

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/SB 2096

SPONSOR: Health, Aging, and Long-Term Care Committee and Senator Wasserman Schultz

SUBJECT: Nursing Homes

DATE: April 16, 2003 REVISED: _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	<u>Harkey</u>	<u>Wilson</u>	<u>HC</u>	<u>Favorable/CS</u>
2.	_____	_____	<u>AHS</u>	_____
3.	_____	_____	<u>AP</u>	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____

I. Summary:

The committee substitute requires the Agency for Health Care Administration to require all nursing homes to increase wages, benefits, or a combination thereof by an amount computed by multiplying one dollar by each hour worked by certain hourly staff. The increase in wages and benefits may be used to improve benefits or defray the cost to employees of benefits but it may not be used to defray the cost to facilities of existing benefits such as a premium increase. The increase is an allowable cost for Medicaid cost report purposes, but is not subject to interim rate provisions. Nursing homes that offer health insurance benefits to employees and their families and pay at least 80 percent of the total premium cost are exempt from the provisions of the bill. The Agency for Health Care Administration must monitor nursing homes' compliance with the provisions of the bill. This is a one-time increase that may not be rescinded by the nursing home.

This bill creates an undesignated section of law.

II. Present Situation:

Medicaid

Medicaid is a medical assistance program that pays for health care for the poor and disabled. The federal government, the state, and the counties jointly fund the program. The federal government, through law and regulations, has established extensive requirements for the Medicaid Program. The Agency for Health Care Administration (AHCA or agency) is the single state agency responsible for the Florida Medicaid Program. The Department of Children and Family Services is responsible for determining Medicaid eligibility and managing Medicaid eligibility policy, with approval of any changes by AHCA.

The statutory provisions for the Medicaid Program appear in ss. 409.901 through 409.9205, F.S. Section 409.903, F.S., specifies categories of individuals who are required by federal law to be covered, if determined eligible, by the Medicaid Program (mandatory coverage groups). Section 409.904, F.S., specifies categories of individuals who the federal government gives state Medicaid programs the choice of covering (optional coverage groups). Sections 409.905 and 409.906, F.S., specify the medical and other services the state may provide under the state Medicaid plan.

Nursing facility services are reimbursable under the Medicaid Program. Approximately 650 nursing homes participate in the Florida Medicaid Program. These facilities have nearly 80,000 beds and provide more than 25 million bed-days of care. Medicaid funds approximately 65 percent of resident days in Florida nursing homes.

The nursing home component of the FY 2002-03 Medicaid budget is \$2,167,700,000, with the state share being \$893,300,000 and the federal share being \$1,274,400,000. The estimated Medicaid nursing home caseload for FY 2002-03 is 47,007 cases. Medicaid nursing home expenditures have increased by 174 percent from FY 1990-91 to FY 2002-03. The Medicaid nursing home caseload increased by 21 percent from FY 1990-91 to FY 2002-03. The Medicaid nursing home average annual cost per person has increased by 126 percent from FY 1990-91 to FY 2002-03.

Medicaid Nursing Home Reimbursement

Nursing homes that participate in the Florida Medicaid Program are reimbursed in accordance with The Florida Title XIX Long-Term Care Reimbursement Plan (the Plan). The Plan is incorporated by reference into Chapter 59G of the Florida Administrative Code (FAC) and details the methods and standards by which facilities are reimbursed.

The Plan is often referred to as a cost based prospective reimbursement plan. It is cost based because it utilizes historical data from cost reports to establish reimbursement rates. The Plan is prospective because it adjusts historical costs for inflation in establishing reimbursement rates for subsequent rate semesters.

Each nursing home is required to submit an annual cost report to the agency. Cost reports are due within three calendar months after the end of the facility's cost reporting period. The data within these cost reports are then used to establish reimbursement (per diem) rates in accordance with the Plan.

Per diem rates are established for each facility twice a year, every January 1 and July 1, based on the latest cost reports received by September 30 and March 31, respectively. The January 1 – June 30 and July 1 – December 31 periods are referred to as rate periods or rate semesters. Each semester, a single per diem rate is established for each facility that is paid for all Medicaid patient days.

Nursing home per diem rates are facility specific and are an aggregate of four components:

- operating,

- patient care (which is the sum of direct and indirect patient care subcomponents),
- property, and
- return on equity for money invested and used in providing patient care.

The operating component includes administration, laundry and linen, plant operations, and house keeping expenses. It may also include Medicaid bad debt expenses. The patient care component includes nursing, dietary, other patient care (e.g., social services and medical records) and ancillary expenses. The property component includes interest, depreciation, insurance, property taxes and equipment rental expenses. The return on equity component is a calculation based on the equity in the facility. Each of these components is calculated independently and is then combined to determine the per diem rate.

Wages and benefits, as reported in a nursing home's annual cost report, are reimbursed in the per diem through the appropriate cost center. Wages and benefits of direct care (those employees providing the "hands-on" care) are reimbursed in the direct patient care component of the per diem. The wages and benefits of patient care staff not providing the direct care are reimbursed in the indirect patient care component. The wages and benefits of all other staff employed at the nursing facility are reimbursed through the operating component of the rate.

Operating, patient care and cost-based property components are subject to limits on the maximum amount a provider can receive for the component, regardless of actual cost. These limits are called reimbursement ceilings.

Nursing homes are divided into six classes in determining these ceilings. The classes are based upon size (1-100 beds = small, or over 100 beds = large), and location (North, South, or Central) of the facility within the state.

The operating and patient care cost-based class ceilings are calculated using inflated operating and patient care per diems for the current semester. The cost-based class ceilings for the central class is the simple average of the north and south cost-based ceilings. The operating cost-based class ceilings are based on the statewide operating median plus one (1) standard deviation adjusted for the relationship of the class median to the statewide median. The patient care cost-based class ceilings are based on the statewide patient care median plus a 1.75 standard deviation adjusted for the relationship of the class median to the statewide median.

Effective January 1, 1988, a nursing home target rate system was implemented that limits the rate of increase in operating and patient care per diem rates from one rate semester to the next. Target rates are set for class ceilings and the operating and patient care components for each facility. Targets are inflated from one semester to the next by the target rate of inflation, which is 1.4 times the rate of inflation. Inflation is based on Standard & Poor's DRI Nursing Home Market Basket Index published in the Health Care Cost Review. The DRI is a nationally recognized Health Care Market Basket Index.

Facility-specific new provider limitations are placed on the operating and patient care components for new facilities and facilities that undergo a change of ownership. The limit for new facilities is the average operating and patient care per diem in the district in which the facility is located plus 50 percent of the difference between the average district per diem and the

facility class ceiling. For providers with no cost history resulting from a change of ownership or operator, where the previous provider participated in the Medicaid program, the limit is the previous providers' operating and patient care cost per diem, plus 50 percent of the difference between the previous providers' per diem and the class ceiling. These limitations are also increased by the target rate of inflation each semester.

The nursing home operating and patient care cost per diem paid is the lower of the following,

- cost based class ceiling,
- target rate class ceiling,
- facility specific rate,
- facility specific target rate, or
- facility specific new provider limitation.

As of January 1, 2003, 75 percent of the nursing homes report receiving a payment for their operating cost component that is below their allowed costs. According to the nursing home industry, the average shortfall is \$6.74 per day.

Direct Care Staffing Adjustment

A direct care staffing adjustment was implemented April 1, 2000, as an adjustment to each nursing home's patient care component. The adjustment was intended to assist nursing homes to recruit and retain direct care staff (RNs, LPNs, and CNAs) based on research that suggested a correlation between quality of care and low staff turnover, and adequate staffing ratios. The annualized budget was \$31.7 million dollars. The legislation directed that nursing homes with the poorer staffing ratio would receive a higher adjustment or "add-on" than those homes that had a higher staffing ratio. According to AHCA, as of April 1, 2000, the increase ranged from fifty cents to \$2.81 per Medicaid patient day. The average was \$1.96.

Direct and indirect Patient Care Reimbursement

In CS/CS/CS for Senate Bill 1202, the 2001 Legislature required the agency to amend the long-term care reimbursement plan to create direct care and indirect care subcomponents of the patient care component of the nursing home per diem rate. The direct care subcomponent is to include salaries and benefits of direct care staff, including nurses and CNAs who deliver care to residents. The agency was directed to adjust the patient care component effective January 1, 2002, using funds previously allocated for the case mix add-on. The agency is to report average direct and indirect care costs per resident and per category of staff member to the Legislature by July 1 of each year.

III. Effect of Proposed Changes:

The committee substitute requires the Agency for Health Care Administration to require all nursing homes to increase wages, benefits, or a combination thereof by an amount computed by multiplying one dollar by each hour worked by all hourly staff, including leased staff. The required increase in wages or benefits does not apply to the licensee, the manager, the administrator, the medical director, the physicians, or the pharmacists serving the facility. The

increase in wages and benefits may be used to improve benefits or defray the cost to employees of benefits but it may not be used to defray the cost to facilities of existing benefits such as a premium increase. Nursing homes that offer health insurance benefits to employees and their families and pay at least 80 percent of the total premium cost are exempt from the provisions of the bill.

The increase in wages or benefits will be an allowable cost for Medicaid cost reporting purposes but will not be subject to the interim rate provisions of the Title XIX Long-Term Care Reimbursement Plan.

The Agency for Health Care Administration must develop systems for applying the wages or benefit increases. The increase in wages, benefits, or a combination thereof will be computed by comparing the total of those wages and benefits with the total wages and benefits paid during July 1, 2002 through June 30, 2003. AHCA must monitor nursing homes' compliance with the provisions of the bill. This is a one-time increase that may not be rescinded by the nursing home.

The effective date of the bill is July 1, 2003.

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 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:

Medicaid only reimburses for Medicaid-allowable costs. Increased salary and benefit costs would be applied to an individual staff person, who in all likelihood will be providing care to residents whose care is reimbursed by a variety of payers. Medicaid would, however, only reimburse that portion of the costs which were attributable to

Medicaid-funded residents. Increases in salaries and benefits would also affect prices which would be paid by other payers, including individuals and their families.

Higher wages and benefits would assist in attracting and/or retaining high quality employees.

C. Government Sector Impact:

The bill provides that the increases in wages, benefits, or a combination thereof are an allowable cost for Medicaid cost reporting purposes but are not subject to the interim rate provisions of the Title XIX Long-Term Care Reimbursement Plan. Over time, as the reported costs increased, there would be an increase in Medicaid costs.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Amendments:

None.

This Senate staff analysis does not reflect the intent or official position of the bill's sponsor or the Florida Senate.
