HOUSE OF REPRESENTATIVES
FINAL BILL ANALYSIS

BILL #: 9A

SPONSOR(S): Hudson

COMPANION BILLS: SB 2508-A

FINAL HOUSE FLOOR ACTION:

81 **Y's** 32 **N's**

GOVERNOR'S ACTION: Approved

SUMMARY ANALYSIS

HB 9A passed the House on June 19, 2015, as SB 2508-A. The bill conforms statutes to the funding decisions related to the Medicaid Program included in the General Appropriations Act (GAA) for Fiscal Year 2015-2016. The bill:

- Amends the definition of "rural hospital" to exclude hospitals meeting the qualifications of a federal "sole community hospital" having up to 340 beds.
- Continues the rural designation of certain critical access hospitals beyond June 30, 2015.
- Authorizes the Agency for Health Care Administration (AHCA) to receive intergovernmental transfers (IGTs) of funds from local governmental entities for the Medicaid program and directs AHCA to seek federal waiver authority to maintain a low-income pool under parameters provided in the GAA for offsetting shortfalls in Medicaid reimbursement or paying for otherwise uncompensated care.
- Clarifies existing law regarding reimbursement provisions, provider notification requirements, and the administrative challenge process for Medicaid inpatient and outpatient hospital rates.
- Provides that quality assessments paid by nursing homes to AHCA are due on the 20th of each month, instead of the 15th of each month as under current law.
- Creates the Graduate Medical Education Startup Bonus Program within the Statewide Medicaid Residency Program (SMRP). In any fiscal year in which funds are appropriated for the startup bonus program, hospitals eligible to participate in the SMRP may apply for up to $100,000 per newly created residency slot that is dedicated to a physician specialty in statewide supply/demand deficit. Such physician specialties and subspecialties are those identified in the GAA.
- Eliminates Intermediate Care Facilities for the Developmentally Disabled from the statutory rate freeze.
- 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.
- Clarifies that Achieved Savings Rebates that are refunded to the state will be placed in General Revenue unallocated, less any applicable federal share to be refunded to the federal government.
- Clarifies the Grants and Donations Trust Fund as the designated state trust fund that managed care plans can contribute to for purposes of supporting Medicaid and indigent care.
- Repeals the statute related to State and local Medicaid partnerships and Low Income Pool.
- Removes reference to supporting the Healthy Start contract with certified public expenditures.
- Clarifies the factors upon which the Agency for Health Care Administration shall reconcile the payments made to Long Term Care Managed Care Plans for changes in Nursing Home rates.
- Provides that AHCA may enter into a contract with any other state or territory for joint fiscal agent operations only if AHCA may terminate contract if not in best interest of state.
- Provides that the model, methodology, and framework for hospital funding programs contained in the document titled "Medicaid Hospital Funding Programs" are incorporated by reference for the purpose of displaying, demonstrating, and explaining the calculations used by the Legislature when making appropriations in the GAA for the 2015-2016 fiscal year for various Medicaid programs.

The bill was approved by the Governor on June 23, 2015, ch. 2015-225, L.O.F., and will become effective on July 1, 2015.

I. SUBSTANTIVE INFORMATION

A. EFFECT OF CHANGES:

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 up to 100 persons per square mile;
- An acute care hospital in a county with a population density up to 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 up to 100 persons per square mile;
- A hospital classified as a sole community hospital under 42 C.F.R. s. 412.92 which has up to 340 licensed beds;
- A hospital with a service area that has a population of up to 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), Florida Statutes. Hospital under this section that have received funding under the Disproportionate Share Financial Assistance Program for Rural Hospitals beginning no later than July 1, 2002, are deemed a rural hospital through June 30, 2015.

The bill amends s. 395.602(2)(e), F.S., to revise the definition of "rural hospital." The bill deletes the provision regarding a hospital that is classified as a sole community hospital under Title 42, s. 412.92, of the Code of Federal Regulations, having up to 340 licensed beds. Additionally, the bill continues the rural hospital designation for those facilities that received funding under the Disproportionate Share Financial Assistance Program for Rural Hospitals beginning no later than July 1, 2002, from June 30, 2015 to June 30, 2021, after the next United States census.

Intergovernmental Transfers (IGTs)

Currently, Medicaid reimbursement payments are made to all institutional providers through a per diem rate, with the exception of Hospital Inpatient reimbursements, which are made through Diagnosis Related Groupings (DRGs). The State's share of the payment for these reimbursements comes from the State's general revenue, public medical assistance, or through intergovernmental transfers (IGTs). Additionally, the current Low Income Pool (LIP) relies upon funds from the State's general revenue and IGTs to fund the state's share of the program.

The bill authorizes AHCA to continue to receive IGTs from local governmental entities for the Medicaid program and directs AHCA to seek federal waiver authority to maintain a low-income pool under parameters provided in the General Appropriations Act for offsetting shortfalls in Medicaid reimbursement or paying for otherwise uncompensated care.

Medicaid Hospital Reimbursement

Prior to July 2013, hospitals were reimbursed for Medicaid eligible hospital inpatient stays and hospital outpatient encounters through a per diem rate. The per diem rates were facility-specific and based upon each hospital's prior year appropriate and adjusted costs as reported to AHCA in an annual cost report. After AHCA set a separate inpatient and outpatient rate for each hospital, the hospitals were notified of their new rates through a letter from AHCA. The rates were subject to challenge through a provision included in the Hospital Inpatient and Hospital Outpatient Reimbursement Plans.

In July 2011, the Legislature amended s. 409.905(5), F.S., relating to hospital inpatient services, to require errors in cost reporting or calculation of rates discovered after September 30 to be reconciled in

a subsequent rate period[1]. Additionally, this change prohibited AHCA from making any adjustment to a hospital's reimbursement rate more than 5 years after a hospital is notified of an audited rate established by the AHCA.

In 2012, the Legislature amended s. 409.905(5), F.S., to change the September 30 date to October 31.[2]

In 2013, the Legislature amended s. 409.905(5) and (6), F.S., to its existing state.[3] Currently, for both hospital inpatient and outpatient services, errors in source data or calculations discovered after October 31 must be reconciled in a subsequent rate period.[4] The AHCA is prohibited from making any adjustment to a hospital's reimbursement more than five years after a hospital is notified of an audited rate established by the agency.

Currently, there are several lawsuits involving AHCA where hospitals are challenging the rate per diems regardless of the amount of time passed since the initial rate setting period. Some of these challenges involve rates initially set as far back as the 1980's and 1990's.[5]

The bill clarifies existing law regarding reimbursement provisions, provider notification requirements, and the administrative challenge process for Medicaid inpatient and outpatient hospital rates. Specifically, the bill requires AHCA to furnish providers with a written notice of the audited hospital cost-based per diem reimbursement rate for inpatient and outpatient rates established by the AHCA. This written notification shall constitute final agency action.

The bill specifies that a substantially affected provider seeking to correct or adjust the calculation of a reimbursement rate, based on a challenge other than a challenge to a methodology used to calculate a reimbursement rate, may request an administrative hearing by filing a petition with the agency within 180 days after receipt of the written notice by the provider. Failure to timely file a complaint petition in is deemed conclusive acceptance of the reimbursement rate.

A challenge to the methodology that is specified in an agency rule or in a reimbursement plan incorporated by reference in such rule and that is used to calculate a reimbursement rate will not result in a correction or an adjustment of a reimbursement rate for a rate period that occurred more than 5 years preceding the date the petition was filed.

The bill specifies that the AHCA may not be compelled by an administrative body or a court to pay compensation to a hospital relating to the establishment of reimbursement rates by the agency or for remedies relating to such rates, unless an appropriation made by law is enacted for the exclusive, specific purpose of paying such additional compensation.

Intermediate Care Facilities for the Developmentally Disabled (ICF/DD)

Currently, Medicaid reimburses ICF/DD providers through a cost-based reimbursement methodology. Cost-based reimbursement is accomplished through establishing a reimbursement rates based upon each individual ICF/DD's historic cost of providing services, which is then indexed using pre-determined health care inflation indices to provide an inflationary increase. The Agency collects the cost data from annual cost reports submitted by the ICF/DD providers to use in calculating and setting cost-based reimbursement rates. Other provider types that are reimbursed using a cost-based methodology include nursing homes, hospital outpatient services, rural health clinics, county health departments, hospices, and federally qualified health centers. Additionally, these provider types may be subject to specified reimbursement ceilings and targets.

[1] Chapter 2011-135, s. 9, L.O.F.
[2] Chapter 2012-33, s. 5, L.O.F.
[3] Chapter 2013-48, s. 3, L.O.F.
[4] Section 409.905(5) and (6), F.S.
[5] Agency for Health Care Administration, *Senate Bill 322 Analysis* (January 28, 2015)

Chapter 2008-143, L.O.F., directed the Agency to establish provider rates for hospitals, nursing homes, community intermediate care facilities for the developmentally disabled and county health departments in a manner that would result in the elimination of automatic cost-based rate increases for a period of two fiscal years, until July 1, 2011. Chapter 2011-61, L.O.F., revised statute to ensure there would be no rate increases above the July 1, 2011 average unit cost level.

The bill amends s. 409.908(23)(c), F.S., to exclude the community intermediate care facilities for the developmentally disabled Medicaid reimbursement rates from being limited to the July 1, 2011 level.

Nursing Home Quality Assessment

Chapter 2009-4, L.O.F, created s. 409.9082, F.S., to provide for a quality assessment on nursing home facility providers and required the assessment to be imposed beginning April 1, 2009. The statute requires the AHCA to calculate the assessment annually on a per-resident-day basis, exclusive of those days funded by the Medicare program. The purpose of the nursing home quality assessment is to assure continued quality of care and the collected assessments are to be used to obtain federal financial participation through the Medicaid program in order to make Medicaid payments for nursing home facility services up to the amount of nursing home facility Medicaid rates as calculated in accordance with the approved state Medicaid plan. The AHCA is required to collect the assessment from the nursing home facility providers by the 15th day of each calendar month.

The bill provides that the quality assessments paid by the nursing homes to AHCA are due on the 20th of each month, instead of the 15th of each month as under current law.

Graduate Medical Education/Statewide Medicaid Residency Program

Currently, hospitals are reimbursed for their Graduate Medical Education (GME) through the Statewide Medicaid Residency Program, as specified in s. 409.909, Florida Statutes. This program authorizes the AHCA to make payments to hospitals for their costs associated with GME and for tertiary health care services provided to Medicaid beneficiaries. Current statute provides an allocation fraction to be used for distributing funds to participating hospitals. 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 bill amends the Statewide Medicaid Residency Program (SMRP) to provide that residency specialties must be reported using the current residency code in the Intern and Resident Information System required by Medicare and annual allocations calculated under the SMRP must be capped at two times the average per-resident allocation amount for all hospitals.

The bill also creates the Graduate Medical Education Startup Bonus Program within the SMRP. In any fiscal year in which funds are appropriated for the startup bonus program, hospitals eligible to participate in the SMRP may apply for up to $100,000 per newly created residency slot that is dedicated to a physician specialty in statewide supply/demand deficit. The physician specialties and subspecialties, including both adult and pediatric, that are in statewide supply/demand deficit are as follows: allergy or immunology; anesthesiology; cardiology; endocrinology; family medicine; general surgery; hematology; oncology; infectious diseases; nephrology; neurology; obstetrics/gynecology; ophthalmology; orthopedic surgery; otolaryngology; psychiatry; pulmonary; radiology; rheumatology; thoracic surgery; and urology.

Disproportionate Share Hospital Program (DSH)

The Medicaid Disproportionate Share Hospital Program funding distributions are provided to hospitals that provide a disproportionate share of the Medicaid or charity care services to uninsured individuals. Each year, the Legislature delineates how the funds will be distributed to each eligible facility.

The bill updates existing law to provide payments for the 2015-2016 fiscal year related to hospitals in the Disproportionate Share Hospital (DSH) Programs and Medicaid DSH distributions for nonstate, government-owned or operated hospitals that were eligible for payment on July 1, 2011.

Achieved Savings Rebate

Chapter 2011-134, L.O.F., created the Statewide Medicaid Managed Care program, thereby establishing the Medicaid program as a statewide, integrated managed care program for all covered services. Medicaid consists of two managed care programs:

- Medicaid Managed Medical Assistance Program (MMA) – primary and acute care; and
- Long-Term Care Managed Care Program (LTC) – residential and home and community based care, lone or paired with primary acute care for comprehensive coverage.

The Achieved Savings Rebate program is specific to the MMA component of managed care and was created to monitor plan expenditures and impose incentives and disincentives to ensure proper use of state funds.

To calculate whether the plans have achieved a savings for the reporting year and whether they may retain them or must pay a rebate to the state, plans must submit to the Agency an annual financial audit. Plans regulated by the Office of Insurance Regulation must also submit an annual statement pursuant to s. 624.424, Florida Statutes. In addition, the Agency must audit the plans' financial information. The Agency must contract with independent certified public accountants to conduct the audits, and plans must pay the costs.

The achieved savings rebate will be calculated by determining pre-tax income as a percentage of revenues and applying the following income sharing ratios:

- 100% of the income up to and including 5% of the revenue will be retained by the plan.
- 50% of the income above 5% and up to 10% of the revenue will be retained by the plan with the other 50% refunded to the state.
- 100% of the income above 10% will be refunded to the state.

If the plan meets or exceeds quality measures defined by the Agency, then the plan may retain an additional 1% of revenue.

Plans that are required to pay a rebate to the state, must refund the money to the state; however, statute does not specify in to which fund it shall be deposited. The bill amends s. 409.967(3)(f)(2) and (3) to specify that the achieved savings rebates will be deposited into the General Revenue Fund, less any applicable federal share to be paid back to the federal government.

Medical Loss Ratio

The SMMC also permitted the Agency to calculate a medical loss ratio for managed care plans. The calculation allows for use of uniform financial data collected from all plans and shall be computed for each plan on a statewide basis. The method of calculating the medical loss ratio is required to meet the following criteria:

- Must be consistent with Title 45 Code of Federal Regulations, part 158;
- Funds provided by the plans to graduate medical education institutions shall be classified as medical expenditures, provided the funding is sufficient to sustain the positions for the number of years necessary to complete the residency requirements and the residency positions funded by the plans are active providers of care to Medicaid and uninsured patients; and

- Prior to final determination of the medical loss ratio for any period, a plan may contribute to a designated state trust fund for the purpose of supporting Medicaid and indigent care and have the contribution counted as a medical expenditure for the period.

Plans that contribute funds for the purpose of supporting Medicaid and indigent care are to deposit funds in a designated state trust fund; however, statute does not specify in to which fund it shall be deposited. The bill amends s. 409.967(4)(c) to specify that the funds be deposited into the Grants and Donations Trust Fund within the Agency.

Low Income Pool

The Low Income Pool (LIP) was originally created as a result of the original 1115 Waiver that established the Managed Medicaid Pilot program. Pursuant to s. 409.91211(1)(b), F.S., the Managed Medicaid Pilot waiver was "contingent upon federal approval to preserve the upper-payment-limit funding mechanism for hospitals, including a guarantee of a reasonable growth factor, a methodology to allow the use of a portion of these funds to serve as a risk pool for demonstration sites, provisions to preserve the state's ability to use intergovernmental transfers, and provisions to protect the disproportionate share program." The LIP was to be used to provide supplemental payments to hospitals that provide services to Medicaid recipients, the uninsured and underinsured individuals. The LIP program also authorized supplemental Medicaid payments to provider access systems, such as federally qualified health centers, county health departments, and hospital primary care programs, to cover the cost of providing services to Medicaid recipients, the uninsured and the underinsured.

Florida law provides that distribution of the Low-Income Pool funds should:

- Assure a broad and fair distribution of available funds based on the access provided by Medicaid participating hospitals, regardless of their ownership status, through their delivery of inpatient or outpatient care for Medicaid beneficiaries and uninsured and underinsured individuals;
- Assure accessible emergency inpatient and outpatient care for Medicaid beneficiaries and uninsured and underinsured individuals;
- Enhance primary, preventive, and other ambulatory care coverages for uninsured individuals;
- Promote teaching and specialty hospital programs;
- Promote the stability and viability of statutorily defined rural hospitals and hospitals that serve as sole community hospitals;
- Recognize the extent of hospital uncompensated care costs;
- Maintain and enhance essential community hospital care;
- Maintain incentives for local governmental entities to contribute to the cost of uncompensated care;
- Promote measures to avoid preventable hospitalizations;
- Account for hospital efficiency; and
- Contribute to a community's overall health system.

On April 11, 2014, the Centers for Medicaid and Medicare Services (CMS) extended the 1115 demonstration waiver, titled Managed Medical Assistance, for three years; however, they extended the LIP for only one year from July 1, 2014 through June 30, 2015. The total computable amount of LIP funding for the 2014-15 fiscal year is approximately $2.16 billion.

On May 21, 2015, the CMS outlined an approach to the LIP that allows for a two-year transition of the LIP by reducing the size of the pool from $2.16 billion in the 2014-15 fiscal year to $1.0 billion in the 2015-16 fiscal year. Additionally, during the 2016-17 fiscal year, the LIP pool will be further reduced to $600,000,000 until June 2017, when Florida's current demonstration period ends.

The bill repeals s.409.97, F.S. that governs the current Low Income Pool program. Additionally, the bill provides that the model, methodology, and framework for hospital funding programs contained in the document titled "Medicaid Hospital Funding Programs," dated June 16, 2015, are incorporated by reference for the purpose of displaying, demonstrating, and explaining the calculations used by the

Legislature when making appropriations in the General Appropriations Act for the 2015-2016 fiscal year for various Medicaid programs.

MomCare Network

Under SMMC, the Agency is directed to contract with an administrative services organization representing all Healthy Start Coalitions in order to continue the MomCare waiver services of care coordination, and other services. All managed care plans must contract with the Healthy Start Coalitions in their regions in order to coordinate services provided to pregnant women and infants. Current statute provides that the Agency will support this contract with certified public expenditures of general revenue appropriated for Health Start services and any earned federal matching funds.

Chapter 2014-51, L.O.F., transferred the funding from the Department of Health to the Agency, thereby, no longer relying on certified public expenditures to support the contracts. The bill amends s. 409.975(4)(a), F.S., to remove reference to certified public expenditures.

Nursing Home Pass-through Reconciliation

Under SMMC, the long-term care managed care plans must offer a network contract to nursing homes, hospices, and aging network providers who previously participated in home and community based waivers. Nursing home and hospice providers must participate in all selected plans that offer them contracts. The plans and the providers are required to negotiate mutually acceptable payment terms and rates. However, both nursing home and hospice providers shall receive a "pass-through" rate set by the Agency. This means that nursing home and hospice providers continue to receive a Medicaid reimbursement rate based upon historical data as provided in each facility's Medicaid cost report.

Current statute provides that the Agency reconcile the long-term care managed care plan rates based on any change in Medicaid reimbursement rate for a nursing home or hospice. However, the statute does not define the parameters upon which the reconciliation shall be based. The bill amends s. 409.983(6), F.S., to clarify that the reconciliation is based on changes in nursing home provider reimbursement rates, and not reconciled based on days.

Fiscal Agent Operations

The Agency is the single State agency responsible for administering the Medicaid program in Florida. As such, the Agency contracts with an entity to operate as the state's fiscal agent. Fiscal agent operations consist of distributing Medicaid publications and forms, providing enrollment broker services to Medicaid recipients, enrolling Medicaid providers, maintaining the recipient eligibility system, and processing and paying all Medicaid claims.

Recent Medicaid program changes, including the transition to Statewide Medicaid Managed Care, conversion to Diagnosis Related Groupings for inpatient reimbursements, and other federally mandated requirements, have required expanded operations and required revisions to the Florida Medicaid Management Information System and Decision Support System. Due to these continuing revisions, the bill provides that AHCA may partner with a state or territory for the purpose of providing Medicaid fiscal agent operations only if Florida may terminate such a partnership if the state decides it is not in the best interest of the state.

Medicaid Hospital Funding Programs

In crafting the General Appropriation Act, the Legislature has historically incorporated by reference the document entitled "Medicaid Hospital Funding Programs" for the purpose of displaying the calculations used by the legislature in making appropriations for the Low-Income Pool, Disproportionate Share Hospital, and Hospital Exemptions Programs. The incorporation by reference has been achieved through language included in the implementing bill which provided the statutory authority necessary to implement and execute the General Appropriations Act (GAA). The statutory changes and

incorporation were effective for only one year and either expired on July 1 or revert to the language as it existed before the changes made by the implementing bill.

The bill provides that the model, methodology, and framework for hospital funding programs contained in the document titled "Medicaid Hospital Funding Programs," dated June 16, 2015, are incorporated by reference for the purpose of displaying, demonstrating, and explaining the calculations used by the Legislature when making appropriations in the General Appropriations Act for the 2015-2016 fiscal year for various Medicaid programs including Rural Hospital Financial Assistance, Hospital Inpatient Services, Hospital Outpatient Services, Low Income Pool, the Disproportionate Share Hospital Program, Graduate Medical Education and Prepaid Health Plans. The bill also provides Legislative intent regarding the appropriations for the various Medicaid programs and provides for the bill to be deemed invalid, non-severable, and to have never become law under specified conditions.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   The State will earn $213,466,404 in federal Medicaid funds that will be generated through the implementation of the DSH programs; $604,300,000 in federal Medicaid funds under the Low Income Pool program; $108,774,000 under the Statewide Medicaid Residency Program and the newly created Graduate Medical Education Startup Bonus Program; and $149,476,494 through the Intermediate Care Facilities for the Developmentally Disabled.

2. Expenditures:

   The Conference Report on Senate Bill 2508-A General Appropriations Act contains the following appropriation:

(continued on next page)

	FY 2015-16
GRADUATE MEDICAL EDUCATION	
General Revenue	$ 31,584,356
Grants and Donations Trust Fund	$ 39,641,644
Medical Care Trust Fund	$ 108,774,000
Total	**$ 180,000,000**
LOW INCOME POOL	
General Revenue	$ 450,000
Grants and Donations Trust Fund	$ 395,250,000
Medical Care Trust Fund	$ 604,300,000
Total	**$ 1,000,000,000**
Hospital Inpatient Services	
General Revenue	$ 187,959,736
Health Care Trust Fund	$ 42,300,000
Grants and Donations Trust Fund	$ 16,630,452
Medical Care Trust Fund	$ 543,248,124
Public Medical Assistance Trust Fund	$ 47,450,732
Refugee Assistance Trust Fund	$ 2,976,973
Total	**$ 840,566,017**
Other Provider Access Grants	
General Revenue	**$ 28,550,939**
REGULAR DISPROPORTIONATE SHARE (DSH)	
General Revenue	$ 750,000
Grants and Donations Trust Fund	$ 89,205,900
Medical Care Trust Fund	$ 138,764,925
Total	**$ 228,720,825**
MENTAL HEALTH HOSPITAL DSH	
Medical Care Trust Fund	$ 72,256,892
Total	**$ 72,256,892**
TUBERCULOSIS DSH	
Medical Care Trust Fund	$ 2,444,587
Total	**$ 2,444,587**
DISPRPORTIONATE SHARE HOSPITAL (DSH) SUBTOTAL	
General Revenue	*$ 750,000*
Grants and Donations Trust Fund	*$ 89,205,900*
Medical Care Trust Fund	*$ 213,466,404*
SUBTOTAL	***$ 303,422,304***
INTERMEDIATE CARE FACILITIES / DEVELOPMENTALLY DISABLED	
General Revenue	$ 82,403,570
Grants and Donations Trust Fund	$ 15,147,690
Medical Care Trust Fund	$ 149,476,494
Total	**$ 247,027,754**
TOTAL BUDGETARY IMPACT	
General Revenue	$ 331,698,601
Health Care Trust Fund	$ 42,300,000
Grants and Donations Trust Fund	$ 555,875,686
Medical Care Trust Fund	$ 1,619,265,022
Public Medical Assistance Trust Fund	$ 47,450,732
Refugee Assistance Trust Fund	$ 2,976,973
Total	**$ 2,599,567,014**

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

In order to earn matching federal dollars, local governments and other local political subdivisions would be required to contribute Intergovernmental Transfers (IGTs) of $89,205,900 for the DSH program; $395,250,000 for the Low Income Pool program; and $39,641,644 for the Statewide Medicaid Residency Program and the Graduate Medical Education Startup Bonus Program.

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 and underinsured individuals.

Hospitals provisionally designated as "sole community" and funded with nonrecurring funds during Fiscal Year 2014-15 will not receive $7,542,036 in state and federal funds.

Rural hospitals that received funding under the Disproportionate Share Financial Assistance Program for Rural Hospitals beginning no later than July 1, 2002, will continue to receive funds of $1,896,907 (state and federal) through June 30, 2021.

Intermediate Care Facilities for the Developmentally Disabled will receive increased Medicaid reimbursements of approximately $3,925,940 due to the elimination of the statutory rate freeze.

Hospitals eligible to participate in the Statewide Medicaid Residency Program and the newly created Graduate Medical Education Startup Bonus Program will receive Medicaid reimbursements of $180,000,000 during Fiscal Year 2015-2016.

D. FISCAL COMMENTS:

The AHCA will distribute a total of $303,422,304 through federal Disproportionate Share Hospital (DSH) Program to hospitals providing a disproportionate share of Medicaid or charity services. Hospitals that participate in the Low Income Pool will continue to receive funding for Fiscal Year 2015-16, utilizing the full $1.0 billion LIP pool as authorized by CMS. Additionally, hospitals will receive increased Medicaid reimbursements of approximately $1,036 million due to an increase in base DRG rates, continued DRG Exemptions and Buybacks, and the Liver Transplant Global Fee.