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 Policy and Steering Committee on Ways and Means

BILL: CS/CS/SB 1464

INTRODUCER: Policy and Steering Committee on Ways and Means, Committee on Health and Human Services Appropriations and Senator Peaden

SUBJECT: Agency for Health Care Administration

DATE: March 26, 2010 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Kynoch	Hansen	HA	**Fav/CS**
2.	Kynoch	Coburn	WPSC	**Fav/CS**
3.				
4.				
5.				
6.				

Please see Section VIII. for Additional Information:

A. COMMITTEE SUBSTITUTE.....	X	Statement of Substantial Changes
B. AMENDMENTS.....		Technical amendments were recommended
		Amendments were recommended
		Significant amendments were recommended

I. Summary:

The bill:

- Increases the assessment on inpatient hospital revenues from 1.5 percent to 2.0 percent of net operating revenue and increases the assessment on inpatient hospital revenue from 1.0 percent to 1.5 percent of net operating revenue. This provision has an effective date contingent upon the state not receiving enhanced Federal Medicaid Assistance Percentage rate for the period January 1, 2011, through June 30, 2011.
- Requires the Agency for Health Care Administration (agency) to transition all Medicaid recipients enrolled in the Adult Day Health Care and Channeling Services waivers into other federally approved home and community-based waivers.
- Revises the dates that nursing home quality assessment revenues may be used to restore rate reductions and removes the requirement that the quality assessment terminates and the agency discontinues collection of the quality assessment if the average Medicaid rate paid to nursing home facilities is reduced below the rate in effect on December 31, 2008.
- Revises the dates that intermediate care facility for the developmentally disabled (ICF/DD) quality assessment revenues may be used to restore rate reductions and removes the requirement that the quality assessment terminates and the agency discontinues collection of

the quality assessment if the average Medicaid rate paid to ICF/DD facilities is reduced below the rate in effect on October 1, 2008.

- Revises the years of audited data used in determining Medicaid and charity care days for each hospital in the Disproportionate Share Hospital (DSH) program; continues for the 2010-2011 fiscal year, the prohibition on funding for the regional perinatal intensive care centers DSH program and the primary care DSH program; and authorizes payment for the DSH program for teaching hospitals for the 2010-2011 fiscal year.
- Requires Medicaid managed care plans and provider service networks to include in their provider network any pharmacy which is located in a rural county willing to accept the reimbursement terms and conditions established by the managed care plan.
- Modifies nursing home staffing requirements to allow for a combined direct care staffing requirement of 3.9 hours per resident per day.

This bill substantially amends ss. 395.701, 400.141, 409.906, 409.9082, 409.9083, 409.911, 409.9112, 409.9113, and 409.9117, F.S.

II. Present Situation:

Medicaid Home and Community-Based-Services Waiver Programs

In 1981, the U.S. Congress approved the use of Medicaid home and community-based-services (HCBS) waiver programs to allow states to provide certain Medicaid services in the home for persons who would otherwise require institutional care in a hospital, nursing facility, or intermediate care facility. These programs are federally-approved Medicaid initiatives authorized by Title XIX of the Social Security Act, Section 1915.

States may offer a variety of services to consumers under a HCBS waiver program, and the number of services that can be provided is not limited. These programs may provide a combination of both traditional medical services (*e.g.*, dental services, skilled nursing services, etc.) and non-medical services (*e.g.*, respite care, case management, environmental modifications, etc.). Family members and friends may be providers of waiver services if they meet the specified provider qualifications. The HCBS waiver programs are initially approved for 3 years and may be renewed at 5-year intervals.[1] If a state terminates a HCBS waiver, federal law requires that recipients receive continued services in an amount that does not violate the comparability of service requirements established in the Social Security Act.[2] In effect, the state has to transition recipients into programs with comparable services.

Home and Community Based Programs for the Elderly

The State currently operates the following home and community based waiver programs for frail elders who meet specified eligibility criteria, including nursing home level of care:[3,4]

[1] U.S. Centers for Medicare and Medicaid Services. Found at: http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/05_HCBSWaivers-Section1915(c).asp (last visited on March 9, 2009).
[2] 42 C.F.R. 441.356.
[3] *The Alzheimer's Disease Waiver Program Does Not Delay Nursing Home Entry More Effectively Than Other Waivers and Costs the State More Per Participant Than Most Waivers That Serve Similar Persons*, Office of Program Policy Analysis and

- The Aged and Disabled Adult waiver (ADA) serves 9,000 elders statewide. It was implemented April 1, 1982.
- The Assisted Living for the Elderly waiver (ALE) serves 2,800 statewide and was implemented on February 1, 1995.
- The Nursing Home Diversion program (NHD) was implemented in December 1998 in the Orlando area and now serves 18,500 clients in 37counties.The Department of Elder Affairs has contracts with managed care providers for services.
- The Adult Day Health Care waiver was implemented on April 1, 2004. The program serves 28 elders and is only available in Lee and Palm Beach counties.
- The Channeling waiver serves 1,400 clients only in Broward and Miami-Dade counties and operates through an annual contract with an organized health care delivery system.
- The Alzheimer's Disease waiver was implemented on April 1, 2005. The program is only available in Broward, Miami-Dade, Palm Beach, and Pinellas counties. Pursuant to
- s. 430.502(9), F.S., this program is eliminated as of April 30, 2010.[5]

Each of the programs above offer a variety of services around which a client creates a case plan to meet his or her needs. The services provided in the Adult Day Health Care and Channeling waivers are also available to elders in the ADA, ALE and NHD programs.

Health Care Assessments

Currently, 43 states impose provider assessments on at least one category of health care providers. Assessments are most frequently imposed on nursing homes, but other entities such as hospitals, intermediate care facilities, and health maintenance organizations are assessed as well. Federal regulations define 19 separate classes of health care services and providers as eligible for assessment programs. Florida currently has a provider assessment in place for hospital inpatient and outpatient services to fund public medical assistance as specified in s. 395.701, F.S.

Generally, states implement provider assessments to generate revenue to support their Medicaid programs, using funds raised through the assessment to draw down federal matching funds. Provider assessments are often used to give rate increases to providers when state general revenue funds are not available, or to create funding for payments intended to help achieve specific programmatic goals, such as improved quality of care. States often redirect a portion of the assessment proceeds away from the providers paying the assessment and use the funds for either other health related purposes or general state expenses. Federal rules prohibit states from making payments to providers that are directly correlated to the amount of assessment paid, so some redistribution among providers is expected, regardless of any redirection of funds to the state. All provider assessment programs must be approved by the federal government. In order to receive federal approval, a provider assessment program must comply with the federal Medicaid

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Governmental Accountability, February 2010, available at http://www.oppaga.state.fl.us/MonitorDocs/Reports/pdf/1023rpt.pdf (last visited March 15, 2010).

[4] E-mails from Sarah Owen, Director of Legislative Affairs, Department of Elder Affairs, March 15, 2010, 10:02 AM and 11:01 AM (on file with the Committee).

[5] The Department of Elder Affairs has taken steps to transition current program participants to other waiver programs. E-mail from Sarah Owen, Director of Legislative Affairs, Department of Elder Affairs, February 6, 2010, 4:04 PM (on file with the Committee).

Voluntary Contribution and Provider Specific Tax Amendments of 1991 and federal regulations under 42 CFR 433.54-74. Typically, revenue from an assessment will be deemed acceptable to the federal Centers for Medicare and Medicaid Services (CMS) as legitimate state match if it meets the following criteria:

- The assessment is broad based;
- The assessment is applied uniformly;
- The assessed entity is not held harmless for the assessment paid; and
- The assessment is less than 5.5 percent of industry's net patient revenue.

A health care related assessment is considered broad based if the assessment is imposed on at least all health care items or services within a class of providers. Some states have excluded or "carved out" certain classes of providers from the assessment in an effort to mitigate the redistribution of money that occurs within assessment programs. Federal regulations allow certain groups of providers to be legitimately exempted from a provider assessment if the state can demonstrate that the assessment is generally redistributive. A provider assessment is considered to be uniformly imposed if a state can demonstrate that the assessment is applied on the same basis at the same rate for each provider. An assessment is not uniformly imposed if it permits credits, deductions, or exclusions that result in returning all or part of the assessment.

Most assessments are based on a flat amount per day or licensed bed and are considered uniform, but other assessment bases such as net revenue would also fulfill this requirement. States are prohibited from establishing programs that would have the effect of offsetting or reducing the impact of the assessment on providers. This prohibition is called the "hold harmless" provision. The three main components of the federal law governing hold harmless are as follows:

- Providing a direct or indirect payment, in addition to any Medicaid payments, to providers paying the assessment and the amount of such payment is positively correlated either to the amount of the assessment or to the difference between the amount of the assessment and the amount of the payment under the Medicaid state plan.
- Making all or any portion of the Medicaid payments to the assessed provider vary only with the amount of the total assessment paid.
- Imposing the assessment includes a guarantee to hold the assessed provider harmless for any portion of the cost of the assessment.

Nothing prohibits the state from utilizing assessment revenue to finance Medicaid payments as long as it does not create a violation of provider assessment regulations. Regardless of whether the payment enhancements are financed entirely by assessment funding or a blend of general revenue funds and assessment monies, CMS will evaluate the changes to determine whether or not a hold harmless situation exists.

The federal government effectively limits the amount of money raised through provider assessments by imposing additional and significantly more onerous requirements on assessment programs if the assessment exceeds 5.5 percent of aggregate net patient revenue for the class of providers. Until recently, the cap was 6 percent, but the ceiling was reduced under the federal Deficit Reduction Act (DRA) of 2005. For provider assessment plans that meet the federal tests, a state plan amendment is submitted to CMS.

Waivers may be pursued for states seeking to implement a plan that does not meet one or more of the federal requirements. While CMS carefully scrutinizes state plan amendment requests and may take months to approve one, the approval process is generally less cumbersome for an amendment than a waiver.

Hospital Assessments

In 1984 Florida became one of the first states in the nation to impose a provider assessment on hospitals. A 1.5 percent assessment of hospital net operating revenues was imposed on all hospital inpatient and outpatient services. Hospital net operating revenue is defined as gross revenue (total hospital charges) minus deductions from gross revenue. Hospital net operating revenue equals the revenue collected from patient services billings. Chapter 2000-256, L.O.F, reduced the assessment on hospital outpatient services from 1.5 percent to 1.0 percent.

Assessment revenue is deposited into the Public Medical Assessment Trust Fund for redistribution to those hospitals which provided a disproportionate share of care to Medicaid and charity patients.

Nursing Home Assessments

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 assessment may not exceed the federal ceiling of 5.5 percent of the total aggregate net patient service revenue. The bill required the agency 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 that 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 in effect on December 31, 2007. The law terminates the assessment if the agency fails to obtain necessary federal approval for matching federal funds or it the assessment plus the federal matching funds are insufficient to restore rate reductions.

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

Chapter 2009-55, L.O.F., created a quality assessment on ICF/DDs effective October 1, 2009. The purpose of this assessment is to ensure continued quality of care through restoring rate reductions. Like the nursing home assessment, the amount of the ICF/DD assessment is limited to the federal ceiling of 5.5 percent of total aggregate net patient service revenues for each facility. The law terminates the assessment if the agency fails to obtain necessary federal approval for matching federal funds or if the assessment and federal matching funds are inadequate to cover the cost of rate reductions imposed on ICF/DDs by the legislature. A sunset date of the assessment of October 1, 2011, is included in the law.

Disproportionate Share Hospital Programs

There are currently five separate Medicaid disproportionate share programs that are operational in Florida. The programs are as follows: the original program established in s. 409.911, F.S.; the Teaching Hospitals program established in s. 409.9113, F.S.; the Mental Health Hospital program established in s. 409.9115, F.S.; the Rural Hospital/Financial Assistance program established in s. 409.9116, F.S.; and the Specialty Hospital program established in s. 409.9118, F.S.

Additionally, there are three separate Medicaid DSH programs that are listed in law but are not operational at this time. The programs are as follows: the Regional Perinatal Intensive Care Center (RPICC) program established in s. 409.9112, F.S.; the Primary Care program established in s. 409.9117, F.S.; and the Specialty Hospitals for Children program established in s. 409.9119, F.S.

Medicaid Managed Care Programs

The State of Florida operates a Medicaid managed care program through a federal s. 1915(b) waiver obtained from the Centers for Medicare and Medicaid Services in 1991. The managed care waiver provides the state with the authority to mandatorily assign eligible beneficiaries[6] and, within specific areas of the state, limit choice to approved managed care providers. The federal waiver requires Florida Medicaid recipients to be given a choice of managed care providers. The Medicaid managed care program is delineated into two major categories of providers: MediPass and managed care plans. However, s. 409.91211, F.S., codifies the Medicaid reform managed care pilot program in Baker, Broward, Clay, Duval, and Nassau Counties. Eligible Medicaid recipients in these counties must enroll in a managed care plan and do not have the ability to choose the MediPass program. Reform plans offer comprehensive, catastrophic and enhanced benefits which are allowed to vary within certain parameters from plan to plan. Medicaid recipients receive choice counseling to help them select among the plans. As of February 2009, there were 210,565 Medicaid recipients enrolled in Medicaid reform plans.

Medicaid managed care plans contract with providers as needed based on agency requirements for network adequacy. Most plans obtain pharmaceutical services through pharmacy benefit managers, which are firms that specialize in establishing formularies, negotiating rates relating to the formulary, and facilitating delivery of prescriptions to plan members. According to the managed care industry, requiring plans to admit to their network any pharmacy willing to accept the plan's reimbursement terms and conditions may result in increased costs due to fraud and by limiting the plan's ability to negotiate discounts based on volume.

[6] Certain persons are ineligible for mandatory managed care enrollment. The major population groups excluded from enrolling in managed care altogether include the Medically Needy, recipients who reside in an institution, those in family planning waivers, and those who are eligible for Medicaid through the breast and cervical cancer program. Dual eligibles (persons who have both Medicaid and Medicare coverage) are excluded from enrollment in MediPass, yet the dual eligibles and others (SOBRA pregnant women and children in foster care) may voluntarily enroll in any other type of managed care plan.

Nursing Facility Staffing
Current law establishes the minimum daily staffing requirements for certified nursing assistant staff at 2.7 hours of direct care per resident per day and establishes the minimum daily staffing requirements for licensed nursing staff at 1.0 hours of direct care per resident per day. Additionally, current law specifies that a minimum weekly average certified nursing assistant staffing of 2.9 hours of direct care per resident per day is required and that a week is defined as Sunday through Saturday. A minimum ratio of at least one certified nursing assistant per 20 residents and a minimum ratio of at least one licensed nurse per 40 residents is required at all times. The current minimum staffing requirements for nursing homes were gradually implemented beginning January 1, 2003 through January 1, 2007.

III. Effect of Proposed Changes:

Section 1 amends s. 395.701, F.S., to increase the assessment on inpatient hospital revenues from 1.5 percent to 2.0 percent of net operating revenue and increases the assessment on inpatient hospital revenue from 1.0 percent to 1.5 percent of net operating revenue. This provision has an effective date contingent upon the state not receiving the enhanced Federal Medicaid Assistance Percentage (FMAP) rate for the period January 1, 2011, through June 30, 2011. This FMAP rate enhancement increases the share of Medicaid costs paid by the federal government from the actual match rate of 55.45 percent for federal Fiscal Year 2011 to an enhanced rate of 67.64 percent.

Section 2 amends s. 400.141, F.S., conforming a cross-reference to changes made by the act.

Section 3 amends s. 400.23, F.S., providing flexibility to nursing home facilities for meeting the minimum staffing requirements. The Florida minimum staffing requirements are aligned with the CMS proposed "optimum level" with one hour of licensed nurse time and 2.9 certified nursing assistant per patient day requirement for a total direct care staffing requirement of 3.9 hours per resident per day. This bill maintains a total direct care staffing requirement of 3.9 hours per resident per day, and maintains the daily staffing minimums of 1.0 hours of direct licensed nursing staff and 2.7 hours of direct certified nursing assistant staff; however, the bill allows for additional flexibility in meeting the needs of higher acuity residents with additional licensed nursing staff.

Section 4 amends s. 409.906, F.S., to require the Agency for Health Care Administration (agency), in consultation with the Department of Elder Affairs, to phase out the Adult Day Health Care and Channeling Services waivers and to transfer existing wavier recipients into the other federally approved home and community-based waivers. Effective July 1, 2010, the Adult Day Health Care and Channeling Services waivers programs shall cease to enroll new members. Existing enrollees in these waivers are to receive counseling regarding available options and must be offered an alternative home and community based services program based on eligibility and personal choice. Enrollees shall continue to receive services without interruption. Providers of the phased out waivers, in consultation with the Areas Agencies on Aging, are required to assist in the transition. Provision of the Adult Day Care and Channeling Services waivers shall cease effective December 31, 2010. The agency is given authority to seek federal waiver approval to administer this change.

Section 5 amends s. 409.9082, F.S., to revises the dates that nursing home quality assessment revenues may be used to restore rate reductions and removes the requirement that the quality assessment terminates and the agency discontinues collection of the assessment if the average Medicaid rate paid to nursing home facilities is reduced below the rate in effect on December 31, 2008.

Section 6 amends s. 409.9083, F.S., to revise the dates that intermediate care facility for the developmentally disabled (ICF/DD) quality assessment revenues may be used to restore rate reductions and removes the requirement that the quality assessment terminates and the agency discontinues collection of the assessment if the average Medicaid rate paid to ICF/DD facilities is reduced below the rate in effect on October 1, 2008.

Section 7 amends s. 409.911, F.S., to specify that the average audited disproportionate share data from 2003, 2004, and 2005 will be used to determine Medicaid and charity care days for each hospital in the Disproportionate Share program for FY 2010-2011.

Section 8 amends s. 409.9112, F.S., to continue the prohibition on distributing funds through the Regional Perinatal Intensive Care Disproportionate Share program, through FY 2010-2011.

Section 9 amends s. 409.9113, F.S., to authorize Disproportionate Share payments to teaching hospitals, through FY 2010-2011.

Section 10 amends s. 409.9117, F.S., to continue the prohibition on distributing funds through the Primary Care Disproportionate Share program, through FY 2010-2011.

Section 11 creates an unnumbered section of Florida law to require Medicaid managed care plans and provider service networks to include in their provider network any pharmacy which is located in a rural county willing to accept the reimbursement terms and conditions established by the managed care plan. Rural county is defined as any county with a population of less than 200,000 according to the 2000 official census. Forty seven counties meet this definition.

Section 12 provides that the bill is effective July 1, 2010.

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 Article VII, Section 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 Article I, Section 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 Article III, Subsection 19(f) of the Florida Constitution.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

The bill increases the assessment on hospital inpatient and outpatient revenues by 0.5 percent. The increase to the inpatient assessment is projected to generate $107.6 million in Fiscal Year 2010-2011, and the increase to the assessment on outpatient revenues is projected to generate $55.8 million in Fiscal Year 2010-2011.

B. Private Sector Impact:

Hospitals would be required to pay the additional assessment specified above.

Nursing homes will have greater flexibility in staffing standards.

Medicaid managed care plans will be required to contract with any pharmacy which is willing to accept the plans reimbursement terms and conditions for pharmacies located in a rural county.

Government Sector Impact:

The requirement for managed care plans to contract with pharmacies in rural counties willing to accept their reimbursement terms and conditions may result in additional Medicaid costs to the state.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

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

CS by Policy and Steering Committee on Ways and Means on March 26, 2010:
The committee substitute provides that the increase in the assessment on hospital revenue is contingent upon the state failing to receive the enhanced Federal Medicaid Assistance Percentage rate for the period January 1, 2011, through June 30, 2011.

CS by Health and Human Services Appropriations on March 19, 2010:
Senate Bill 1464 was originally filed as a shell bill expressing legislative intent to revise laws relating to Health and Human Services. The Health and Human Services Appropriations Committee adopted the committee substitute as described in this bill analysis and does the following:

- Increases the assessment on inpatient hospital revenues from 1.5 percent to 2.0 percent of net operating revenue and increases the assessment on inpatient hospital revenue from 1.0 percent to 1.5 percent of net operating revenue.
- Requires the Agency for Health Care Administration (agency) to transition all Medicaid recipients enrolled in the Adult Day Health Care and Channeling Services waivers into other federally approved home and community-based waivers.
- Revises the dates that nursing home quality assessment revenues may be used to restore rate reductions and removes the requirement that the quality assessment terminates and the agency discontinues collection of the quality assessment if the average Medicaid rate paid to nursing home facilities is reduced below the rate in effect on December 31, 2008.
- Revises the dates that intermediate care facility for the developmentally disabled (ICF/DD) quality assessment revenues may be used to restore rate reductions and removes the requirement that the quality assessment terminates and the agency discontinues collection of the quality assessment if the average Medicaid rate paid to ICF/DD facilities is reduced below the rate in effect on October 1, 2008.
- Revises the years of audited data used in determining Medicaid and charity care days for each hospital in the Disproportionate Share Hospital (DSH) program; continues for the 2010-2011 fiscal year, the prohibition on funding for the regional perinatal intensive care centers DSH program and the primary care DSH program; and authorizes payment for the DSH program for teaching hospitals for the 2010-2011 fiscal year.
- Requires Medicaid managed care plans and provider service networks to include in their provider network any pharmacy which is located in a rural county willing to accept the reimbursement terms and conditions established by the managed care plan.
- Modifies nursing home staffing requirements to allow for a combined direct care staffing requirement of 3.9 hours per resident per day.

B. Amendments:

None.