HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 5301 PCB HCA 10-02 Medicaid Services
SPONSOR(S): Health Care Appropriations Committee and Grimsley
TIED BILLS: **IDEN./SIM. BILLS:** SB 1464

	REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
Orig. Comm.:	Health Care Appropriations Committee	8 Y, 3 N	Hicks	Pridgeon
1)	Full Appropriations Council on Education & Economic Development	16 Y, 2 N	Hicks	Voyles
2)				
3)				
4)				
5)				

SUMMARY ANALYSIS

This bill conforms statutes to the funding decisions included in the proposed General Appropriations Act (GAA) for Fiscal Year 2010-2011. The bill:

- Modifies nursing home staffing requirements to allow for a combined direct care staffing requirement of 3.9 hours per resident per day.
- Eliminates optional Medicaid eligibility and coverage for pregnant women with incomes between 150 and 185 percent of the federal poverty level.
- Extends the date that the Medicaid Aged and Disabled (MEDS-AD) and Medically Needy programs are set to sunset to June 30, 2011.
- Eliminates optional Medicaid chiropractic services for adult recipients.
- Revises the years of audited data used in determining Medicaid and charity care days for hospitals in the Disproportionate Share Hospital (DSH) Program; revises the formula used to make disproportionate share payments to provider service network hospitals; and changes the distribution criteria for Medicaid DSH payments to implement funding decisions for the DSH program.
- Modifies the formula used for calculating reimbursements to providers of prescribed drugs, effective March 1, 2011.
- Clarifies the use of the funds collected as a result of implementing quality assessment programs for nursing homes and privately operated intermediate care facilities for the developmentally disabled.
- Allows the Agency for Health Care Administration (AHCA) and the Department of Elder Affairs (DOEA) to accept and forward applications for expansion of services to the Centers for Medicare and Medicaid Services (CMS) for the Program of All-inclusive Care for the Elderly (PACE).

This bill has an effective date of July 1, 2010.

HOUSE PRINCIPLES

Members are encouraged to evaluate proposed legislation in light of the following guiding principles of the House of Representatives

- Balance the state budget.
- Create a legal and regulatory environment that fosters economic growth and job creation.
- Lower the tax burden on families and businesses.
- Reverse or restrain the growth of government.
- Promote public safety.
- Promote educational accountability, excellence, and choice.
- Foster respect for the family and for innocent human life.
- Protect Florida's natural beauty.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

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.

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 would maintain a total direct care staffing requirement of 3.9 hours per resident per day, and would maintain 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 proposed language would allow for additional flexibility in meeting the needs of higher acuity residents with additional licensed nursing staff.

Optional Medicaid Eligibility and Coverage

Current law allows Medicaid reimbursement for medical assistance and related services for beneficiaries deemed eligible subject to income, assets, and categorical eligibility tests set forth in federal and state law. Payment on behalf of these Medicaid eligible beneficiaries is subject to the availability of moneys and any limitations established by the GAA or chapter 216, F.S.

- **The Medicaid Aged and Disabled Program (MEDS-AD)** eligibility category is an optional Medicaid eligibility group. The program provides Medicaid coverage to individuals who are age 65 or older or totally and permanently disabled, have incomes less than 88 percent of the federal poverty level, not eligible for Medicare and meet asset limits. Section 409.904(1), F.S., directed the AHCA to seek federal waiver authority to revise Medicaid eligibility coverage for the Medicaid MEDS-AD eligibility group beginning January 1, 2006. The AHCA received approval of the 1115 Research and Demonstration Waiver on November 22, 2005. In accordance with the

approved waiver, the revised program covers individuals without Medicare residing in the community or receiving Medicaid-covered institutional care services, hospice services, or home and community based services (HCBS), or if individuals are eligible for Medicare, and are also eligible for and receiving Medicaid-covered institutional care services, hospice services, or home and community based waiver services.

Medicaid is required to provide Medicare "buy-in" coverage for aged and disabled individuals who are Medicare beneficiaries. Therefore, if Medicaid coverage is eliminated for persons eligible under the criteria for the MEDS-AD program, those who are eligible for Medicare will continue to have Medicaid coverage for Medicare premiums, deductibles, and coinsurance. This program is expected to have an average monthly enrollment of approximately 18,101 individuals in Fiscal Year 2010-11.

- **The Medically Needy** eligibility category is an optional Medicaid eligibility group. Title XIX of the Social Security Act specifies categories of individuals that the federal government gives state Medicaid programs the option of covering through their state plan. The Medically Needy program covers persons who have experienced a catastrophic illness and either have no health insurance, or have exhausted their benefits. On a month by month basis, the individual's medical expenses are subtracted from his or her income. If the remainder falls below Medicaid's income limits, the individual may qualify for Medicaid for the full or partial month depending on the date the medical expenses were incurred. The amount of expenses that must be deducted from the individual's income to make him or her eligible for Medicaid is called "share of cost." A person eligible for the Medically Needy Program is eligible for all Medicaid services with the exception of services in a skilled nursing facility, an intermediate care facility for the developmentally disabled, assistive care services, home and community-based services, or the payment of Medicare premiums by Medicaid. This program is expected to serve an average monthly enrollment of approximately 21,583 individuals in Fiscal Year 2010-11.

- **Pregnant Women with Income of 150-185% of the Federal Poverty Level –** This optional eligibility category provides Medicaid coverage for pregnant women with income of 150 percent up to 185 percent of the federal poverty level. Full Medicaid benefits are available to those deemed eligible to receive coverage under this optional eligibility group. It is estimated that this program will have an average monthly enrollment of 5,796 beneficiaries in Fiscal Year 2010-2011.

- **Chiropractic Services –** Currently law allow Medicaid reimbursement to providers for at least 27 optional services, including chiropractic services. Medicaid reimburses chiropractic services rendered by a licensed, Medicaid participating chiropractic physician. Chiropractic services include manual manipulation of the spine and initial services and screening and x-rays provided by a licensed chiropractic physician. For Fiscal Year 2010-2011, it is estimated that approximately 6,183 adult beneficiaries would be eligible for this Medicaid coverage.

The bill extends the sunset date for the MEDS-AD and Medically Needy programs from December 31, 2010 to June 30, 2011 restoring Medicaid coverage to eligible individuals with non-recurring funds. The bill also eliminates optional Medicaid coverage for pregnant women with income of 150 percent up to 185 percent of the federal poverty level, effective January 1, 2011, and eliminates Medicaid reimbursement for optional Medicaid chiropractic services for adult recipients.

Medicaid Reimbursement for Prescribed Drugs Services

Reimbursement for prescribed drug claims is made in accordance with the provisions of 42 CFR 447.512-516; and ss. 409.906(20), 409.908, 409.912(39) (a), F.S.

The current reimbursement for covered drugs dispensed by a licensed pharmacy, approved as a Medicaid provider, or an enrolled dispensing physician filling his own prescriptions, is the lesser of:

- Average Wholesale Price (AWP) minus 16.4%, plus a dispensing fee of $3.73 or
- Wholesaler Acquisition Cost (WAC) plus 4.75%, plus a dispensing fee of $3.73 or
- The Federal Upper Limit (FUL) established by the CMS, plus a dispensing fee of $3.73 or
- The State Maximum Allowable Cost (SMAC), plus a dispensing fee of $3.73 or
- The provider's Usual and Customary (U&C) charge, inclusive of dispensing fee.

AWP and WAC are published by First Data Bank (FDB) as reference prices for pharmaceuticals. AWP is a "list price" and is higher than the cost wholesalers actually pay. WAC is slightly more representative of costs actually paid by wholesalers, and is more accurate with respect to branded pharmaceuticals than generics. Third party payors and State Medicaid Programs use these published prices (AWP and WAC) in their retail pharmacy reimbursement calculations.

On March 30, 2009, the U.S. District Court for the District of Massachusetts entered a Final Order and Judgment approving a class action settlement that involved two major publishers of drug pricing information, FDB and Medi-Span. The Plaintiffs in this case alleged that FDB's and Medi-Span's policies and practices caused them to pay inflated prices for certain pharmaceutical products.

The settlement requires FDB and Medi-Span to reduce the AWP mark-up factor to a standard ceiling of 120 percent of WAC on all National Drug Codes (NDCs). This change took effect on September 26, 2009, and will affect all prescriptions where the reimbursement calculation was based on AWP. With respect to Florida Medicaid, 25.39 percent of prescriptions are reimbursed based on AWP. These are primarily branded pharmaceuticals still under patent. Both FDB and Medi-Span have independently announced plans to discontinue publishing AWP by March, 2011.

This bill modifies reimbursement for prescribed drugs to the lesser of the wholesaler acquisition cost, the federal upper limit, the state maximum allowable cost, or the usual and customary charge billed by the provider, effective March 1, 2011, to adjust for the removal of the AWP component for all drugs from the reimbursement formula.

Nursing Home Facility Providers Quality Assessment Program

Section 409.9082, F.S., establishes a quality assessment program for nursing home facility providers. The program had an effective date of April 1, 2009. Federal regulations provide that assessment revenues cannot exceed 5.5 percent of the total aggregate net patient service revenue of the assessed facilities. The AHCA was authorized to calculate the assessment annually on a per-resident-day basis, exclusive of those days funded by the Medicare program. Certain nursing home facilities are exempt from the imposition of the quality assessment. The purpose of the nursing home quality assessment is to ensure continued quality of care and that the collected assessments are 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.

This bill clarifies that the nursing home facility quality assessment collected by the AHCA shall be used to restore rate reductions effective on or after January 1, 2008 as provided in the GAA.

Privately Operated Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) Quality Assessment Program

Section 409.9083, F.S., establishes a quality assessment program for intermediate care facilities for the developmentally disabled. Federal regulations provide that assessment revenues cannot exceed 5.5 percent of the total aggregate net patient service revenue of the assessed facilities. The AHCA was authorized to calculate the quality assessment rate annually on a per-resident-day basis. The purpose of the facility quality assessment is to ensure continued quality of care and that the collected

assessments are used to obtain federal financial participation through the Medicaid program in order to make Medicaid payments for ICF/DD services up to the amount of the Medicaid rates as calculated in accordance with the approved state Medicaid plan in effect on April 1, 2008.

This bill clarifies that the ICF/DD quality assessment collected by the AHCA shall be used to restore rate reductions effective on or after October 1, 2008 as provided in the GAA.

Disproportionate Share Program (DSH)

Each year the Low-Income Pool Council (formerly Disproportionate Share Council) makes recommendations to the Legislature on the Medicaid Disproportionate Share Hospital Program funding distributions to hospitals that provide a disproportionate share of the Medicaid or charity care services to uninsured individuals. However, the legislature delineates how the funds will be distributed to each eligible facility.

The bill amends several provisions of chapter 409, F.S., to update for the most recent years of audited data used to implement the changes in DSH program funding for Fiscal Year 2010-2011. The bill:

- Revises the method for calculating disproportionate share payments to hospitals for Fiscal Year 2010-2011 by changing the years of averaged audited data from 2003, 2004, and 2005 to 2004, 2005, and 2006;
- Revises the formula used to calculate disproportionate share payments to provider service network (PSN) hospitals;
- Revises the time period from Fiscal Year 2009-2010 to 2010-2011 during which the AHCA is prohibited from distributing funds under the Disproportionate Share Program for regional perinatal intensive care centers;
- Requires that funds for statutorily defined teaching hospitals in Fiscal Year 2010-2011 be distributed in the same proportion as funds were distributed under the Disproportionate Share Program for teaching hospitals in Fiscal Year 2003-2004, or as otherwise provided in the GAA; and
- Revises the time period from Fiscal Year 2009-2010 to Fiscal Year 2010-2011 during which the AHCA is prohibited from distributing funds under the primary care disproportionate share program.

Program of All-Inclusive Care for the Elderly (PACE)

PACE is a capitated benefit model authorized by the federal Balanced Budget Act of 1997 that features a comprehensive service delivery system and integrated federal Medicare and state Medicaid financing. The model was tested through CMS demonstration projects that began in the mid-1980s.[1] The PACE model was developed to address the needs of long-term care clients, providers, and payors.

For most participants, the comprehensive service package permits them to continue living at home while receiving services rather than receiving services in other more costly long term care settings. Capitated financing allows providers to deliver all the services that participants need rather than being limited to those services reimbursable under the Medicare and Medicaid fee-for-service systems. [2]

The Balanced Budget Act of 1997 established the PACE model of care as a permanent entity within the Medicare program and enabled states to provide the PACE services to Medicaid beneficiaries as a state option without a Medicaid waiver. The state plan must include PACE as an optional Medicaid benefit before the State and the Secretary of the Department of Health and Human Services can enter into program agreements with PACE providers.[3]

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[1] Centers for Medicare and Medicaid Services website: http://www.cms.hhs.gov/PACE/ (last visited on March 12, 2010).

[2] *Id.*

[3] *Id.*

A PACE organization is a not-for-profit private or public entity that is primarily engaged in providing the PACE services and must:[4]

- Have a governing board that includes community representation;
- Be able to provide the complete service package regardless of frequency or duration of services;
- Have a physical site to provide adult day services;
- Have a defined service area;
- Have safeguards against conflicts of interest;
- Have demonstrated fiscal soundness; and
- Have a formal participant bill of rights.

The PACE project is a unique federal/state partnership. The federal government establishes the PACE organization requirements and application process. The state Medicaid agency or other state agency is responsible for oversight of the entire application process, which includes reviewing the initial application and providing an on-sight readiness review before a PACE organization can be authorized to serve patients. An approved PACE organization must sign a contract with the CMS and the state Medicaid agency.[5]

Florida PACE Project

The Florida PACE project is one project among many that provide alternative, long-term care options for elders who qualify for Medicare and the state Medicaid program. The PACE project was initially authorized in Chapter 98-327, Laws of Florida, and is codified in s. 430.707(2), F.S. The PACE model targets individuals who would otherwise qualify for Medicaid nursing home placement and provides them with a comprehensive array of home and community based services at a cost less than the cost of nursing home care. The PACE project is administered by DOEA in consultation with AHCA.

Section 3, Chapter 2006-25, L.O.F., included proviso language in the 2006-2007 GAA to authorize 150 additional clients for the existing PACE project in Miami-Dade County and funding for the development of PACE projects to serve 200 clients in Martin and St. Lucie counties, and 200 clients in Lee County.

Section 3, Chapter 2008-152, L.O.F., included proviso language in the 2008-09 GAA to reallocate 150 unused PACE slots to Miami-Dade, Lee and Pinellas Counties. Each site received 50 slots.

Section 20 of 2009-55, Laws of Florida, directed the AHCA, upon federal approval of an application to be a site for PACE, to contract with one private, not-for-profit hospice organization located in Hillsborough County, which provides comprehensive services, including hospice care for frail and elderly persons. This section also authorized the AHCA, in consultation with DOEA and subject to an appropriation, to approve up to 100 slots for the program.

In addition to receiving the necessary legislative authority, the development of a new PACE organization or the expansion of an existing program is a lengthy process that includes: identifying a service area, acquiring and renovating a PACE facility and processing the PACE application through the state and the federal review system.

The bill allows any entity that is authorized to provide benefits pursuant PACE on or before July 1, 2010 to submit an application to expand a PACE Pilot project. The bill authorizes the AHCA, in consultation with DOEA, to accept and forward to CMS an application to expand a PACE Pilot project from a current PACE entity in good standing with the AHCA, DOEA, and CMS.

[4] PACE Fact Sheet, available at http://www.cms.hhs.gov/PACE/Downloads/PACEFactSheet.pdf.

[5] *Id.*

B. SECTION DIRECTORY:

Section 1: Amends s. 400.141, F.S., conforming a cross-reference to changes made by the act.

Section 2: Amends s. 400.23, F.S., providing flexibility to nursing home facilities for meeting the minimum staffing requirements.

Section 3: Amends s. 409.903, F.S., eliminating the eligibility and coverage of pregnant women with income of 150-185% of the federal poverty level.

Section 4: Amends s. 409.904, F.S., extending the sunset date for the Medically Aged and Disabled waiver and Medically Needy programs.

Section 5: Amends s. 409.906, F.S., eliminating chiropractic optional Medicaid services for adult recipients.

Section 6: Amends s. 409.908, F.S., modifying the reimbursement methodology for a provider of prescribed drugs services.

Section 7: Amends s. 409.9082, F.S., clarifying the use of the nursing home facility quality assessment.

Section 8: Amends s. 409.9083, F.S., clarifying the use of the quality assessment on privately operated intermediate care facilities for the developmentally disabled.

Section 9: Amends s. 409.911, F.S., revising the share data used to calculate disproportionate share payments to hospitals; and revising the formula used to distribute disproportionate share funds to provider service network (PSN) hospitals.

Section 10: Amends s. 409.9112, F.S., revising the time period during which the AHCA is prohibited from distributing disproportionate share payments to regional perinatal intensive care centers.

Section 11: Amends s. 409.9113, F.S., requiring the AHCA to distribute moneys provided in the GAA to statutorily defined teaching hospitals and family practice teaching hospitals under the teaching hospitals disproportionate share program for Fiscal Year 2010-2011.

Section 12: Amends s. 409.9117, F.S., prohibiting the AHCA from distributing moneys under the primary care disproportionate share program for Fiscal Year 2010-2011.

Section 13: Amends s. 409.912, F.S., modifying the reimbursement methodology for a provider of prescribed drugs.

Section 14: Amends s. 430.707, F.S., allowing AHCA and DOEA to accept and forward an application for expansion of services to CMS for PACE.

Section 15: Provides an effective date of July 1, 2010.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   $136,723,385 million in federal Medicaid funds will be generated through the implementation of the DSH programs. The privately operated intermediate care facility quality assessment and the nursing home facility quality assessment will generate $84,981,277 million in federal Medicaid funds.

2. Expenditures:

	FY 2010-11	FY 2011-12
OPTIONAL MEDICAID ELIGIBILITY AND COVERAGE		
MEDS-AD Program		
General Revenue	$228,008,289	
Grants and Donations Trust Fund	$ 32,423,511	
Medical Care Trust Fund	$366,070,093	
Total	**$626,501,893**	
Medically Needy Program		
General Revenue	$264,928,422	
Health Care Trust Fund	$ 28,400,000	
Grants and Donations Trust Fund	$ 66,399,527	
Medical Care Trust Fund	$457,442,063	
Total	**$817,170,012**	
Pregnant Women with Income of 150-185% of FPL		
General Revenue	($ 12,999,350)	($12,999,350)
Grants and Donations Trust Fund	($ 266,746)	($ 266,746)
Medical Care Trust Fund	($ 16,386,884)	($16,386,884)
Total	**($ 29,652,980)**	**($29,652,980)**
Chiropractic Services		
General Revenue	($ 320,786)	($ 106,929)
Medical Care Trust Fund	($ 513,290)	($ 171,097)
Refugee Assistance Trust Fund	($ 2,271)	($ 757)
Total	**($ 836,347)**	**($ 278,783)**
DISPROPORTIONATE SHARE PROGRAM		
Grants and Donations Trust Fund	$109,847,192	
Medical Care Trust Fund	$136,723,385	
Total	**$246,570,577**	
PHARMACY PROGRAM REDUCTION		
General Revenue	($ 5,657,881)	($11,315,763)
Medical Care Trust Fund	($ 9,053,199)	($18,106,397)
Total	**($ 14,711,080)**	**($29,422,160)**

QUALITY ASSESSMENT PROGRAMS		
Nursing Home Facilities		
Grants and Donations Trust Fund	$ 53,600,846	
Medical Care Trust Fund	$ 85,766,928	
Total	**$139,367,774**	
Privately Operated Intermediate Care Facilities for the Developmentally Disabled		
Grants and Donations Trust Fund	($ 491,042)	
Total	**($ 491,042)**	
PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY		
General Revenue	$ 1,027,534	$ 616,520
Medical Care Trust Fund	$ 1,644,161	$ 986,497
Total	**$ 2,671,695**	**$ 1,603,017**
General Revenue	**$ 474,986,228**	**($23,805,522)**
Health Care Trust Fund	**$ 28,400,000**	**($ 0)**
Grants and Donations Trust Fund	**$ 261,513,288**	**($ 266,746)**
Medical Care Trust Fund	**$1,021,693,257**	**($33,677,881)**
Refugee Assistance Trust Fund	**($ 2,271)**	**($ 757)**
Grand Total	**$1,786,590,502**	**($57,750,906)**

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   Local governments and other local political subdivisions may provide $109,847,192 million in contributions for the DSH programs.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Hospitals providing a disproportionate share of Medicaid or charity care services will receive additional reimbursements towards the cost of providing care to uninsured individuals. The nursing home facility providers will be able to restore reductions to the reimbursement rates through the quality assessments.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This legislation does not appear to require counties or municipalities to take an action requiring the expenditure of funds; reduce the authority that municipalities or counties have to raise revenue in the aggregate; or reduce the percentage of a state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The AHCA has sufficient rulemaking authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

IV. AMENDMENTS/COUNCIL OR COMMITTEE SUBSTITUTE CHANGES