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:	SB 2512
INTRODUCER:	Appropriations Committee
SUBJECT:	Medicaid
DATE:	March 27, 2014
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Brown	Kynoch		**AP SPB 7100 as introduced**

I. Summary:

SB 2512 amends statutes relating to the following aspects of the Medicaid program:
- The definition of rural hospitals;
- Disproportionate share hospital programs; and
- Statewide Medicaid Managed Care.

The bill conforms Medicaid-related statutes to the Senate proposed General Appropriations Bill, SB 2500.

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]

An acute care hospital that has not previously been designated as a rural hospital and that meets the criteria of the definition will be granted rural hospital status upon submitting an application, including supporting documentation, to the AHCA.[2]

The provision in the definition regarding a hospital in an area that was directly impacted by a catastrophic event on August 24, 1992,[3] for which the Governor of Florida declared a state of emergency, became law in 1999[4] and pertained to only one hospital – SMH Homestead Hospital.[5] That hospital is now known as Homestead Hospital[6] and no longer meets the statutory definition of a rural hospital.

Currently, 28 hospitals are designated as rural hospitals:[7]

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
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

[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. 395.602(2)(e), F.S.
[3] Hurricane Andrew struck Homestead, Florida, on August 24, 1992, as a category 5 storm.
[4] *See* ch. 99-209, Laws of Florida.
[5] Senate Fiscal Policy Committee, *Senate Staff Analysis and Economic Impact Statement for CS/CS/SB 890,* April 14, 1999, available at < http://archive.flsenate.gov/data/session/1999/Senate/bills/analysis/pdf/SB0890.fp.pdf >, last visited March 16, 2014.
[6] *See* < https://baptisthealth.net/en/facilities/homestead-hospital/pages/about.aspx >, last visited March 16, 2014.
[7] *See* < http://www.floridahealthfinder.gov/facilitylocator/FacilitySearch.aspx >, last visited March 16, 2014.

Rural Hospital	County	City	Beds
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	25
Shands Starke Regional Medical Center	Bradford	Starke	25
Tri County Hospital - Williston	Levy	Williston	40

Rural hospitals are eligible to participate in Medicaid's rural hospital financial assistance programs under s. 409.9116, F.S. Rural hospitals may also receive special consideration in the General Appropriations Act for Medicaid reimbursement due to their rural status.

Sole Community Hospitals

The federal Medicare program classifies a hospital as a "sole community hospital" based on criteria specified in title 42, s. 412.92, of the Code of Federal Regulations, including whether the hospital is situated in a federally-designated rural area, the hospital's capacity, and the hospital's distance from other hospitals. A sole community hospital is given special treatment and is eligible for payment adjustments from the Medicare program due to the federal government's consideration of the hospital's accessibility to residents of rural areas who have limited options for hospital services.

Florida contains seven sole community hospitals, all but two of which qualify as rural hospitals under Florida Statutes.[8]

Disproportionate Share Hospital Programs

Federal law requires state Medicaid programs to make Disproportionate Share Hospital (DSH) payments to qualifying hospitals that serve a large number of Medicaid recipients and uninsured individuals. The federal government annually provides a limited DSH allotment to each state. States may appropriate these federal funds based on the amount of state dollars appropriated as matching funds for the federal DSH allotment, up to but not exceeding the federal limit. The Legislature delineates how DSH funds will be distributed to each eligible facility in the General Appropriations Act.

Currently, Florida has five, separate Medicaid DSH programs that are operational:
- 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.
- The Specialty Hospital DSH program established in s. 409.9118, F.S.

[8] The sole community hospitals in Florida are: Desoto Memorial Hospital (Arcadia); Doctors' Memorial Hospital (Perry); Ed Fraser Memorial Hospital (MacClenny); Flagler Hospital (St. Augustine); Raulerson Hospital (Okeechobee); Jackson Hospital (Marianna); and Lower Keys Medical Center (Key West). Flagler Hospital and Lower Keys Medical Center are not considered rural hospitals under Florida law.

For states to receive DSH payments, federal law requires states to submit an independent certified audit and an annual report to the secretary of the federal Department of Health and Human Services, describing DSH payments made to each DSH hospital. Florida law requires the Agency for Health Care Administration (AHCA) to use audited data from specified years to determine the amount of Medicaid and charity care to be used in calculating DSH payments.[9]

Statewide Medicaid Managed Care

Part IV of ch. 409, F.S., was created in 2011 by ch. 2011-134, L.O.F., and governs the Statewide Medicaid Managed Care program (SMMC). The program, authorized by a federal Medicaid waiver, is designed for the AHCA to issue invitations to negotiate[10] and competitively procure contracts with managed care plans in 11 regions of the state to provide comprehensive Medicaid coverage for most of the state's enrollees in the Medicaid program. SMMC has two components: managed medical assistance (MMA) and long-term care managed care (LTCMC).

The LTCMC component began enrolling Medicaid recipients in August 2013 and is scheduled to complete its statewide roll-out in March 2014.[11] The MMA component is scheduled to begin enrolling Medicaid recipients in May 2014 and finish its roll-out in August 2014.[12]

Provider Service Networks

Types of managed care plans that are eligible for SMMC include health insurers, exclusive provider organizations, health maintenance organizations, provider service networks (PSNs), and federally-authorized accountable care organizations, among other entities.[13]

A PSN is defined as a type of managed care plan of which a controlling interest is owned by a health care provider, or group of affiliated providers, or a public agency or entity that delivers health services. For the purpose of this definition, "health care provider" includes Florida-licensed health care professionals or licensed health care facilities, federally qualified health care centers, and home health care agencies.[14]

The AHCA is required to procure a specified number of managed care plans per region or a number of plans that range between a minimum and maximum specified for each region. At least two plans per region must be procured, and at least one plan per region must be a PSN, if a PSN submits a responsive bid during the procurement. If no PSN submits a responsive bid for a region, the AHCA is required to procure no more than one less than the maximum number of plans for that region during the initial procurement and, within 12 months after the initial invitation to negotiate, attempt once again to procure a PSN for that region.[15]

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[9] *See* s. 409.911(2), F.S.
[10] An "invitation to negotiate" is a written or electronically posted solicitation for vendors to submit competitive, sealed replies for the purpose of selecting one or more vendors with which to commence negotiations for the procurement of commodities or contractual services. *See* s. 287.012(17), F.S.
[11] *See* < http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml#LTCMC >, last visited March 20, 2014.
[12] *See* < http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml#MMA >, last visited March 20, 2014.
[13] *See* s. 409.962(6), F.S.
[14] *See* s. 409.962(13), F.S.
[15] *See* s. 409.974(1), F.S.

SMMC allows for contracted managed care plans to be paid via one of two methods. A managed care plan that is not a PSN is required to be a "prepaid plan," which is a plan licensed or certified in Florida as a risk-bearing entity and paid a prospective per-member-per-month payment by the AHCA known as a capitation. A PSN may qualify as a prepaid plan under s. 409.912(4)(d), F.S., which provides that a PSN may be reimbursed on a prepaid basis by complying with the solvency requirements for health maintenance organizations under s. 641.2261(2), F.S., and by meeting appropriate financial reserve, quality assurance, and patient rights requirements established by the AHCA.[16]

Managed care plans that provide for services on a prepaid, capitated basis agree to accept the capitation payment and assume financial risk for delivering all covered services, regardless of whether the capitation fully covers the cost for all services that need to be provided. Capitation is designed to provide the state with less risk and more predictability for Medicaid expenditures and to incent the capitated entities to manage the provision of services in a cost-effective manner. Capitation rates must be certified as actuarially sound by a third-party actuary in compliance with federal guidelines.

SMMC gives PSNs the option for their network providers to be paid on a fee-for-service basis by the state's Medicaid fiscal agent instead of the PSN being paid by capitation. The fee-for-service option is available to a PSN only for the first two years of its operation under the SMMC, at which point the PSN is required to convert to a prepaid PSN.[17]

Medically Needy

The Medically Needy program serves families and individuals that are categorically eligible for Medicaid but do not qualify for Medicaid due to having income or assets that exceed eligibility thresholds. If such a person or family has medical expenses in any given month that reach a certain level based on the person's or family's income, that person or family may be determined eligible for Medically Needy for that month and may receive the same services as other Medicaid recipients, except for certain long-term care services.[18] The level of expenses the person or family must incur in order to be eligible for Medically Needy is known as the "share of cost." Outside of SMMC, Medically Needy recipients are excluded from Medicaid managed care enrollment due to their month-to-month eligibility.[19]

Under Florida law, the SMMC program requires a person eligible for the Medically Needy program to enroll in a managed care plan in the MMA component, contingent on federal approval. Such a person is required to meet his or her share of cost by paying a monthly premium to the managed care plan, up to the share of cost amount, again contingent on federal approval. The state Medicaid program is required to pay the remainder, if any, of the premium that would be paid to the plan. Under those conditions, a person eligible under Medically Needy in SMMC is granted 12 months of continuous eligibility, as long as the share of cost is paid in

[16] *See* s. 409.962(12), F.S.
[17] *See* s. 409.968(2), F.S.
[18] *See* s. 409.904(2), F.S.
[19] *See* s. 409.9122(2)(a), F.S.

the form of a premium. Managed care plans are required to allow a 90-day grace period for non-payment of premiums before a Medically Needy recipient may be disenrolled.[20]

The federal Medicaid program approved the AHCA's waiver request for the MMA component in June 2013 but refused to grant approval for Medically Needy recipients to be charged a monthly premium as a condition of eligibility. Without approval to charge premiums, SMMC cannot provide coverage to Medically Needy recipients in the manner for which it was designed; however, state law still requires Medically Needy recipients to be enrolled in managed care plans under SMMC.

Group Home Facilities for Persons with Developmental Disabilities

The Agency for Persons with Disabilities (APD) is responsible for providing all services for persons with developmental disabilities that are provided under ch. 393, F.S., including the operation of all state-related institutional programs and the programmatic management of Medicaid waivers established to provide services to persons with developmental disabilities.[21] A person determined eligible by the APD to receive APD services is known as a "client,"[22] and the term includes persons receiving APD services and those on a waiting list to receive APD services.

The AHCA has been granted waiver authority from the federal Medicaid program for the state to implement a four-tiered system to serve eligible clients through a Developmental Disabilities Waiver (DD waiver). For the purpose of this waiver program, eligible clients include individuals with a diagnosis of Down syndrome or a developmental disability. The APD is required to assign all clients receiving services through this waiver to a tier, based on financial eligibility guidelines and APD assessments.[23]

Under the DD waiver, the APD operates four tier-based programs that provide home and community-based supports and services to clients living at home or in a home-like setting. DD waiver services are funded by state revenue and federal Medicaid matching dollars. APD operates the DD waiver under the authorization of the AHCA's Division of Medicaid.

The purpose of the DD waiver is to promote, maintain, and restore the health of APD clients; to minimize the effects of illness and disabilities through the provision of needed supports and services in order to delay or prevent institutionalization; and to foster the principles of self-determination as a foundation for services and supports. The intent of the waiver is to provide a viable choice of services that allow clients to live as independently as possible in their own home or in the community and to achieve productive lives as close to normal as possible, as opposed to residing in an institutional setting.[24]

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[20] *See* ss. 409.972(1) and 409.975(7), F.S.
[21] *See* s. 20.197(3), F.S.
[22] *See* s. 393.063(5), F.S.
[23] *See* s. 393.0661(2), F.S.
[24] Agency for Health Care Administration, *Developmental Disabilities Waiver Services Coverage and Limitations Handbook*, November 2010, sec. 1, p. 8, available at < http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/DD_Waiver_Handbook_Final_Rule_Nov_2010.pdf >, last visited March 20, 2014.

Under ch. 393, F.S., the Legislature declared that all persons with developmental disabilities who live in licensed community homes will have a living environment comparable to other Floridians and that such residences will be considered and treated as a functional equivalent of a family unit and not as an institution, business, or boarding home.[25]

The APD regulates group home facilities for persons with developmental disabilities. A "group home facility" is an APD-licensed residential facility that provides a family living environment, including supervision and care necessary to meet the physical, emotional, and social needs of its residents. The capacity of a group home facility is limited to at least four but not more than 15 residents.[26] "Residential facilities" provide room and board and personal care for persons with developmental disabilities.[27] "Personal care services" are defined as individual assistance with or supervision of essential activities of daily living for self-care, including ambulation, bathing, dressing, eating, grooming, toileting, and other similar services that are incidental to the care furnished and essential to the health, safety, and welfare of a person with developmental disabilities if no one else is available to perform those services.[28]

Not all residents of APD-licensed group homes are APD clients. Some are private-pay residents. Some are eligible for Medicaid without being eligible for DD waiver services. The APD currently issues licenses to 1,661 group homes statewide in which approximately 8,000 persons with developmental disabilities reside. Approximately 250 of these residents are not APD clients while 7,673 APD clients in group home settings are enrolled in Medicaid for health care services. The number of group home residents who are not APD clients but are Medicaid-eligible is unknown.[29]

Under SMMC, all Medicaid recipients are required to receive covered Medicaid services through managed care plan enrollment, except for certain groups of individuals that are exempt from participation in SMMC.[30] Other Medicaid-eligible individuals are not required to enroll in managed care plans but may do so voluntarily, including Medicaid recipients who are receiving DD waiver services or are on a waiting list to receive DD waiver services,[31] which includes all APD clients. However, a resident of an APD-licensed group home who is not an APD client is not included in this "voluntary" category for managed care plan enrollment and is therefore required to join a Medicaid managed care plan under SMMC if he or she is Medicaid eligible and enrolls in Medicaid.

[25] *See* s. 393.062, F.S.
[26] *See* s. 393.063(17), F.S.
[27] *See* s. 393.063(28), F.S.
[28] *See* s. 393.063(24), F.S.
[29] Email from APD staff to Senate Appropriations Committee staff, March 20, 2014, on file with staff of the Senate Health and Human Services Appropriations Subcommittee.
[30] *See* s. 409.965, F.S.
[31] *See* s. 409.972(2), F.S.

The Children's Medical Services Network

The Children's Medical Services program (CMS) is established within the Department of Health (DOH) pursuant to ch. 391, F.S. The program is designed to provide children who have chronic health care needs with a family-centered, comprehensive, coordinated, and statewide managed system of care that links community-based health care with multidisciplinary, regional, and tertiary pediatric specialty care.[32] The program also has a preventative component designed to provide essential preventive, evaluative, and early intervention services for children who are at risk for having special health care needs, in order to prevent or reduce long-term disabilities.[33] To be eligible for CMS through Medicaid, a child must meet Medicaid's financial eligibility criteria and be clinically eligible for CMS based on a diagnosis of one or more chronic and serious medical conditions.[34]

The CMS Network is defined as a statewide managed care system that includes health care professionals, health care facilities, and entities licensed or certified to provide health services in Florida that also meet criteria established by the DOH. Health services under the CMS Network include the prevention, diagnosis, and treatment of human disease, pain, injury, deformity, or disabling condition.[35] CMS delivers services to Medicaid recipients through the CMS Network.

Under the MMA component of SMMC, the CMS Network is listed by name as an eligible managed care plan.[36] The CMS Network's participation in SMMC is required under a single, statewide contract with AHCA that is not subject to the SMMC's procurement requirements or limitations on the number of plans per region. However, the CMS Network must meet all other requirements for managed care plans under the MMA component.[37]

III. Effect of Proposed Changes:

Section 1 amends s. 395.602(2)(e), F.S., to revise the definition of "rural hospital." The bill deletes the obsolete provision regarding a hospital 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 adds a provision for "rural hospital" to include a hospital classified as a sole community hospital under title 42, s. 412.92, of the Code of Federal Regulations, having up to 340 licensed beds.

Section 2 amends s. 409.911(2)(a), F.S., by requiring the Agency for Health Care Administration (AHCA) to use the average of the 2006, 2007, and 2008 audited disproportionate share data to determine each hospital's Medicaid days and charity care for the 2014-2015 fiscal year, as opposed to the average of the 2005, 2006, and 2007 data.

Section 3 amends s. 409.962(13), F.S., to revise the definition of "provider service network" (PSN) within the Statewide Medicaid Managed Care program (SMMC). The bill requires that a

[32] *See* s. 391.016(1), F.S.
[33] *See* s. 391.016(2), F.S.
[34] *See* s. 391.029, F.S.
[35] *See* ss. 391.021(1) and 391.021(5)-(6), F.S.
[36] *Supra*, note 13.
[37] *See* s. 409.974(4), F.S.

group of affiliated health care providers that owns a controlling interest in a PSN must be affiliated for the purpose of providing health care. The bill also provides that the term "health care providers" includes Florida-licensed health care "practitioners," as opposed to Florida-licensed health care "professionals," among other entities.

Section 4 amends s. 409.972, F.S., to repeal the requirement that a person eligible for the Medically Needy program under SMMC must enroll in a managed care plan and pay a monthly premium up to his or her share of cost, contingent on federal approval. The bill also adds Medicaid recipients residing in group home facilities licensed by the Agency for Persons with Disabilities (APD), regardless of APD client status, to the list of Medicaid recipients who are not required to enroll in managed care plans under SMMC but may do so voluntarily. These provisions are effective upon the bill becoming law.

Section 5 amends s. 409.974(1), F.S., to require the AHCA to procure and contract with managed care plans in each SMMC region under specified parameters regarding the number of PSNs and total plans per region. The bill also provides that in a region containing only one contracted PSN, if changes in the PSN's ownership or business structure result in the PSN no longer meeting the definition of a PSN, the AHCA is required, within 12 months, to terminate that plan's contract, provide notice of another invitation to negotiate, and procure and contract with another PSN in that region.

Section 6 amends s. 409.974(4), F.S., to require that the Children's Medical Services Network (CMS Network), following a successful readiness review, must operate as a fee-for-service PSN under the managed medical assistance component of SMMC until July 1 of the fiscal year following the date on which the CMS Network qualifies to operate as a prepaid plan. The bill requires that while the CMS Network operates as a fee-for-service PSN, it is required to use the AHCA's third-party fiscal agent to pay claims. These provisions take effect upon the bill becoming law.

Section 7 amends s. 409.975(7), F.S., by repealing requirements relating to the responsibilities of managed care plans to enroll and provide services for Medically Needy recipients under SMMC. This repeal takes effect upon the bill becoming law.

Section 8 provides that, except for sections 4, 6, 7, and 8, which take effect upon the bill becoming law, the bill takes effect July 1, 2014.

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:

Two private sector hospitals that do not currently meet the definition of rural hospital will meet the definition under the SB 2512.[38] This could impact their Medicaid reimbursement under the diagnosis related group (DRG) methodology for inpatient services. If the Agency for Health Care Administration accepts applications by these two hospitals for rural status to take effect July 1, and if the Fiscal Year 2014-2015 DRG methodology uses the same adjustors for rural hospitals that were used in the 2013-2014 methodology, the two hospitals, combined, will experience an estimated increase in revenue of approximately $5.1 million in Fiscal Year 2014-2015.[39]

C. Government Sector Impact:

The proposed Senate General Appropriations Bill, SB 2500, contains an appropriation of $2,727,133 from the General Revenue Fund and $4,016,519 from the Medical Care Trust Fund, to provide funding for the rural status of the two hospitals that may be classified as rural hospitals – under Section 1 of the bill – in the Fiscal Year 2014-2015 Medicaid DRG hospital inpatient reimbursement methodology.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 395.602, 409.911, 409.962, 409.972, 409.974, and 409.975.

[38] Flagler Hospital and Lower Keys Medical Center.
[39] Email from AHCA staff to Senate Appropriations Committee staff, March 22, 2014, on file with staff of the Senate Health and Human Services Appropriations Subcommittee.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.