodology to determine the hospital's reimbursement. The methodology includes many calculations to account for current and anticipated trends and for rate cuts and policy measures applied by the Legislature. Based on all these factors, a customized "per diem" is calculated for each hospital based on that hospital's cost reports and the various calculations contained in the methodology.

Per Diems

Hospitals are paid a flat "per diem" for a Medicaid inpatient "day." An inpatient day occurs when a Medicaid patient is admitted to the hospital and stays overnight to receive treatment. One such overnight stay counts as an inpatient "day," and the hospital receives a per diem payment

for that day that is the same for any Medicaid patient who stays overnight at that hospital, regardless of the treatments provided. For example, with any specific hospital, the Medicaid per diem reimbursement paid to the hospital for two separate inpatient days will be the same dollar figure, regardless of differences in the treatments provided.

Reimbursement Ceilings

In 1990, Florida began placing recurring "reimbursement ceilings" on the growth allowed for hospital per diems. For that year, the ceiling was set at 3.3 percent, meaning that a hospital's per diem was allowed to increase by no more than 3.3 percent of the previous year's rate, regardless of the increase called for by the cost-based methodology. In subsequent years, the ceiling has been set each year based on a formula using inflation factors.

Exemptions from Reimbursement Ceilings

The state began applying reimbursement ceilings effective July 1990, but certain hospitals are exempt from the ceilings, which means yearly increases in their rates are not limited by the full application of the reimbursement ceilings. A rate that is exempt from the ceilings is commonly called the "exempt rate." All hospitals that are defined as rural hospitals were exempted on an ongoing basis at the outset. Over the years, other hospitals have been made exempt from reimbursement ceilings:

- In 1991, hospitals whose charity and Medicaid days exceeded 15 percent of their overall days were exempted. (That percentage has been lowered over the years and now stands at 11 percent, which allows more hospitals to qualify for the exemption.)
- In 2000, certain teaching hospitals, children's hospitals, and certain specialized hospitals were made exempt.
- In 2001, trauma centers whose percentage of Medicaid days exceeded 9.6 percent were made exempt. (This percentage has also been reduced and is now 7.3 percent.)
- In 2004 and 2005, certain hospitals with neonatal intensive care units were made exempt.
- In 2008, more hospitals were made exempt, including hospitals experiencing an increase in Medicaid caseload by more than 25 percent in any year and hospitals whose Medicaid per diem rate is at least 25 percent below the Medicaid per patient cost for the year.

Currently 28 rural hospitals are exempt from the reimbursement ceilings and an additional 84 of Medicaid's 243 hospitals are exempt by virtue of meeting one of the criteria specified in the General Appropriations Act (GAA). Being exempt can significantly increase a hospital's per diem. On the average, a non-rural hospital's exempt rate is roughly twice as high as what that hospital would be paid without the exemption.

Funding for Exemptions

Exemptions for rural hospitals are funded with state general revenue (GR) and federal Medicaid matching dollars. The other exemptions described above 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.

These IGTs allow the state to exempt certain hospitals from the reimbursement ceilings and pay them higher Medicaid rates without expending state GR directly on the hospital reimbursements.

IGTs in General

The IGTs described above are used to fund exemptions. IGTs are also used to augment hospital payments in other ways. 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. Local taxing authorities donate IGTs voluntarily and are not required to provide the IGTs.

The Sources of IGTs for Exemptions

IGTs are donated to the state by local taxing authorities, but not all local taxing authorities donate IGTs in this way. A hospital may be exempt from the reimbursement ceilings based on meeting the criteria described above, and is therefore paid the higher exempt rate, even though no local dollars from that hospital's county or local taxing district are donated. Certain donor counties and taxing authorities contribute IGTs that, along with federal match, are used to fund exemptions across the entire state for hospitals that meet the criteria for being exempt.

Self-funded Exemptions

In 2008, the Legislature began passing budget proviso each year allowing public hospitals that did not qualify for exemptions as described above to provide their own funds or local governmental funds in order to "self-fund" an exemption for the hospital. Such "self-funded" exemptions are not part of the process described above and are handled as stand-alone exemptions for individual hospitals that would not otherwise qualify for exemptions. Beginning in 2009, non-public hospitals with graduate medical education positions were also allowed to self-fund exemptions from their reimbursement ceilings in this way. For the current fiscal year, the GAA contains proviso allowing any hospital to self-fund an exemption from the inpatient and outpatient reimbursement ceilings, up to spending authority of $129 million in IGTs and $176 million in federal match.

Legislative Rate Cuts

Beginning in 2005, the Legislature began reducing rates for many Medicaid providers, including hospitals, to help balance the overall state budget. The GAA has included seven cuts to hospital rates and the hospital inpatient line item since 2005-06, for an average of about 4 percent for each cut. The 2011-12 fiscal year rate cut was the most severe at approximately 12.5 percent. In its rate-setting methodology, AHCA refers to these cuts as "Medicaid Trend Adjustments," and each cut has been applied separately whenever new hospital rates have been calculated based on each year's most recent cost reports.

IGTs to "Buy Back" the Rate Cuts

In 2007 the GAA included proviso to allow the use of IGTs and federal match to reinstate rate reductions for hospitals whose Medicaid and charity days exceeded 30 percent and had more than 10,000 Medicaid days, and for hospitals or hospital systems that established a provider

service network (PSN) during the prior state fiscal year. This was the precursor for what is known as “buying back” the rate cuts.

Beginning in 2008, the Legislature began passing proviso in the GAA allowing certain hospitals to use additional IGTs (above and beyond the IGTs used to fund exemptions) to “buy back” all or a portion of the rate cuts imposed by the GAA in the 2008-09 fiscal year and in prior years. In this way, certain hospitals would not be paid less due to the Legislative rate cuts if local IGTs could be secured to offset the effect of the rate cuts. In the first fiscal year that “buy-backs” were implemented (2008-09), they were applied to the following hospitals:

- Hospitals that were part of a system that operates a provider service network,[3] including Jackson Memorial, hospitals in Broward Health, hospitals in Memorial Healthcare System, Shands Jacksonville, and Shands Gainesville;
- Children’s specialty hospitals whose Medicaid and charity days equaled or exceeded 30 percent;
- Rural hospitals; and
- Public hospitals, teaching hospitals that had 70 or more resident physicians, and hospitals whose Medicaid and charity days exceeded 25 percent.

In 2009, designated trauma hospitals were added to the list of hospitals allowed to use IGTs to buy back their rate cuts. In 2010, hospitals with graduate medical education positions that did not otherwise qualify were added to the list.

For 2011-12, several changes were made in the GAA relating to buy-backs, including:

- Proviso language similar to prior years (along with specific spending authority for IGTs and federal match) relating to buy-backs for public hospitals, teaching hospitals that had 70 or more resident physicians, designated trauma hospitals, and hospitals with graduate medical education positions, was left in place. Spending authority of $290 million in IGTs and $368 million in federal match was provided for these buy-backs.
- In addition to the proviso above, proviso was included to allow all other hospitals to use up to $161 million in IGTs and $205 million in federal match in order to self-fund inpatient and outpatient buy-backs.

For the current fiscal year, the GAA includes proviso similar to the 2011-12 proviso that provides spending authority of $238 million in IGTs and $325 million in federal match for the criteria-based and self-funded buy-backs described above.

Potential Application and Effect of IGTs Has Grown

When exemptions and buy-backs were first implemented, they were limited in scope for certain hospitals meeting certain criteria. Over the years, their scope has gradually expanded. With the language in the 2011-12 and 2012-13 GAAs, IGTs can theoretically be used to (1) apply exemptions to any hospital in the state, and (2) buy back the Legislative rate cuts for any

[3] *See* s. 409.912(4)(d), F.S.

hospital. In order to do so, however, IGTs must be secured to pay the non-federal share, and the spending authority designated in the GAA may not be exceeded.

Diagnosis Related Group (DRG) System for Hospital Reimbursement

DRG is a type of prospective payment system for reimbursing hospitals. DRGs classify an inpatient stay into a group based on a patient's diagnoses, gender, age, and other factors, which can include hospital case mix and overall wellness or acuity of the hospital's overall patient population. 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 the federal Medicare program and seeks to tailor reimbursement more closely to actual costs of treatment for each individual patient.

Thirty-eight states currently use or are considering transitioning to a DRG reimbursement methodology for their Medicaid programs. Among the states that use a DRG reimbursement methodology, the most prevalent methodologies are All Patient Refined DRGs (APR-DRGs) and the Medicare DRGs (MS-DRGs). The major difference between these two methodologies is that MS-DRGs are intended for use on Medicare population (age 65 and older or aged 65 and under with a disability). 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.[4]

In 2011, the Legislature directed the AHCA to develop a plan to convert hospital inpatient rates to a prospective payment system utilizing DRGs and to propose the adaptation of an existing DRG system, to the extent possible, while maintaining budget neutrality. The plan was to be submitted to the governor, the president of the Senate, and the speaker of the House of Representatives no later than January 1, 2013.[5]

In 2012, the Legislature added specific parameters for the DRG transition plan and required the AHCA's engagement of a consultant with expertise and experience in the implementation of DRG systems. The AHCA was also required to include in its plan a timeline necessary to allow for full implementation by July 1, 2013.[6] The AHCA retained Navigant Healthcare as its DRG consultant and the final plan was published 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;

[4] Navigant Healthcare, *DRG Conversion Implementation Plan Final, December 21, 2012,* available at: http://ahca.myflorida.com/Medicaid/cost_reim/index.shtml
[5] *See* ch. 2011-135, L.O.F.
[6] *See* ch. 2012-33, L.O.F.

- Teaching hospitals;
- In-state / out-of-state / border hospitals;
- Long-term acute care;
- Rehabilitation hospitals and distinct part units; and
- 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 and recommended that the base rate only include the portion of the rate funded from state general revenue and the Public Medical Assistance Trust Fund, thereby excluding IGTs from the base rate. Distributions of IGT funds 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:

- 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.
    -

Graduate Medical Education

Graduate medical education (GME) is the education and training of physicians following graduation from a medical school in which 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.[7]

Graduate medical education is significant because:[8]

- 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 are more likely to stay as practicing physicians.
- Medical residents act as "safety nets" of care for indigent, uninsured, and under-served patients in the state.
- 13.2 percent of the physicians from the 2009 survey indicated that they plan to retire in the next 5 years.

[7] 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
[8] *Id.*

Currently, hospitals are reimbursed by Florida Medicaid for GME costs through their Medicaid hospital inpatient reimbursements. The costs directly related to each hospital's residency program are considered allowable costs for the cost reports that hospitals submit to the AHCA and are included in the calculation of Medicaid per diems paid to the hospitals by the Medicaid program.

Disproportionate Share Hospital (DSH) Program

Each year the Low-Income Pool Council9 (LIP Council) makes recommendations to the Legislature on the Medicaid Disproportionate Share Hospital Program's funding distributions to hospitals that provide a disproportionate share of the Medicaid services or charity care services to uninsured individuals. The Legislature delineates how the funds will be distributed to each eligible facility.

There are currently five separate Medicaid disproportionate share programs that are operational in Florida. The programs are:

- The original program (Regular DSH) established in s. 409.911, F.S.;
- The Teaching Hospital DSH program established in s. 409.9113, F.S.;
- The Mental Health Hospital DSH program established in s. 409.9115, F.S.;
- The Rural Hospital DSH/Financial Assistance program established in s. 409.9116, F.S.; and
- The Specialty Hospital DSH program established in s. 409.9118, F.S.

In 2012 the Legislature directed the Department of Health (DOH) to develop and implement a transition plan for the closure of A.G. Holley State Hospital and its tuberculosis treatment program that was housed at the facility.[10] The DOH plan included specific steps to end voluntary admissions, transfer tuberculosis 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 A.G. 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 who were previously treated at A.G. Holley. A.G. Holley officially closed on July 2, 2012.

III. Effect of Proposed Changes:

Section 1 of the bill amends s. 395.602, F.S., by providing that hospitals licensed as rural hospitals in the 2010-11 or 2011-12 fiscal years are deemed to continue to be rural hospitals from the date of designation through June 30, 2015, if they continue to have 100 or fewer beds and an emergency room.

Section 2 of the bill amends s. 409.905, F.S., by:

[9] *See* s. 409.911(10), F.S.
[10] See ss. 81-83, ch. 2012-184, L.O.F.

- Deleting provisions of current law requiring the AHCA to implement a cost-based reimbursement methodology for hospital inpatient reimbursement;
- Requiring the AHCA to implement a prospective payment methodology for hospital inpatient reimbursement that categorizes inpatient admissions into DRGs and assign relative payment weights to adjust the base rate according to a measure of hospital resources used to treat patients in specific DRG categories;
- Requiring the AHCA to establish a uniform base rate for all hospitals not exempted under s. 409.908(1), F.S., and to limit the base rate by the hospital inpatient appropriation specified in the GAA, prior to the inclusion of intergovernmental transfers that may be provided to adjust inpatient reimbursement;
- Deleting provisions of current law requiring the AHCA to develop and submit a plan for converting the current cost-based methodology to a DRG methodology; and
- Specifying that Florida's hospital outpatient reimbursement methodology will remain cost-based under certain provisions of current law that are deleted or amended under the new DRG provisions for inpatient reimbursement.

Section 3 of the bill amends s. 409.908, F.S., by providing that hospital inpatient reimbursement is limited as provided in s. 409.905(5), F.S., with the following exceptions:

- The AHCA may modify inpatient reimbursement for specific types of services or diagnoses, Medicaid recipient ages, and hospital provider types, if authorized by the GAA.
- While maintaining budget neutrality, the AHCA may modify reimbursement to providers determined to be long-term acute care hospitals.
- The AHCA may establish an alternative to a DRG-based prospective payment system to set reimbursement rates for:
  - State-owned psychiatric hospitals;
  - Newborn hearing screening services;
  - Transplant services for which the AHCA has established a global fee; and
  - Medicaid recipients who have treatment-resistant tuberculosis who need long-term, hospital-based treatment.

Also, Section 3 provides that in order for the AHCA to certify IGTs donated by local governments for the purpose of making special payments to hospitals in any given fiscal year, local governments must submit a final, executed letter of agreement to the AHCA, and the letter must be received by the AHCA no later than October 1 of that fiscal year.

Section 4 of the bill creates s. 409.909, F.S., to establish the Statewide Medicaid Residency Program (SMRP). Under the SMRP:

- 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.
- On or before September 15 of each year, the AHCA is required to calculate an allocation fraction for each hospital participating in the program, based on the following formula:

  HAF = [0.9 x (HFTE/TFTE)] + [0.1 x (HMP/TMP)]

  Where:

  HAF = A hospital's allocation fraction.

  HFTE = A hospital's total number of FTE residents.

  TFTE = The total FTE 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 SMRP in the GAA multiplied by its allocation fraction. However, 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 and 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.
- The AHCA is authorized to adopt rules to administer the SMRP.

Section 5 of the bill amends s. 409.911, F.S., to revise the years of audited data to be used by the AHCA in calculating DSH program payments to hospitals for state Fiscal Year 2013-2014 by specifying the use of data from 2005, 2006, and 2007.

Section 6 of the bill amends s. 409.9118, F.S., to authorize DSH funding under the DSH for Specialty Hospitals Program for hospitals that are under contract with the DOH to admit tuberculosis patients on an inpatient basis who have active tuberculosis or a history of noncompliance with the treatment of tuberculosis.

Section 7 of the bill provides that the bill takes effect July 1, 2013.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Hospitals may experience differences in Medicaid reimbursements after the transition to DRGs and the implementation of the SMRP begin on July 1, 2013. To the extent that hospitals treat tuberculosis patients who would have been admitted to A.G. Holley, such hospitals will receive funding from the DSH for Specialty Hospitals Program that they otherwise would not have received.

C. Government Sector Impact:

The AHCA's plan to transition from a cost-based system to a DRG-based system for hospital inpatient reimbursement was required to be budget neutral. GME costs are removed from direct hospital reimbursement for Medicaid services and transferred to the SMRP. The Senate proposed General Appropriations Bill for the 2013-2014 fiscal year includes an additional $8.5 million in recurring general revenue and $12 million in recurring federal match for the SMRP.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.