SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

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

BILL: CS/CS/SB 2092

SPONSOR: Appropriations Subcommittee on Health and Human Services, Health, Aging and Long-Term Care Committee and Senator Sanderson

SUBJECT: Hospitals and Community Hospital Education

DATE: April 18, 2001 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Munroe	Wilson	HC	Favorable/CS
2.	White	O'Farrell	ED	Fav/1 amendment
3.	Peters	Belcher	AHS	Favorable/CS
4.			AP	
5.				
6.				

I. Summary:

The CS/CS/SB 2092 specifies procedures for computing the maximum amount that specified counties must pay for the treatment of indigent residents of the county at a hospital located outside the county. It provides for the exclusion of active-duty military personnel and certain institutionalized county residents from the state population estimates when calculating a county's financial responsibility for the hospital care. The bill requires the county of residence to accept the hospital's documentation of financial eligibility and county residence and requires that the documentation meet specified criteria.

The bill transfers by a type two transfer, defined in s. 20.06, F.S., the Community Hospital Education Program (CHEP) from the Board of Regents to the Department of Health. The bill provides that the Department of Health may spend up to $75,000 of the state appropriations allocated to the CHEP for administrative costs. The bill implements the recommendation of the Graduate Medical Education Committee to allow Florida medical schools to apply for Graduate Medical Education Innovations Program funding for the direct costs of providing graduate medical education in community-based clinical settings on a competitive grant or formula basis with specified exceptions. The bill modifies the membership of the Graduate Medical Education Committee.

The bill revises the definition of "charity care" or "uncompensated charity care" for purposes of the Medicaid disproportionate share program to mean that portion of hospital charges reported to the Agency for Health Care Administration for which there is no compensation *other than restricted or unrestricted revenues provided to a hospital by local governments or tax districts regardless of the method of payment* for care provided to a patient whose family income for the 12 months preceding the determination is less than or equal to *200 percent* rather than 150

percent of the federal poverty level, unless the amount of hospital charges due from the patient exceeds 25 percent of the annual family income.

The bill revises the eligibility criteria for the Primary Care Disproportionate Share Program to allow payment to hospitals when they agree to coordinate and provide primary care services free of charge, except for copayments, to all persons with incomes up to 100 percent of the federal poverty level and to persons on a sliding fee scale with incomes up to 200 percent of the federal poverty level, to specify that such persons must not otherwise be covered by Medicaid or another program administered by a governmental entity.

This bill amends sections 154.306, 381.0403, 409.908, 409.911, and 409.9117, Florida Statutes, and creates one undesignated section of law.

II. Present Situation:

Health Care Responsibility Act

The Florida Health Care Responsibility Act (HCRA) (ss. 154.301-154.316, F.S.), was first enacted in 1977 (ch. 77-455, L.O.F.). It was later revised by the 1988 Legislature to place the financial obligation for reimbursing hospitals for emergency inpatient and outpatient services, provided to out-of-county indigent patients, on the counties in which the patient resides (ch. 88-294, L.O.F.). The 1991 Legislature amended the act to increase the number of eligible applicants through the creation of a spend-down program and to increase hospital reimbursement rates. Both of these measures pertained only to counties that were not at their 10-mill cap on ad valorem taxes as of October 1, 1991. Such counties are referred to as spend-down provision eligible counties. (ch. 91-173, L.O.F.). The 1998 the Legislature further amended the act to allow counties the option of using up to one-half of the designated HCRA funds to reimburse participating hospitals, within the county, for emergency inpatient and outpatient services provided to in-county indigent patients (ch. 98-191, L.O.F.).

Under s. 154.306, F.S., a county=s financial obligation for qualified applicants does not exceed 45 days per county fiscal year. The rate of payment set by this act is 100 percent of the per diem reimbursement rate currently in effect for the out-of-county hospital under Medicaid, except that those counties that were at their 10-mil cap on October 1, 1991, reimburse hospitals for such services at not less than 80 percent of the hospital Medicaid per diem. If a county has negotiated a formal agreement with a hospital, the payment rate set by the agreement is substituted for the payment rate set by the statute. The maximum a county is required to pay is equivalent to $4 multiplied by the most recent official state population estimate for the county. *Currently, all active duty military personnel and institutionalized persons are included in the counties= population estimates.*

The Agency for Health Care Administration reports that the reimbursement cap was reached by four counties (Gilchrist, Hardee, Levy and Nassau) in FY 98/99, and four counties (Bradford, Hardee, Levy, and Suwannee) in FY 99/00.

Numbers of Active Duty Military and Institutionalized People in Florida

According to the Bureau of Economic and Business Research at the University of Florida, the number of prisoners and other institutionalize persons in counties with a population of less than 100,000, as of April 1, 2000, was 49,302. These same counties had a military popula tion of 808

Committee on Graduate Medical Education

Proviso language accompanying Specific Appropriation #191 of the FY 1999-2000 General Appropriations Act established a committee to study graduate medical education in Florida. Section 27 of chapter 2000-163, Laws of Florida, codified the provisions relating to graduate medical education in s. 381.0403(9), F.S. The committee membership included the four medical school deans, hospital administrators, and the president of the Florida Medical Association. Committee members serve without compensation and must produce an annual report on graduate medical education. The annual report must be provided to the Governor, the President of the Senate, and Speaker of the House of Representatives by January 15th annually. At the committee's January, 2001, meeting the committee members recommended that medical schools be eligible to compete for any competitive grant funding made available through the Program for Graduate Medical Education Innovations only if such funds are used to support costs incurred by medical schools as a direct result of the provision of graduate medical education in hospital and community-based clinical settings.

Community Hospital Education Program

The 1971 Legislature created s. 381.0403, F.S., the Community Hospital Education Program (CHEP). This program is the only source of direct state funding for primary care graduate medical education[1] in Florida. The objective of the CHEP is to increase the number of primary care physicians practicing in Florida by assisting Florida hospitals defray the high costs of these programs. Annual appropriations are distributed to Florida internship and residency programs based on policies enacted by an 11 member Community Hospital Education Council (CHEC), appointed by the Governor. The statute requires highest priority for family practice residencies. The CHEC has historically limited eligibility for funding to Aprimary care@ specialties, defined as general internal medicine, general pediatrics, obstetrics/gynecology, emergency medicine, psychiatry and combined internal medicine/pediatrics, as well as family practice.

The FY 1999-2000 CHEP appropriation of $8.5 million is being used to support approximately 1,543 interns and residents in 58 programs sponsored by 28 teaching hospitals. Family practice residents are being supported at $11,500 per capita, while all other CHEP-supported specialties are receiving $2,650 per capita. CHEP annual appropriations have traditionally been made in the Board of Regents General Office Budget, because the board has statutory responsibility to provide administrative support to the Community Hospital Education Council.

Section 381.0403(3)(a), F.S., provides that, when feasible and to the extent allowed through the General Appropriations Act, state funds shall be used to generate federal matching funds under

[1]The terms Agraduate medical education@ and Ainternships and residencies@ are interchangeable.

Medicaid, or other federal programs, and the resulting combined state and federal funds shall be allocated to participating hospitals for the support of graduate medical education, for administrative costs associated with the production of the annual report on graduate medical education and for administration of CHEC. In years that funds are transferred to the Agency for Health Care Administration from the Board of Regents, the Board of Regents must certify specified information to the agency.

Program for Graduate Medical Education Innovations

The Program for Graduate Medical Education Innovations was created under the Board of Regents to foster graduate medical education innovations. Funds appropriated annually by the Legislature shall be distributed to participating hospitals or consortia of participating hospitals and Florida medical schools on a competitive grant or formula basis to achieve workforce policy objectives such as increasing the number of residents in primary care and other high demand specialties and fellowships; promoting more physicians to practice in medically under-served areas; encouraging the use of more geriatricians; and encouraging more ethnic and racial diversity within the state's physician workforce. Participating hospitals or consortia of participating hospitals and Florida medical schools may apply to CHEC for funding under the program.

Type-two Transfers

Section 20.06, F.S., provides methods of reorganizing the executive branch of government. A type two transfer under s. 20.06, F.S., is defined to mean the transfer of a program, activity, or function and all its statutory powers, duties, and functions, and its records, personnel, property, and unexpended balances of appropriations, allocations, or other funds from one agency to another.

Medicaid

Medicaid is a medical assistance program that pays for health care for the poor and disabled. The program is jointly funded by the federal government, the state, and the counties. The federal government, through law and regulations, has established extensive requirements for the Medicaid program. The Agency for Health Care Administration is the single state agency responsible for the Florida Medicaid Program. The statutory provisions for the Medicaid program appear in ss. 409.901 through 409.9205, F.S.

The Medicaid Disproportionate Share Hospital Program

Federal law requires state Medicaid programs to "take into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs" when determining payment rates for inpatient hospital care. This requirement is referred to as the Medicaid disproportionate share hospital payment adjustment. Currently, under the Florida Medicaid program, there are seven separate programs specifically designed to provide enhanced Medicaid reimbursement for certain classes of hospitals rendering disproportionate levels of services to Medicaid recipients and indigent clients. While the federal government, via the Balanced Budget Act of 1997, has imposed limits on the total amount of each state=s Medicaid

budget that can flow through the disproportionate share program and specific limits on mental health disproportionate share, each state has the flexibility to array these expenditures as the state sees fit. One of the Governor=s budget recommendations for fiscal year 2000-2001 is the creation of a children=s hospital disproportionate share program.

Section 409.911, F.S., defines "charity care" or "uncompensated charity care" for purposes of the Medicaid disproportionate share program to mean that portion of hospital charges reported to the Agency for Health Care Administration for which there is no compensation for care provided to a patient whose family income for the 12 months preceding the determination is less than or equal to 150 percent of the federal poverty level, unless the amount of hospital charges due from the patient exceeds 25 percent of the annual family income. However, in no case shall the hospital charges for a patient whose family income exceeds four times the federal poverty level for a family of four to be considered charity. Proviso language accompanying the 2000-2001 General Appropriations Act created the Disproportionate Share Program Taskforce. The Disproportionate Share Program Taskforce submitted a recommendation, among others, that the definition of "charity care" for purposes of the Medicaid disproportionate share program be revised to increase minimum family income for eligibility under the program from less than or equal to 150 percent of federal poverty level to less than or equal to 200 percent of the federal poverty level.

The Primary Care Disproportionate Share program pays disproportionate care funds to hospitals that provide primary care services in the community. Seven hospitals participate in this program.

III. Effect of Proposed Changes:

Section 1. Amends s. 154.306, F.S., which establishes a county's financial responsibility for indigent patients treated at certain out-of-county hospitals under the Florida Health Care Responsibility Act. The population figures used to compute the maximum amount the county is required to pay are reduced to exclude the number of inmates and patients residing in institutions operated by the federal government, the Department of Corrections, the Department of Health, or the Department of Children and Family Services, and the number of active-duty military personnel residing in the county. However, this alternate calculation is only available to counties with a population of 100,000 or less, and only if those counties agree to accept as valid, without reverification, documents certifying financial eligibility and county residency, which are used to request reimbursement for services.

Section 2. Amends s. 381.0403, F.S., to transfer the Community Hospital Education Program from the Board of Regents to the Department of Health. The bill provides that the Department of Health may spend up to $75,000 of the state appropriation allocated to the CHEP for administrative costs associated with the production of the annual report and for administration of CHEC.

The bill implements the recommendation of the Graduate Medical Education Committee to allow Florida medical schools to apply for Graduate Medical Education Innovations Program funding for the direct costs of providing graduate medical education in community-based clinical settings on a competitive grant or formula basis to achieve state health care workforce policy objectives.

Florida medical schools may not apply for Graduate Medical Education Innovations Program funds when such innovations directly compete with services or programs provided by participating hospitals, or both hospitals and consortia.

The bill modifies the membership of the Graduate Medical Education Committee. The committee must be comprised of 11 members: five members must be deans of the medical schools or their designees; the Governor must appoint two members, one of whom must be a representative of the Florida Medical Association who has supervised or currently supervises residents or interns and one of whom must be a representative of the Florida Hospital Association; the Secretary of the Agency for Health Care Administration must appoint two members, one of whom must be a representative of a statutory teaching hospital and one of whom must be a physician who has supervised or is currently supervising residents or interns; and the Secretary of the Department of Health must appoint two members, one of whom must be a representative of a statutory family practice teaching hospital and one of whom must be a physician who has supervised or is currently supervising residents or interns. With the exception of the deans, members must serve 4-year terms. The bill provides for staggered terms for the committee members. A member's term shall be terminated when the member's representative status no longer exists. Once the committee is appointed, it must elect a chair to serve for a 1-year term.

Section 3. Creates an undesignated section of law, to transfer all statutory powers, duties, and functions and the records, personnel, property, and unexpended balances of appropriations, allocations, or other funds of the Community Hospital Education Program from the Board of Regents to the Department of Health. A type two transfer under s. 20.06, F.S., is defined to mean the transfer of a program, activity, or function and all its statutory powers, duties, and functions, and its records, personnel, property, and unexpended balances of appropriations, allocations, or other funds from one agency to another.

Section 4. Amends s. 409.908, F.S., relating to reimbursement of Medicaid providers, to change references to the Board of Regents to the Department of Health to conform to the transfer of the Community Hospital Education Program from the Board of Regents to the Department of Health. Provides for the certification of local matching funds under the Medicaid program as state match under Title XIX (Medicaid) to the extent that the local health care provider is entitled to and contracted to receive such local funds as the benefactor under the General Appropriations Act, and pursuant to an agreement between the Agency and the local government entity. The local governmental entity is to use a certification form prescribed by the Agency and is to identify certain criteria specified by the Agency. The Agency is directed to prepare a statement of impact that documents the specific activities undertaken using such funds, to be submitted to the Legislature annually by January 1.

Section 5. Amends s. 409.911, F.S., relating to the Medicaid disproportionate share program, to revise the definition of "charity care" or "uncompensated charity care" for purposes of the Medicaid disproportionate share program to mean that portion of hospital charges reported to the Agency for Health Care Administration for which there is no compensation *other than restricted or unrestricted revenues provided to a hospital by local governments or tax districts regardless of the method of payment* for care provided to a patient whose family income for the 12 months preceding the determination is less than or equal to *200 percent* rather than 150 percent of the

federal poverty level, unless the amount of hospital charges due from the patient exceeds 25 percent of the annual family income. However, in no case shall the hospital charges for a patient whose family income exceeds four times the federal poverty level for a family of four to be considered charity care.

Section 6. Amends s. 409.9117, F.S., to revise the eligibility criteria for the Primary Care Disproportionate Share Program to allow payment to hospitals when they agree to coordinate and provide primary care services free of charge, except for copayments, to all persons with incomes up to 100 percent of the federal poverty level and to persons on a sliding fee scale with incomes up to 200 percent of the federal poverty level, to specify that such persons must not otherwise be covered by Medicaid or another program administered by a governmental entity.

Section 7. Provides an effective date of July 1, 2001.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Art. VII, s. 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Art. I, s. 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Art. III, s. 19(f) of the Florida Constitution.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None

B. Private Sector Impact:

Participating hospitals could receive less reimbursement for services provided to non-resident indigent patients. The burden for this uncompensated care would shift to the hospitals, the paying patients, and the taxpayers in the county in which the care is provided. This reduction in medical payments could be offset, to some extent, by the requirement that counties honor requests for reimbursement without re-verification by the county of residence.

Medical schools may benefit to the extent they may compete for Graduate Medical Education Innovations Program funding for the direct costs of providing graduate medical education in community-based clinical settings.

C. Government Sector Impact:

Some counties will likely pay less to hospitals for the medical care of their indigent residents receiving care in facilities in another county. The bill excludes approximately 50,110 people from the calculation of population for counties with less than 100,000 persons. If all of these counties currently reimburse hospitals up to the cap, this could reduce their statewide financial obligations under the HCRA by an aggregate sum of $200,440.

This reduction in medical payments could be offset, to some extent, by the requirement that counties honor requests for reimbursement without re-verification by the county of residence.

The Department of Health will incur costs to administer the Community Hospital Education Program. The bill authorizes the Department of Health to spend up to $75,000 of the state appropriation allocated to this program for the administrative costs associated with the production of an annual report and for administration of CHEC.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Amendments:

None