

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 5201 PCB HCA 17-01 Medicaid Services
SPONSOR(S): Health Care Appropriations Subcommittee, Brodeur
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Health Care Appropriations Subcommittee	13 Y, 0 N	Clark	Pridgeon
1) Appropriations Committee	25 Y, 0 N	Clark	Leznoff

SUMMARY ANALYSIS

The bill conforms statutes to the funding decisions related to the Medicaid Program included in the House proposed General Appropriations Act (GAA) for Fiscal Year 2017-2018. The bill:

- Amends the definition of a "rural hospital" to eliminate sole community hospitals with up to 175 beds;
- Consolidates the Project AIDS Care waiver, Adult Cystic Fibrosis waiver, and Traumatic Brain Injury and Spinal Cord Injury waiver within the Medicaid Long Term Care waiver, effective January 1, 2018;
- Removes obsolete language related to ambulatory surgical center reimbursements due to the implementation of a prospective payment system;
- Removes Hospital Outpatient services reimbursements from the statutory rate freeze due to the implementation of a prospective payment system;
- Requires local governments that submit Intergovernmental Transfers to AHCA to submit the total amount of the funds as agreed upon in the executed letter of agreement, no later than October 31 of the year the funds are pledged unless an alternative plan is specifically approved by AHCA;
- Revises "Medicaid Payments" within the Statewide Medicaid Residency Program to include Hospital Outpatient Medicaid rates due to the implementation of a prospective payment system;
- Revises the years of audited data used in determining Disproportionate Share Hospital payments;
- Provides conforming cross-references.

The bill provides for an effective date of July 1, 2017.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Medicaid

Medicaid is the health care safety net for low-income Floridians. Medicaid is a federal and state partnership established to provide coverage for health services for eligible persons. The program is administered by the Agency for Health Care Administration (AHCA) and financed by federal and state funds. AHCA delegates certain functions to other state agencies, including the Department of Children and Families, the Department of Health (DOH), the Agency for Persons with Disabilities, and the Department of Elderly Affairs (DOEA).

The Florida Medicaid program covers approximately 4 million low-income individuals, including approximately 2.3 million, or 58.7%, of the children in Florida.¹ Medicaid is the second largest single program in the state, behind public education, representing 31 percent of the total FY 2016-2017 budget. Medicaid expenditures represent over 19 percent of the total state funds appropriated in FY 2016-2017.

Medicaid Waivers

States have some flexibility in the provision of Medicaid services. Section 1915(b) of the Social Security Act provides authority for the Secretary of the U.S. Department of Health and Human Services to waive requirements to the extent that he or she “finds it to be cost-effective and efficient and not inconsistent with the purposes of this title.” Also, Section 1115 of the Social Security Act allows states to use innovative service delivery systems that improve care, increase efficiency, and reduce costs.

States may also ask the federal government to waive federal requirements to expand populations or services, or to try new ways of service delivery. For example, Florida has a Section 1115 waiver to use a comprehensive managed care delivery model for primary and acute care services, the Statewide Medicaid Managed Care (SMMC) Managed Medical Assistance (MMA) program.² In addition to the Section 1115 waiver for the MMA program, Florida also has a waiver under Sections 1915(b) and (c) of the Social Security Act to operate the SMMC Long-term Care (LTC) program.³

Approximately 82% of the Medicaid population in Florida is enrolled in the MMA and LTC programs.⁴

Florida’s Medicaid Managed Care Long-term Care Program

The LTC program provides long-term care services to eligible Medicaid beneficiaries. Individuals must enroll in the LTC program if they are age 65 or older and eligible for Medicaid, age 18 or older and eligible for Medicaid by reason of a disability, or determined by the Comprehensive Assessment and Review of Long-term Care Services (CARES) unit⁵ at DOEA to need nursing facility level of care and also meets one or more established criteria, such as receiving TANF or enrolled in hospice care.⁶

¹ Agency for Health Care Administration, *Florida Statewide Medicaid Monthly Enrollment Report*, February 2017, available at http://www.fdhc.state.fl.us/medicaid/Finance/data_analytics/enrollment_report/index.shtml (last accessed March 17, 2017).

² S. 409.964, F.S.

³ Id.

⁴ Supra, FN 1.

⁵ CARES is a federally mandated pre-admission screening program to assess each individual who requests Medicaid reimbursement for nursing facility placement, or who seeks to receive home and community-based services through other Medicaid waivers.

⁶ Agency for Health Care Administration, *Statewide Medicaid Managed Care, Long-term Care Program Snapshot*, December 6, 2016, available at https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC/SMMC_LTC_Snapshot.pdf (last accessed February 27, 2017).

The LTC program also allows individuals who are eligible for various other Home and Community-based Services (HCBS) waivers⁷ to enroll. Such waivers include:

- Developmental Disabilities Waiver (iBudget);
- Traumatic Brain and Spinal Cord Injury Waiver;
- Project AIDS Care Waiver; and
- Adult Cystic Fibrosis Waiver.⁸

LTC plan providers also cover some expanded benefits, such as dental, emergency financial assistance, non-medical transportation, over-the-counter medications/supplies, and vision services.⁹

Traumatic Brain and Spinal Cord Injury Waiver

The Traumatic Brain and Spinal Cord Injury (TB/SCI) waiver is an HCBS waiver operated by DOH that provides services for individuals with traumatic brain injuries and spinal cord injuries.¹⁰ For purposes of the waiver, “traumatic brain injury” is an injury that produces an altered state of consciousness or anatomic, motor, sensory, or cognitive/behavioral deficits and “spinal cord injury” is an injury that has significant involvement of two of the following: motor deficit, sensory deficit, or bowel and bladder dysfunction.¹¹ To be eligible, individuals must be 18 years of age or older, be Medicaid eligible, have one of the conditions previously described, and meet nursing home level of care as determined by CARES.¹²

The TB/SCI waiver includes services such as assistive technologies, attendant care, adult companion, counseling, personal care, and support coordination. Currently, the TB/SCI waiver has approximately 350 individuals enrolled with 350 on the waitlist.¹³

Adult Cystic Fibrosis Waiver

The Adult Cystic Fibrosis (ACF) waiver is an HCBS waiver operated by DOH that provides services for individuals with a diagnosis of cystic fibrosis; a chronic, progressive, and terminal genetic disorder that affects a person’s lungs and digestive system.¹⁴ To be eligible, individuals must be 18 years of age or older, be Medicaid eligible, have a diagnosis of cystic fibrosis, and meet nursing home level of care as determined by CARES.¹⁵

The ACF waiver includes services such as case management, counseling, personal care, prescription drugs, respite care, and respiratory therapy. Currently, the ACF waiver has approximately 140 individuals enrolled with none on the waitlist.¹⁶

⁷ *Infra*, FN 10; Medicaid HCBS waivers are authorized by Section 2176 of the Omnibus Budget Reconciliation Act of 1981 and incorporated into Title XIX of the Social Security Act as Section 1915(c). States can use this authority to offer a broad array of services not otherwise available through Medicaid that are intended to prevent or delay institutional placement. Florida’s HCBS waivers vary on a number of dimensions. Some waivers are limited to persons with specific diseases or physical conditions (such as cystic fibrosis); others serve broader groups (such as persons who are elderly and/or have disabilities). Waivers also differ with respect to the number and types of services provided, payment method, and whether waiver services are available statewide or limited to a few counties.

⁸ *Supra*, FN 6.

⁹ *Id.*

¹⁰ Office of Program Policy Analysis and Government Accountability, *Profile of Florida’s Medicaid Home and Community-Based Services Waivers*, Report No. 13-07, March 2013, available at <http://www.opaga.state.fl.us/MonitorDocs/Reports/pdf/1307rpt.pdf> (last accessed February 27, 2017).

¹¹ *Id.*

¹² *Id.*

¹³ Agency for Health Care Administration, Agency Analysis of 2017 House Bill 619, p. 3 (Feb. 6, 2017).

¹⁴ *Supra*, FN 10.

¹⁵ *Id.*

¹⁶ *Supra*, FN 13

Project AIDS Care Waiver

The Project AIDS Care (PAC) waiver is an HCBS waiver operated by AHCA that provides services for individuals with a diagnosis of acquired immune deficiency syndrome (AIDS). To be eligible, individuals must be Medicaid eligible, have a diagnosis of AIDS, have an AIDS-related opportunistic infection, be at risk for hospitalization, meet income eligibility requirements of the Social Security Administration for SSI,¹⁷ and not be enrolled in the MMA or LTC programs.¹⁸ To meet SSI income requirements, an individual must not earn more than \$2,205 per month, or 300% of the Federal Benefits Rate (FBR).¹⁹

The PAC waiver includes services such as case management, home-delivered meals, personal care, restorative massage, specialized medical equipment, and skilled nursing. Currently, the PAC waiver has approximately 7,800 individuals enrolled with none on the waitlist.

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.

In 2016, the Legislature amended the definition of a rural hospital to include hospitals classified as sole community hospitals having up to 175 licensed beds, beginning in the 2016-2017 fiscal year.²⁰ Chapter 2016-66, Laws of Florida provided non-recurring funding for the increased cost associated with amending the definition to include hospitals classified as sole community hospitals.

Outpatient Reimbursement

Florida Medicaid currently reimburses hospital outpatient services using hospital specific cost-based rates which pay a flat rate referred to as a “per diem” to each payable revenue code submitted on an outpatient claim. The hospital outpatient rates are based on unaudited, historical cost reports submitted prior to services being rendered. The reimbursement rates are adjusted post-payment for some facilities each year based on audited cost reports. The cost report audit and rate adjustment processes can take several years for full reconciliation and finalization of payment.

During the 2015 Legislative Session, the Legislature authorized the study and design of an Outpatient Prospective Payment System (OPPS) for Florida Medicaid²¹. The Legislature required that the Agency for Health Care Administration develop a plan to convert Medicaid payments for outpatient services, including hospital outpatient services and ambulatory surgery centers, to a prospective payment system and identify steps necessary for the transition to be completed in a budget neutral manner.

During the 2016 Legislative Session, the Legislature amended s. 409.905, F.S., replacing AHCA’s existing per diem and retroactive adjustment fee methodology for Medicaid outpatient care, with a prospective payment system. Under the new system, AHCA will calculate reimbursement rates annually for Hospital Outpatient Services. Additionally, s. 409.908(5), F.S., was amended to reflect the

¹⁷ SSI is the Supplemental Security Income program, a federal income supplement program designed to help aged, blind, and disabled people with little to no income by providing cash to meet basic needs such as food, clothing and shelter; See Social Security Administration, Supplemental Security Income Home Page – 2016 Edition, *What is Supplemental Security Income?*, available at <https://www.ssa.gov/ssi/> (last accessed February 27, 2017).

¹⁸ Supra, FN 10.

¹⁹ Current FBR is \$735 per month; Department of Children and Families, *SSI-Related Programs – Financial Eligibility Standards*, available at http://www.dcf.state.fl.us/programs/access/docs/esspolicymanual/a_09.pdf (last accessed February 26, 2017).

²⁰ Chapter 2016-65, Laws of Florida

²¹ Chapter 2015-232, Laws of Florida

transition to prospective payment system for ambulatory surgical centers. The new rates are required to go into effect on July 1, 2017, and on July 1 every year thereafter. The new methodology must function like an outpatient prospective payment system by categorizing the amount and type of services used in outpatient visits, and group together procedures that share similar characteristics and costs.

Intergovernmental Transfers

Certain programs, including but not limited to the Statewide Medicaid Residency Program, the Graduate Medical Education Startup Bonus Program, the Disproportionate Share Hospital (DSH), and certain hospital reimbursement exemptions are funded through county and other local tax dollars that are transferred to the state and used to draw federal match. Local dollars transferred to the state and used in this way are known as “intergovernmental transfers” or IGTs. IGTs may be used to augment hospital payments in other ways, specifically through direct payment programs authorized by the federal Centers for Medicare and Medicaid Services (CMS) through waivers or state plan amendments. Examples include the Upper Payment Limit (UPL) and Low Income Pool (LIP) programs. All IGTs are contingent upon the willingness of counties and other local taxing authorities to transfer funds to the state in order to draw down federal match. The local taxing authorities commit to sending these funds to the state in the form of an executed Letter of Agreement with the AHCA. In order for AHCA to make timely payments to hospitals, AHCA must know which local governments will be submitting IGTs and the amount of the funds prior to using the funds to draw the federal match. Current law requires local governments who will be submitting IGTs to submit to AHCA the final executed letter of agreement containing the total amount of the IGTs authorized by the entity, no later than October 1 of each year. Currently, there is no date requirement for the local governments to transfer the actual IGTs to AHCA.

Statewide Medicaid Residency Program

In 2013, the Legislature created the Statewide Medicaid Residency Program (SMRP) to fund graduate medical education (GME).²² 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. These residency programs vary in length from three to seven years. Previously, graduate medical education was reimbursed through hospital inpatient and outpatient reimbursements.

The SMRP defines “Medicaid payment” as payments made to reimburse a hospital for direct inpatient services, as determined by AHCA. Consequently, AHCA must calculate an allocation fraction in accordance with statutory formula on or before September 15 of each year. A hospital’s annual allocation equals the funds appropriated for the SMRP in the GAA multiplied by its allocation fraction. Regardless of the formula, a hospital’s annual allocation may not exceed two-times the average per resident amount for all hospitals. Any funds beyond this amount must be redistributed to participating hospitals whose annual allocation does not exceed this limit. AHCA must distribute each participating hospital’s annual allocation in four installments on the final business day of each quarter of the state fiscal year.²³

Disproportionate Share Hospital Program

The Medicaid Disproportionate Share Hospital (DSH) 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 either through statutory formulas or other direction in the implementing bill or proviso.

²² Chapter 2013-48, Laws of Florida

²³ S. 409.909, F.S.

Effect of Proposed Bill

Medicaid Waivers

The bill requires PAC, ACF, and TB/SCI waiver beneficiaries to transition to the LTC program by January 1, 2018. Once all eligible Medicaid beneficiaries have transitioned, AHCA must seek federal approval to terminate the waivers. Waiver consolidation removes administrative burdens on AHCA and DOH by transferring Medicaid beneficiaries from these HCBS waivers into the LTC program. Similar services, and in some cases expanded services, are available to the waiver beneficiaries in the LTC program as are currently available through the waivers.

Project AIDS Care Waiver Consolidation

The bill would transfer approximately 7,800 individuals from the PAC waiver to the LTC program.

The bill amends eligibility requirements, subject to federal approval, for individuals who would otherwise be eligible for the PAC waiver but do not meet the eligibility requirements for the LTC program. The bill makes those individuals with a diagnosis of AIDS, an AIDS-related opportunistic infection, at risk of hospitalization as determined by AHCA, and income at or below 300% of the FBR eligible for Medicaid. This change in the eligibility requirement would allow an individual otherwise eligible for the PAC waiver, who does not meet the nursing home level of care requirement for the LTC program, to be eligible for the MMA program.

The LTC program offers similar services to those offered under the PAC waiver. Some services will not be available, such as massage therapy, but other services available under the LTC program will replace those services.²⁴

Adult Cystic Fibrosis Waiver Consolidation

The bill would transfer approximately 140 individuals from the ACF waiver to the LTC program.

The bill amends CARES screening requirements to include “hospital level of care” for individuals diagnosed with cystic fibrosis. Currently, to meet LTC eligibility requirements, CARES must determine an individual requires “nursing facility care.” This change will allow those individuals diagnosed with cystic fibrosis who do not meet the nursing facility level of care requirement to be eligible for the LTC program.

The LTC program offers similar services to those offered under the ACF waiver, but certain services are not available, such as nutritional supplements and the amount of sterile saline needed by individuals with ACF. AHCA will require LTC program plans to cover over-the-counter benefits to fill the gap in available services.²⁵

Traumatic Brain Injury and Spinal Cord Injury Waiver

The bill transfers approximately 350 individuals from the TB/SCI waiver to the LTC program, and 350 individuals from the TB/SCI waiver waitlist to the LTC program waitlist. It is likely those individuals transferred onto the LTC waitlist will transition into the LTC program faster than they would have moved into the TB/SCI waiver due to their high level of acuity and the large number of people enrolled per year from the waitlist into the LTC program.

²⁴ Supra, FN 13 at pg. 4.

²⁵ Supra, FN 13 at pg. 5.

The LTC program offers services similar to those available through the TB/SCI waiver and expanded benefits will be available to individuals who transfer.

The bill also deletes s. 409.906(13)(b), F.S., a section of law that allows AHCA to consolidate certain waiver programs that will become obsolete upon passage of the bill.

Sole Community Hospitals

The bill amends s. 395.602, F.S., to revise the definition of “rural hospital” by deleting the provision allowing a hospital to qualify as a rural hospital by being classified as a sole community hospital having up to 175 licensed beds since the increased costs associated with this change was funding with non-recurring appropriations.

Outpatient Reimbursement

During the 2016 Legislative Session, the Legislature required that the Agency for Health Care Administration implement prospective payments for outpatient services, including hospital outpatient services and ambulatory surgery centers.²⁶ The bill deletes obsolete language in s. 409.908(5), F.S., due to the statutorily required implementation of a prospective payment system effective July 1, 2017. The new rates go into effect on July 1, 2017, and on July 1 every year thereafter. Additionally, the bill eliminates hospital outpatient services from the statutory rate freeze that ensures no increase in statewide expenditures resulting from a change in unit costs effective July 1, 2011.

Intergovernmental Transfers

The bill amends s. 409.908, F.S., to require the local governments to submit to AHCA the total amount of the IGTs as agreed upon in the executed letter of agreement, no later than October 31 of the year the IGTs are pledged unless an alternative plan is specifically approved by AHCA.

Statewide Medicaid Residency Program

This legislation amends s. 409.909, F.S., to modify the definition of “Medicaid payments” under the SMRP to include outpatient services. This change is necessitated by the statutory transition to a prospective outpatient payment system. This is similar to the transition that occurred when Florida moved to inpatient Diagnosis Related Groups.

Disproportionate Share Hospital Program

The bill amends s. 409.911, F.S., to update existing law to provide payments for the 2017-2018 fiscal year related to hospitals in the Disproportionate Share Hospital (DSH) Programs and Medicaid DSH based upon the average of the 2009, 2010, and 2011 audited disproportionate share data to determine each hospital’s Medicaid days and charity care.

The bill provides for an effective date of July 1, 2017.

B. SECTION DIRECTORY:

- Section 1:** Amends s. 395.602, F.S., relating to rural hospitals.
- Section 2:** Amends s. 409.904, F.S., relating to optional payments to eligible persons.
- Section 3:** Amends s. 409.906, F.S., relating to optional Medicaid services.
- Section 4:** Amends s. 409.908, F.S., relating to reimbursement of Medicaid providers.
- Section 5:** Amends s. 409.909, F.S., relating to Statewide Medicaid Residency Program.

²⁶ Chapter 2016-65, Laws of Florida

- Section 6:** Amends s. 409.911, F.S., relating to Disproportionate Share Program
Section 7: Amends s. 409.979, F.S., relating to eligibility.
Section 8: Amends s. 391.055, F.S., conforming cross-references.
Section 9: Amends s. 393.0661, F.S., conforming cross-references.
Section 10: Amends s. 409.968, F.S., conforming cross-references.
Section 11: Amends s. 427.0135, F.S., conforming cross-references.
Section 12: Amends s. 1011.70, F.S., conforming cross-references.
Section 13: Provides an effective date of July 1, 2017.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

\$476,864,450 in federal Medicaid funds will be generated through the implementation of the Hospital Outpatient Prospective Payment System, the GME program, and the DSH programs:

- Hospital Outpatient Services = \$146,635,622
- Graduate Medical Education = \$110,916,000
- Disproportionate Share Hospital Program = \$219,313,128

2. Expenditures:

The bill will require a transfer of General Revenue funds from DOH to AHCA relating to the TB/SCI waiver in the amount of \$1,976,544. The bill will require a transfer of General Revenue funds from DOH to AHCA related to the ACF waiver in the amount of \$474,206.

The bill will require AHCA to internally transfer General Revenue of \$1,668,324 between budget categories to transfer the PAC waiver to the LTC program.

The bill does not increase the Medicaid outpatient reimbursements as the transition from a cost-based reimbursement system to a prospective payment system is required to be budget neutral.

The bill will require AHCA to make payments to eligible DSH providers, based on the statutory formulas, a total amount of \$309,917,284 (\$6.5 million General Revenue).

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

In order to earn matching federal dollars for IGT funded programs, local governments and other local political subdivisions would be required to provide \$249,828,895 in contributions, no later than October 31, 2017.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

D. FISCAL COMMENTS:

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

2. Other:

B. RULE-MAKING AUTHORITY:

C. DRAFTING ISSUES OR OTHER COMMENTS:

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES