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HOUSE OF REPRESENTATIVES
COMMITTEE ON
HEALTH CARE SERVICES
BILL RESEARCH & ECONOMIC IMPACT STATEMENT

BILL #: CS/SB 250

RELATING TO: Certificates of Need

SPONSOR(S): Senate Committee on Health Care

COMPANION BILL(S):

ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE:
(1) HEALTH CARE SERVICES
(2) HEALTH & HUMAN SERVICES APPROPRIATIONS
(3)
(4)
(5)

I. SUMMARY:

Committee Substitute for Senate Bill 250 amends the certificate-of-need (CON) law relating to nursing homes to do the following:

- To modify the procedure for imposing conditions on a CON for a nursing home that was issued in reliance on the applicant's statements to provide a specified number of nursing home beds to Medicaid recipients.

- To revise a provision in the nursing home licensure law by deleting language that pertains to CON regulation.

- To exempt from CON review certain state veterans' nursing homes operated by or on behalf of the Florida Department of Veterans' Affairs when specified conditions are met.

- To amend the law relating to CON conditions and monitoring to explicitly clarify that a nursing home CON issued in reliance upon an applicant's statement to provide Medicaid nursing home beds must include a statement of such commitment. The CON program is required to notify the Medicaid program and the Department of Elderly Affairs when it imposes Medicaid conditions on a CON for a nursing home that will operate in an area in which a community diversion pilot project is implemented. Additionally, explicit authority is provided for a holder of a CON to apply to the Agency for Health Care Administration (AHCA) for a modification of conditions imposed on its CON.

Finally, the bill creates an interagency workgroup with participation from private-sector interested parties to study and monitor issues pertaining to ensuring a sufficient supply of Medicaid nursing home beds. The workgroup is required to submit two reports and it is abolished effective January 1, 2000.

This bill has no fiscal impact on state or local governments.

II. SUBSTANTIVE RESEARCH:

A. PRESENT SITUATION:

CERTIFICATE-OF-NEED REGULATION

Beginning in the late 1960's, the federal government directly regulated market entry of health care providers through CON regulation. The State of Florida, in compliance with federal law, enacted CON regulation in the early 1970's. In regulating market entry, CON is made a pre-requisite to licensure. The federal government repealed its CON regulation in 1981.

Under Florida's CON regulation, before a person (natural or corporate) may be granted a state license to operate a nursing home, hospital, home health agency, intermediate care facility, or hospice, the person must apply to the agency for state recognition of market need for such a facility or service. Furthermore, once awarded a CON, as provided under ss. 408.031- 408.045, F.S., the Health Facility and Services Development Act, and granted a license to operate, the person may need to subsequently obtain other CONs before proceeding with the implementation of a business decision, such as pursuing conversion from one type of facility to another type of facility or offering a new service.

The state's CON program is centered around three main policy objectives: (1) cost containment of overall health care expenditures, (2) ensuring a minimum level of quality of health care, and (3) ensuring access to health care goods and services. Through control of the supply of health care facilities and services, CON regulation attempts to minimize the costs of excess supply, help prevent non-price competition, and slow the proliferation of new technology before its usefulness has been established. Additionally, CON regulation is designed to promote equal service and equal geographic access to quality health care, assure and reward quality care, and encourage responsiveness to community interests.

To receive authorization to operate a nursing home facility, an applicant must first receive a written statement issued by AHCA's CON program that states there is a community need for a new, converted, expanded, or otherwise significantly modified nursing home facility in the area in which it is to be established or modified. Need determination is a part of the health planning function of the CON program. The CON program uses various planning techniques. It obtains utilization data from health care facilities and health care providers to determine market developments in terms of the cost of services delivered, the level of service utilization, health care consumer demographic profiles, and to assess the need for increased facility capacity or service availability in a geographic area of the state.

Exemption from Certificate-of-Need Regulation

Health care services or projects that are otherwise subject to CON review may be exempted from review, as provided in subsection 408.036(3), F.S. This provision is comprised of an enumeration of services and projects that AHCA is required to exempt from review based upon the request of the service provider or health care facility operator when supported by documentation required by AHCA. Nursing home facilities are subject to CON review under subsection 408.036(1), F.S., including nursing homes

that are operated by or on behalf of the Florida Department of Veterans' Affairs in accordance with the provisions of part II of chapter 296, F.S.

Certificate-of-Need Conditions

As provided in s. 408.040, F.S., AHCA may approve a CON application, with conditions, for nursing home beds and other facilities and services. For CON applicants, AHCA includes Form CON-1, Schedule C in the application packet for the applicant to indicate whether, or to what extent, it is willing to meet the stated local health council preference, if any, for providers to make a stated amount of services available to Medicaid recipients who seek services in the area where the applicant intends to operate. Once a condition is imposed on a CON, it continues in effect for the duration of the nursing home's existence under that CON.

A condition may require the health care provider who will license and operate the facility or provide a service, such as hospice, to provide service to a needy population group, most typically Medicaid recipients (in recent years). Such a condition may require provision of a minimum of 3 percent of a provider's total annual facility patient days to Medicaid recipients or charity care or 30 percent of the local market's total Medicaid patient days, for example.

Conditions are usually imposed only on CONs pursued through the comparative review process. The CON program reported that for at least the past 10 years, it has not awarded a nursing home CON that did not impose a condition that the applicant certify a portion of its beds for Medicaid reimbursement. However, through litigation some CON Medicaid nursing home conditions have been eliminated. Also, since 1990, AHCA has reduced by 138,045 days the number of CON conditioned Medicaid nursing home patient days.

While not all CON conditions are imposed only on nursing homes and not all CON conditions pertain to the Medicaid program, the majority of CON conditions currently in effect are applicable to Medicaid nursing home beds. In 1981, the Legislature enacted authority for the CON program to impose conditions on a person awarded a CON for community nursing home beds. Such authority resulted, in part, because of findings that Medicaid recipients were encountering barriers to access to various health care services due to the reimbursement rate paid by Medicaid or due to limited health care resources in their communities and, in part, because the state is at risk of losing federal reimbursement if it fails to comply with contract Medicaid requirements.

Preferences as the Bases for CON Conditions

There are no established statutory guidelines for setting CON conditions. The CON program cited s. 400.071, F.S., as statutory guidance for imposing CON conditions on Medicaid nursing home beds. It is a provision of the nursing home licensure law that states:

The agency shall consider, in addition to the other criteria specified in s. 408.035 [CON review criteria], the statement of intent by the applicant to designate a percentage of the beds of the facility for use by patients eligible for care under Title XIX of the Social Security Act, the percentage to be all or a portion of the need for such beds as identified

in the local health plan. It is the intent of the Legislature that preference be given to an application which most closely meets the need for such beds.

A publicly adopted methodology is *not* used to impose Medicaid conditions on CON nursing home beds. Conditions are imposed as a result of application review and selection based on information solicited by AHCA and submitted by the applicant as a response to preferences for Medicaid commitments stated by some local health councils. The CON program provides funding from CON fees to the 11 local health planning councils established in the state, as provided under s. 408.033, F.S. The local health councils provide the CON program various local health care data. For example, they collect local Medicaid utilization information in the form of Medicaid patient days on a monthly or quarterly basis. This information is forwarded to the CON program for verification and editing and, once determined to be accurate, is used as the basis for CON comparative review need projections. Another role of the local health councils is to provide preference statements for award of CONs. The statements may be expressions of preference for applicants that agree to serve a specified percentage of Medicaid patients, care for AIDS patients, or offer specialized services to Alzheimer's patients.

Certificate-of-Need Condition Monitoring, Modification, and Sanctions

Section 408.040, F.S., also provides for AHCA to perform various monitoring functions relating to the construction of projects and conditions placed on CONs. Administrative rules 59C-1.013 and 59C-1.021, F.A.C., respectively, provide procedures for the monitoring process and penalties for the violation of conditions. The Agency for Health Care Administration has allocated one full-time equivalent position to monitor compliance.

Monitoring of conditions began in 1989. During the first year of monitoring, AHCA (then the Department of Health and Rehabilitative Services) monitored approximately 400 conditions. Between 1989 and 1995 a total of 3,600 CONs were reviewed through the compliance monitoring process. Of the 3,600 CONs monitored during that period, 2,300, or 64%, were found in to be in *substantial* compliance, when reviewed. During FY 1997-1998, AHCA will be monitoring 685 conditions imposed on CONs held by providers of hospital, nursing home, and home health services. Certificates of need issued for hospice services used to be subject to conditions, but are no longer. There are currently conditions imposed on: 364 nursing home CONs, 20 hospital skilled nursing unit CONs, 281 hospital-based CONs (conditions may be imposed on beds or services such as organ transplants or open heart surgery), and 85 home health CONs. Since the start of the monitoring program, the CON Office has determined that 78 CONs were out of compliance with conditions imposed.

Conditions imposed on a CON may be modified, as provided under administrative rule 59C-1.019, F.A.C. An applicant for modification of a CON must submit a written request to AHCA documenting good cause for the modification. The rule lists three examples of "good cause," although other justifications may be submitted, that may be used to document "good cause." The examples are: 1) changes in the adequacy of reimbursement; 2) changes in the overall ability of the health care facility, home health agency, or hospice for which the CON was issued to cover its costs if such changes are of such a degree that the continued viability of the health care facility, home health agency, or hospice is seriously threatened; or 3) changes in agency rules and regulations substantially affecting the project.

Section 408.040, F.S., also delineates the consequences of failure to comply with any conditions placed on an awarded CON. Failure to comply with a CON condition may subject the certificate holder to an administrative fine of up to $1,000 per failure per day. The penalty is to be mitigated relative to the severity of the failure and all monies collected must be deposited in the Public Medical Assistance Trust Fund, which is used to fund the state portion of Medicaid reimbursement to health care providers. As of July 1997, the CON Office has collected a total of $246,229 in administrative assessments, since monitoring began.

THE MEDICAID PROGRAM'S PROVISION OF NURSING HOME SERVICES

The Florida Medicaid program is authorized by Chapter 409, F.S., and is implemented through administrative rules in Chapter 59-G, F.A.C. The state Medicaid program is administered by AHCA. Florida initiated its Medicaid program on January 1, 1970, to provide medical services to indigent people. The determination of recipient eligibility for Medicaid is administered by the Department of Children and Family Services, Economic Self-Sufficiency Services Office and the federal Social Security Administration, for certain categories of elderly and disabled individuals. The Medicaid program is funded through shared federal and state participation, with counties contributing funding to inpatient hospital and nursing home services. Matching federal funds are contingent upon the state's continued compliance with Title XIX of the Social Security Act, the federal Medicaid law, and regulations in Title 42 of the *Code of Federal Regulations*.

One group of services that the federal government requires state Medicaid programs to cover is nursing facility services. Over the years, the Florida Legislature has authorized Medicaid reimbursement for optional services, such as intermediate nursing home care, in addition to the mandatory services required by the federal government, such as skilled nursing care. The state's Medicaid budget for Fiscal Year (FY) 1996-1997 was $6.7 billion and for FY 1997-1998 is $6.9 billion. Medicaid pays for almost two-thirds of all patient days in nursing facilities. For nursing home facility fiscal years ending in calendar year 1995 (the most recent period for which these data are available), Medicaid paid for 64.5 percent, or 14,498,270 of 22,319,997 nursing home patient days (AHCA, *CON/Budget Review Office statistics*).

State General Revenue expenditures for reimbursement of nursing home services for FY 1996-1997 were $553,671,174. The federal participating match for state FY 1996-1997 was $706,611,961. The total Medicaid nursing home budget for FY 1996-1997 was $1,371,446,079. These expenditures reflect a relative proportion of 44.21 percent state funding and 55.79 percent federal funding. Of 2,849,561 unduplicated persons receiving at least one Medicaid-reimbursed service during FY 1996-1997, at least one nursing home service was received by 90,555 unduplicated persons. For FY 1996-1997, there were an average of 46,387 persons per month eligible for Medicaid-reimbursed nursing home services. Approximately 70 percent were eligible for intermediate care and approximately 30 percent qualified for skilled nursing care, including Medicare "cross-overs."

For FY 1997-1998, the Social Services Estimating Conference projects an average of 47,950 persons per month will be eligible for Medicaid-reimbursed nursing home services with projected caseloads of 67 percent eligible for intermediate care and 33 percent eligible for skilled nursing care, including Medicare "cross-overs." The total Medicaid nursing home budget for FY 1997-1998 is $1,419,074,539.

DEPARTMENT OF ELDERLY AFFAIRS

The Department of Elderly Affairs (department) was created in 1991. It is established in statute under s. 20.41, F.S. The department is designated as the state unit on aging, in compliance with the Older Americans Act, and is required to designate and contract with area agencies on aging in each of the department's planning and services areas. The area agencies on aging are required to ensure a coordinated and integrated provision of long-term care services to the elderly and are required to ensure the provision of prevention and early intervention services for the elderly. The department also contracts with the Medicaid program to administer the Comprehensive Assessment and Review for Long-Term Care Services (CARES) program, a screening process used for the determination of Medicaid recipient eligibility for nursing home care.

In March 1997, the federal Health Care Financing Administration approved a 1915(c) waiver of federal requirements under Medicaid for Florida to implement the Capitated Nursing Home Diversion Pilot Project. The Department of Elderly Affairs is the designated state agency responsible for implementation and administrative oversight of the project. The program will operate as a managed care, long-term-care system that will include existing Medicaid services with new “assisted living” services. It is designed to direct persons who qualify for nursing home care reimbursable under the Medicaid program to equivalent, but more cost-effective, alternative long-term-care options.

Those persons eligible to receive services reimbursed under the Medicare and Medicaid programs (“dually eligible”) comprise the project’s targeted population. The project will initially be operated in Palm Beach and Orange Counties. It is scheduled to begin operation January 1, 1998, with an anticipated average monthly caseload of 2,300 persons. Medicaid recipient enrollment is voluntary and access to the project will be managed through the CARES screening process. Under the pilot project, CARES will initiate screening during a Medicaid recipient's hospital stay, if the recipient is hospitalized, or at the earliest intervention point that can be identified prior to admission to a nursing home. The Social Services Estimating Conference has projected targeted savings under state Medicaid expenditures for FY 1997-1998 at $12,394,796.

THE NURSING HOME INDUSTRY IN FLORIDA

The State of Florida licenses nursing homes under part II of chapter 400, F.S. A nursing home license is valid for a period of one year. There are 665 nursing homes licensed to operate in the state with an aggregated total of 78,000 beds. The statewide nursing home occupancy rate ranges from 89% to 92%. Additionally, there are 65 hospital-based skilled nursing units that are comprised of beds licensed for delivery of skilled nursing services. (*AHCA, Division of Health Facility Regulation, Long-Term Care Office*). Florida has one of the lowest nursing home bed ratios in the country, which means that fewer nursing home beds are available to the population 65 years and older than in most other states.

Nursing homes are licensed to provide nursing care, personal care, or custodial care to three or more persons not related to the owner or manager by blood or marriage, for a period exceeding 24-hours. Such individuals may require nursing services because of illness, physical infirmity, or advanced age, but not because of illness of a degree that would necessitate acute care. Such care is more appropriately provided in a hospital setting. Generally, nursing homes provide rehabilitative services, subacute care

services, and services for Alzheimer's patients. Some of the usual diagnoses of nursing home residents include: musculoskeletal disorders, cerebrovascular accidents, respiratory disease, congestive heart failure, organic brain syndrome, and cancer. Additionally, subacute care services may be directed toward wound care, cardiac care, hip and knee replacement, and respiratory care.

B. EFFECT OF PROPOSED CHANGES:

Nursing home beds may become more readily available for Medicaid recipients and veterans. State veterans' nursing homes operated by the Department of Veterans Affairs with at least 50 percent of construction costs federally funded will avoid the CON process.

C. APPLICATION OF PRINCIPLES:

1. Less Government:

a. Does the bill create, increase or reduce, either directly or indirectly:

(1) any authority to make rules or adjudicate disputes?

No.

(2) any new responsibilities, obligations or work for other governmental or private organizations or individuals?

Yes, it creates a work group within the Agency for Health Care Administration to study the need for nursing home beds for Medicaid recipients.

(3) any entitlement to a government service or benefit?

No.

b. If an agency or program is eliminated or reduced:

(1) what responsibilities, costs and powers are passed on to another program, agency, level of government, or private entity?

N/A

(2) what is the cost of such responsibility at the new level/agency?

N/A

(3) how is the new agency accountable to the people governed?

N/A

2. Lower Taxes:

a. Does the bill increase anyone's taxes?

No.

b. Does the bill require or authorize an increase in any fees?

No.

c. Does the bill reduce total taxes, both rates and revenues?

No.

d. Does the bill reduce total fees, both rates and revenues?

No.

e. Does the bill authorize any fee or tax increase by any local government?

No.

3. Personal Responsibility:

a. Does the bill reduce or eliminate an entitlement to government services or subsidy?

No.

b. Do the beneficiaries of the legislation directly pay any portion of the cost of implementation and operation?

N/A

4. Individual Freedom:

a. Does the bill increase the allowable options of individuals or private organizations/associations to conduct their own affairs?

Yes, it provides for a limited deregulation from certificate of need for certain veterans nursing homes.

b. Does the bill prohibit, or create new government interference with, any presently lawful activity?

No.

5. Family Empowerment:

a. If the bill purports to provide services to families or children:

(1) Who evaluates the family's needs?

N/A

(2) Who makes the decisions?

N/A

(3) Are private alternatives permitted?

N/A

(4) Are families required to participate in a program?

N/A

(5) Are families penalized for not participating in a program?

N/A

b. Does the bill directly affect the legal rights and obligations between family members?

No.

c. If the bill creates or changes a program providing services to families or children, in which of the following does the bill vest control of the program, either through direct participation or appointment authority:

(1) parents and guardians?

N/A

(2) service providers?

N/A

(3) government employees/agencies?

N/A

D. STATUTE(S) AFFECTED:

Sections 400.071, 408.034, 408.036, and 408.040, F.S.

E. SECTION-BY-SECTION RESEARCH:

Section 1. Amends s. 400.071, F.S., relating to nursing home licensure applications, to delete language relating to the CON process along with language expressing legislative intent that AHCA give preference to CON applications that most closely meet the state's need for Medicaid beds.

Section 2. Amends s. 408.034, F.S., providing AHCA's duties and responsibilities relating to CON regulation and providing rulemaking authority, to make technical and conforming revisions.

Section 3. Amends s. 408.036, F.S., providing for CON regulation, to add to the list of health care services and projects that are exempt from CON review state veterans' nursing homes that are operated by or on behalf of the Florida Department of Veterans' Affairs when federal funding accounts for a minimum of 50 percent of the costs of construction of the facility and the federal government pays for one-half of the facility residents' care. The exempted nursing home beds are excluded from the CON nursing home bed inventory.

Section 4. Amends s. 408.040, F.S., relating to CON conditions and monitoring of CON conditions, to explicitly require AHCA to include on the CON a statement of the condition on which the CON is issued to a nursing home applicant (when the CON is issued upon reliance on the applicant's statements committing to provide a specified number of beds for use by Medicaid recipients). Additionally, AHCA is required to notify the Medicaid program and the Department of Elderly Affairs when it imposes Medicaid conditions on a CON in an area in which a community diversion pilot project is being implemented. Additionally, a holder of a CON is explicitly authorized to apply to AHCA for a modification of Medicaid conditions that have been imposed on its CON. Finally, technical and conforming revisions are made to existing language.

Section 5. Creates a nine-member interagency workgroup providing for participation of AHCA and the Department of Elderly Affairs along with private sector representation from the Florida Health Care Association, Florida Association of Homes for the Aging, and Florida Legal Services. The workgroup is placed under AHCA's jurisdiction for administrative purposes. Workgroup participants are made responsible for their own expenses, except that AHCA is responsible for expenses incidental to the production of the required interim and final reports. The workgroup must submit an interim report by December 31, 1998, and a final report by December 31, 1999, to the Governor, the

President of the Senate, and the Speaker of the House of Representatives. The workgroup is abolished effective January 1, 2000.

The workgroup is directed to study and monitor developments relating to: 1) ensuring that a sufficient supply of Medicaid-reimbursed nursing home beds are available for Medicaid recipients, 2) identifying alternatives to CON conditions as a means of securing nursing home beds for Medicaid recipients, and 3) recommending to the Medicaid program alternative approaches for obtaining nursing home beds for Medicaid recipients. Also, the workgroup is required to analyze the effect on the Medicaid nursing home bed supply of: 1) case-mix reimbursement, 2) selective contracting with nursing home providers, and 3) market changes brought on by managed care.

Section 6. Provides a July 1, 1998, effective date.

III. FISCAL RESEARCH & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

1. Non-recurring Effects:

None.

2. Recurring Effects:

None.

3. Long Run Effects Other Than Normal Growth:

None.

4. Total Revenues and Expenditures:

None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

1. Non-recurring Effects:

None.

2. Recurring Effects:

None.

3. Long Run Effects Other Than Normal Growth:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

1. Direct Private Sector Costs:

Private sector representatives on the workgroup will incur some costs for participating in the workgroup.

2. Direct Private Sector Benefits:

Veterans may have improved access to nursing home care.

3. Effects on Competition, Private Enterprise and Employment Markets:

None.

D. FISCAL COMMENTS:

The Department of Veterans' Affairs will be able to avoid some of the significant regulatory costs of CON review that are currently required when establishing nursing homes to serve the state's veteran population. The Department of Elderly Affairs and AHCA will incur some costs for the workgroup.

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

This bill does not require counties or municipalities to spend funds or to take an action requiring the expenditure of funds.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

This bill does not reduce the authority that municipalities or counties have to raise revenues.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

This bill does not reduce the percentage of a state tax shared with counties or municipalities.

V. COMMENTS:

None.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

None.

VII. SIGNATURES:

COMMITTEE ON HEALTH CARE SERVICES:

Prepared by:	Legislative Research Director:
Michael P. Hansen	Michael P. Hansen