# HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** HB 1843 Health Care
**SPONSOR(S):** Appropriations and Green
**TIED BILLS:** **IDEN./SIM. BILLS:** SB 1276

| REFERENCE | ACTION | ANALYST | STAFF DIRECTOR |
|---|---|---|---|
| 1) Appropriations | 31 Y, 3 N | Speir | Baker |
| 2) | | | |
| 3) | | | |
| 4) | | | |
| 5) | | | |

## SUMMARY ANALYSIS

House Bill 1843 makes a number of changes to the Medicaid Program, which are necessary to implement the Medicaid funding decisions included in the House Bill 1835 (General Appropriations Act). Specifically, the bill does the following:

- Delays implementation of a nursing home 2.9 hour staffing increase until July 1, 2004.
- Changes KidCare's redetermination review period from 6 to 12 months after January 1, 2005.
- Establishes a hospitalist program.
- Eliminates payment of bed hold days for nursing homes with occupancy rates below 90 percent and eliminates payment of vacancy interim rates for Intermediate Care Facilities for the Developmentally Disabled (ICF/DD).
- Implements utilization management for private duty nursing services and home and community based services.
- Provides adult dental, vision and hearing benefits effective January 1, 2005.
- Consolidates the menus of various home and community based services waivers.
- Mandates payment method for county health departments providing clinic services.
- Authorizes the convening of the Medicaid Disproportionate Share Task Force.
- Grants AHCA the authority to perform provider network management.
- Implements a behavioral health prescribed drug management system.
- Expands the minimum supplemental rebate from 25 percent to 27 percent.
- Limits payment of certain drugs to one dose per month.
- Requires selection of managed care plan at time of Medicaid application.
- Changes the billing process for county nursing home contributions.
- Changes definition of "deductions of revenue" for the Public Medical Assistance Trust Fund.
- Allows Medicaid HMOs to provide behavioral health services to their recipients.

## FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

A. DOES THE BILL:

| | | | |
|---|---|---|---|
| 1. Reduce government? | Yes[] | No[] | N/A[X] |
| 2. Lower taxes? | Yes[] | No[] | N/A[X] |
| 3. Expand individual freedom? | Yes[] | No[] | N/A[X] |
| 4. Increase personal responsibility? | Yes[] | No[] | N/A[X] |
| 5. Empower families? | Yes[] | No[] | N/A[X] |

For any principle that received a "no" above, please explain:

B. EFFECT OF PROPOSED CHANGES:

**Nursing Home Staffing Increase**

In 2000, the Legislature created the Task Force on Availability and Affordability of Long-Term Care to evaluate issues related to quality care, liability insurance, and reimbursement in long-term care. The task force heard public testimony and research findings in its deliberations; although consensus was not reached, recommendations were drafted as a staff report of information discussed by and presented to the task force. Much of the staff report served as a basis for chapter 2001-45, Laws of Florida. The legislation had a multi-prong approach incorporating reforms in tort liability, quality of care and enforcement, and corresponding reimbursement. Adequacy of staffing was central to the quality reforms.

In recognition of the fact that the majority of nursing home care is paid by Medicaid, the Legislature agreed that staffing increases should be supported by an additional Medicaid appropriation to pay for the additional staff required. It was also understood that to obtain a desired level of 2.9 certified nursing assistant hours per resident per day would require additional staff recruitment efforts. Therefore, a gradual increase to 2.9 was enacted in section 400.23, Florida Statutes, specifying the nursing assistant ratio increases to 2.3 effective January 1, 2002; 2.6 effective January 1, 2003; and 2.9 effective January 1, 2004. Additional Medicaid funding for reimbursement of the increased staffing was authorized for each year. Staffing was also enhanced by increased training and documentation requirements in nursing homes.

The Legislature delayed the effective date of the nursing assistant ratio to 2.9 hours until May 1, 2004 in chapter 2003-347, Laws of Florida—the General Appropriations Act. House Bill 1843 further delays the effective date of the increase until July 1, 2004.

The industry is concerned about finding enough qualified individuals to hire as certified nursing assistants. The advocates for the elderly are concerned that recent improvements in quality of care will suffer if this delay is implemented.

**KidCare Redetermination**

The KidCare program currently has a passive redetermination process. Every 6 months the Florida Healthy Kids Corporation sends notices to families requesting them to update their eligibility (income) status, if it has changed. If it has not changed, then the family is not required to respond.

Chapter 2004-1, L.O.F., requires families to provide written documentation of their income status, as well as their children's access to employer sponsored health insurance during redetermination. There is concern based on a federal study that the proactive redetermination will cause some children to lose coverage when their parents fail to file the necessary documentation. House Bill1843 amends the redetermination period from once every 6 months to once every 12 months effective January 1, 2005.

**Deduction of Hospital Revenue**
Florida law requires each hospital to pay assessment equal to 1.5 percent of the hospital's annual net operating revenue for inpatient services. The funds collected by this assessment are deposited into the Public Medical Assistance Trust Fund (PMATF).

The Agency for Health Care Administration (AHCA) has learned that many hospitals do not account for special Medicaid payments as part of their inpatient revenue, which is subject to the PMATF assessment. House Bill 1843 amends the definition of "deductions from revenue" to direct that items deducted from gross revenue shall be reduced by the amounts received for special Medicaid payments and disproportionate share payments. This means that hospitals' PMATF assessment will be higher.

**Hospitalist Program**
Hospitalists are physicians who specialize in managing the care and length of stay of a hospitalized patient while that person is a patient in the hospital. Studies show that hospitalist programs improve and streamline patient care. They reduce the average length of stay as a result of immediate intervention regarding patient status changes. This leads to improved care at a lower cost. Most commercial health insurance companies and health maintenance organizations use hospitalist programs to lower costs per admission by improving quality of care and shortening lengths of stay.

House Bill 1843 directs AHCA to implement a hospitalist program in certain high volume Medicaid participating hospitals with hospitalists managing all aspects of the Medicaid recipients' hospital treatment. Medicaid participating physicians and other practitioners with hospital admitting privileges shall coordinate and review admissions of Medicaid recipients with the hospitalist. Where used, the hospitalist program will replace the existing hospital utilization review program.

**Home and Community Based Services**
Home and community based services (HCBS) waivers are administered by four state agencies, and each program has its own system for determining the services participants will receive. The waivers include:

- Adult Cystic Fibrosis Waiver,
- Aged/Disabled Waiver,
- Assisted Living for the Elderly Waiver,
- Channeling Waiver,
- Comprehensive Adult Day Health Care Waiver,
- Developmental Services Waiver,
- Model Waiver,
- Project Aids Care Waiver,
- Supported Living Waiver, and
- Traumatic Brain Injury/Spinal Cord Injury Waiver.

There are at least 30 waiver services available to waiver participants ranging from home delivered meals to emergency alert response installation. This often results in individuals with the same level of need receiving widely different care plans.

House Bill 1843 authorizes AHCA to consolidate the menu of services in HCBS and to implement utilization review and prior authorization to manage services for the Aged/Disabled Adult Waiver, the Model Waiver, the Supported Living Waiver, and the Traumatic Brain Injury/Spinal Cord Injury Waiver. The utilization review and prior authorization program will ensure that the needs of beneficiaries are assessed using standard criteria and that individuals with similar needs will receive similar levels of services.

**Bed Hold Days**
AHCA currently pays to reserve beds for Medicaid recipients residing in nursing homes, private intermediate care facilities for the developmentally disabled (ICF/DD), and in hospice facilities if the residents require hospitalization or therapeutic leave. The bed-hold payment ensures that Medicaid

residents will be assured of a bed when they return from hospitalization or therapeutic leave. Nursing facilities must have at least an 80 percent Medicaid occupancy rate in the previous quarter of the year to be eligible for bed-hold payments. There is not an occupancy rate requirement for private ICF/DDs. The average nursing home occupancy rate is about 87 percent; the average occupancy rate for private ICF/DDs is about 97 percent.

For each hospital stay, AHCA may reserve a bed in a nursing home up to 8 days and in an ICF/DD up to 15 days. AHCA will also pay to reserve the bed if the recipient leaves the facility to go to a "family type setting." This payment is limited to 16 days for each fiscal year for nursing home residents and 45 days for ICF/DD residents.

House Bill 1843 will eliminate the vacancy interim rate for ICF/DDs while paying nursing home bed hold days to facilities only with occupancy rates of 90 percent or greater.

**Adult Dental, Vision and Hearing**

The Adult Dental, Visual and Hearing services program was eliminated, effective July 1, 2002 , in the 2001 Special Session 'C" (Chapter 2001-377, Laws of Florida). The 2002 Legislature restored the hearing and vision services with nonrecurring funds prior to the elimination of the services on July 1, 2002, and funded emergency dental services for adults. The 2003 Legislature did not restore the funding for the adult vision and hearing services so that they were eliminated effective July 1, 2003. Emergency dental services continue to be covered by Medicaid.

House Bill 1843 would restore adult dental, vision and hearing services effective January 1, 2005. Medicaid would cover adult dental services rendered by licensed, Medicaid participating dentists. Medicaid-reimbursable adult dental services would be provided to recipients age 21 and older. Services would include diagnostic examinations for denture services; radiographs necessary for dentures; extractions and other surgical procedures essential to the preparation of the mouth for dentures; oral prophylaxis; and emergency extractions and abscess treatment to alleviate pain or infection.

Medicaid hearing services would be rendered by licensed, Medicaid participating otolaryngologists, otologists, audiologists, and hearing aid specialists. Hearing services will include cochlear implants, diagnostic testing, hearing aids, hearing aid evaluations, hearing aid fitting and dispensing, and hearing aid repairs and accessories.

Medicaid would also cover visual services rendered by licensed, Medicaid participating ophthalmologists, optometrists, and opticians. Medicaid vision services include eyeglasses, eyeglass repairs and prosthetic eyes and contact lenses.

**Recurring Proviso**

Some provisions have been in proviso language in the General Appropriations Act for the past several years. Recurring proviso requires AHCA to reimburse county health department services at a rate per visit based on total reasonable costs of the clinic. Subsection (19) of section 409.908, Florida Statutes, leaves the method of reimbursement for these services to the agency's discretion.

Recurring proviso also directs AHCA to work with the Department of Children and Family Services to develop a targeted case management program for children whose parents have a history of substance abuse, mental illness, post-partum depression, or domestic violence problems. These are children who are determined to be having, or at-risk of having, significant behavioral and/or performance problems in the home, school or community; who are siblings of a child in state custody; or who are refused entry into their home by their parents.

The Medicaid Disproportionate Share Task Force is given its powers and duties in recurring proviso. The Medicaid Disproportionate Task Force is directed to meet yearly to monitor the special Medicaid payment program and to review the federal Upper Payment Limit (UPL) funding option. The Medicaid Disproportionate Share Task Force is to make recommendations to the Legislature and the Governor on

how the state may use the UPL to promote local primary care networks to uninsured citizens in the state, to increase the accessibility of trauma centers to Floridians, and to ensure the financial viability of the state's graduate medical education programs.

Finally, every year AHCA is authorized in proviso language to contract for drug rebate administration. This recurring proviso language allows AHCA to contract with a third party to handle the numerous tasks necessary to administer the rebate agreements that result in the state receiving federal and supplemental rebates on the prescription drugs the state purchases for its Medicaid recipients. The tasks include calculating the rebate amounts, invoicing the manufacturers and maintaining a database of rebate collections.

House Bill 1843 permanently codifies these provisions in the Florida statutes to address recurring proviso in the Agency for Health Care budget related to the payment for county health department clinic services, development of a targeted case management program for at-risk children, the Medicaid Disproportionate Task Force, and drug rebate administration.

**Provider Network Management**

Currently, AHCA contracts with any willing provider for its fee-for-service system. This means if a provider is licensed and in good standing, a provider may enroll in the Medicaid program. There are currently more than 80,000 providers enrolled in Medicaid.

As a result, AHCA may have many more providers for any particular provider type than is needed to serve the current Medicaid beneficiary population. AHCA expends considerable resources enrolling and monitoring health care providers. One outcome of such a large provider network is that it is difficult for Medicaid to ensure that all providers are operating properly and not committing fraud or abuse.

House Bill 1843 allows AHCA to abandon the "any willing provider" provision and replace it with a new provider network policy that limits the number of fee-for-service providers allowed to serve Medicaid recipients. AHCA would contract with a limited number of fee-for-service providers based on credentialing such as the type used by commercial insurers. Credentialing involves a close review of the provider's participation in other payer networks, licensure history, program integrity history, and references. AHCA would also be allowed to use competitive bidding to build networks.

**Prescription Drugs Rebates**

Federal law currently requires prescription drug manufacturers to pay a rebate on all drugs sold to Medicaid recipients. Florida's Medicaid program requires a supplemental rebate from manufacturers for their drugs to be placed on the Florida Medicaid program's preferred drug list. The combined federal and supplemental rebate must be greater than or equal to 25 percent of the average manufacturer's price. Approximately 40 manufacturers participate in the Florida Medicaid state supplemental rebate program, providing varying amounts of supplemental rebates with a total value of about $70 million annually. Manufacturer revenues from the Florida Medicaid program will represent more than $2.7 billion in FY 2004-2005.

Federal Medicaid regulations also require states to offer the products of manufacturers that enter into federal rebate agreements with the Department of Health and Human Services. This requirement means that Florida Medicaid must cover the products of manufacturers that produce prescribed drugs to treat erectile dysfunction if that manufacturer has entered into a federal rebate agreement. Currently, Florida Medicaid limits coverage of erectile dysfunction prescription drugs to four doses monthly. Many states limit the coverage of these prescribed drugs to one dose per month.

In addition, Florida law grants AHCA the discretion to receive other program benefits as a form of supplemental rebate. Four companies—Pfizer, Astra-Zenaca, Glaxo Smith-Kline, and Bristol-Myers Squibb—have entered value-added agreements with AHCA in lieu of cash rebates as a form of supplemental rebate. The Office of Program Policy Analysis and Government Accountability (OPPAGA)

Report No. 03-27 indicated that the state would save more than $80 million if these value-added contracts were terminated and the drugs from these four manufacturers were placed on the preferred drug list.

House Bill 1843 would increase the minimum combined federal and supplemental rebate from 25 percent to a minimum of 27 percent of the average manufacturer price. The increase would save the state $4.3 million in state funds or $10.6 million in total funds. House Bill 1843 also eliminates value-added agreements and limits the coverage of prescribed drugs to treat erectile dysfunction to one dose per month.

**Behavioral Health**

Florida law exempts behavioral health drugs from the four-brand drug limit and the preferred drug list. The exemption means there is no prohibition on cost or utilization. The exemption also makes it impossible for the Florida Medicaid program to secure supplemental rebates for behavioral health drugs. Spending for mental health drugs was nearly $440 million in FY 2003-204 and is the fastest growing component of the drug program. Mental health costs have increased by 35 percent each of the last two fiscal years compared to 11 percent for all other drug categories.

House Bill 1843 directs AHCA to implement a behavioral pharmacy management system. This system would retroactively review paid claims for prescribed drugs and examine prescribing practices to educate physicians about best practice prescribing guidelines for the recipient based on medical standards. Examples of the review includes concurrent prescriptions for two or more antipsychotic medications to the same patient; excess dosing, as well as prescribed dosages below recognized therapeutic levels; concurrent prescriptions for three or more behavioral drugs to children; concurrent multiple prescribers for patients who receive antipsychotic medications; and failure of high-risk patients to fill antipsychotic prescriptions in a timely fashion.

The 2003 Legislature enacted chapter 2003-279, Laws of Florida, to allow for the use of managed care principles in the provision of behavioral health services for Medicaid recipients. AHCA has not implemented the changes in statute and requested an opinion from the Attorney General. The uncertainty involves whether Medicaid recipients enrolled in Medicaid health maintenance organizations (HMO) may receive their behavioral health services through the HMO or through a capitated behavioral health plan. House Bill 1843 directs that HMO enrollees may have their HMO provide their behavioral health services.

**Medicaid Enrollment**

Currently, Medicaid beneficiaries are provided care through the fee-for-service system for the period between their eligibility start date and their managed care plan enrollment date, which is usually between 60 and 90 days. Fee-for-service is more expensive for the Medicaid program than managed care.

House Bill 1843 would require Medicaid beneficiaries to choose a managed care plan (e.g., HMO or MediPass) at the time of their application. If the individual is determined to be eligible for Medicaid coverage, their enrollment in managed care will coincide with the effective date of their Medicaid eligibility, and thus, the more expensive fee-for-service coverage will not be needed. Recipients will be able to change their managed care choice during the first 90 days of their coverage.

**Billing Process for County Contributions to Nursing Home Care**

OPPAGA suggested in Report No. 03-11 that the Legislature should consider modifying the current cumbersome Medicaid nursing home billing process for county contributions, which relies on establishing county residency. This leads to disputes between the counties, the Department of Children and Family Services and AHCA if the resident's address is a post office box or the information on the application for Medicaid eligibility is incorrect. The counties do not pay for unresolved disputes, and the state must absorb the cost. The OPPAGA report stated that unpaid billings from all counties totaled $4.3 million, or 12.9% of the total $32.8 million billed to counties in Fiscal Year 2001-02.

OPPAGA suggested rescinding the residency requirement and offered three other options—allocate costs based on current percentages; base county contributions on the number of nursing home beds in the county; or base county contributions on the risk of nursing home placement.

House Bill 1843 requires that each county's share be based on each county's current percentage of the total county contribution, which is based on a cap of $55 per month per person. This eliminates the cumbersome billing process and reduces administrative costs for both the counties and AHCA. House Bill 1843 also requires OPPAGA to review the process every five years beginning in 2009 and make recommendations to the Legislature if the current percentages need adjustment.

**Medicaid Super Waiver**
House Bill 1843 gives AHCA the ability to seek the federal waivers necessary to implement Medicaid reform. The goal is for AHCA to seek a waiver that will allow Florida to make fundamental changes to the state Medicaid program in a way that will increase the number of individuals with health insurance coverage within current-level Medicaid and State Children's Health Insurance Program resources.

C. SECTION DIRECTORY:

**Section 1.** Amends s. 395.701, F.S., to change the definition of "deductions from revenue" to reduce items deducted from gross revenue by the amount received in special Medicaid payments and disproportionate share payments.

**Section 2**. Amends s. 400.23, F.S., delaying until July 1, 2004, the requirement that nursing homes provide 2.9 hours of direct care per resident from a certified nursing assistant.

**Section 3.** Amends s. 409.908, F.S., changing the definition of "deductions from gross revenue" to reduce items deducted from gross revenue by the amount received in special Medicaid payments and disproportionate share payments.

**Section 4.** Amends s. 409.814 F.S., changing the redetermination period for the KidCare program from every 6 months to every 12 months.

**Section 5.** Amends s. 409.905, F.S., implementing a hospitalist program, implementing a utilization management program for private duty nursing, and eliminating payment of nursing home bed hold days for nursing homes with less than a 90 percent occupancy rate.

**Section 6.** Amends s. 409.906, F.S., placing recurring targeted cased management proviso into statute, consolidating home and community based service programs, implementing utilization management of home and community based service programs, and eliminating payment of vacancy interim rates for intermediate care facilities.

**Section 7.** Amends s. 409.908, F.S., requiring AHCA to reimburse county health departments per visit based on total reasonable costs of the clinic.

**Section 8.** Amends s. 409.911, F.S., authorizing the Medicaid Disproportionate Share Task Force to convene each fiscal year for the purpose of monitoring the implementation of enhanced Medicaid funding through the special Medicaid payment program.

**Section 9.** Amends s. 409.912, F.S., implementing provider network management; allowing Medicaid HMOs to provide comprehensive behavioral health care services to its enrollees; increasing the minimum supplemental rebate; eliminating the value-added program; limiting erectile dysfunction drugs to one dose a month; implementing a behavioral pharmacy management system, and authorizing AHCA to contract for drug rebate administration.

**Section 10.** Amends s. 409.9122, F.S., requiring the enrollment of Medicaid recipients in managed care on the effective date of their enrollment.

**Section 11.** Amends s. 409.915, Florida Statutes, to base each county's nursing home contribution on its percentage of the total county contribution for Fiscal Year 2003-2004.

**Section 12.** Allows AHCA to apply for a Medicaid waiver to implement Medicaid reform.

**Section 13.** Provides an effective date.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   N/A

2. Expenditures:

| | *FY 2004-05* | *FY 2005-06* |
|---|---|---|
| *Billing Process for County Contributions to Nursing Home Care* | | |
| General Revenue Fund | ($49,105) | ($49,105) |
| Administrative Trust Fund | ($49,106) | ($49,106) |
| Total Funds | $98,211 | $98,211 |
| *Eliminate Value Added Contracts* | | |
| General Revenue Fund | ($30,000,000) | ($30,000,000) |
| Medical Care Trust Fund | ($42,992,701) | ($42,992,701) |
| Total Funds | ($72,992,701) | ($72,992,701) |
| *Limit Lifestyle Drugs* | | |
| General Revenue Fund | ($1,604,726) | ($1,604,726) |
| Medical Care Trust Fund | ($2,299,717) | ($2,299,717) |
| Total Funds | ($3,904,443) | ($3,904,443) |
| *Management of Behavioral Health Prescribed Drugs* | | |
| General Revenue Fund | ($13,900,000) | ($13,900,000) |
| Medical Care Trust Fund | ($19,919,951) | ($19,919,951) |
| Total Funds | ($33,819,951) | ($33,819,951) |
| *Eliminate Nursing Home and ICF/DD Bed Hold Days* | | |
| General Revenue Fund | ($2,690,390) | ($2,690,390) |
| Medical Care Trust Fund | ($3,855,571) | ($3,855,571) |
| Total Funds | ($6,545,961) | ($6,545,961) |
| *Expand Supplemental Drug Rebate* | | |
| General Revenue Fund | ($4,378,336) | ($4,378,336) |
| Grants & Donations Trust Fund | $10,652,886 | $10,652,886 |
| Medical Care Trust Fund | ($6,274,550) | ($6,274,550) |
| Total Funds | $0 | $0 |

| | FY 2004-05 | FY 2005-06 |
|---|---|---|
| *Managed Care Enrollment Date* | | |
| General Revenue Fund | ($2,205,837) | ($2,205,837) |
| Medical Care Trust Fund | ($3,161,165) | ($3,161,165) |
| Total Funds | ($5,367,002) | ($5,367,002) |
| *Home and Community Based Services Utilization Review/Prior Authorization* | | |
| General Revenue Fund | ($721,287) | ($721,287) |
| Medical Care Trust Fund | ($6,490,732) | ($6,490,732) |
| Total Funds | ($7,212,019) | ($7,212,019) |
| *Utilization Management of Private Duty Nursing* | | |
| General Revenue Fund | ($3,370,215) | ($3,370,215) |
| Medical Care Trust Fund | ($4,829,821) | ($4,829,821) |
| Total Funds | ($8,200,036) | ($8,200,036) |
| *Consolidate Menu of Home and Community Based Services* | | |
| General Revenue Fund | ($721,287) | ($721,287) |
| Medical Care Trust Fund | ($6,136,681) | ($6,136,681) |
| Total Funds | ($6,857,968) | ($6,857,968) |
| *Establish Hospitalist Program* | | |
| General Revenue Fund | ($1,288,424) | ($1,288,424) |
| Medical Care Trust Fund | ($1,846,428) | ($1,846,428) |
| Total Funds | ($3,134,852) | ($3,134,852) |
| *Freeze ICF/DD Reimbursement Rates* | | |
| General Revenue Fund | ($1,967,868) | ($1,967,868) |
| Medical Care Trust Fund | ($2,820,132) | ($2,820,132) |
| Total Funds | ($4,788,000) | ($4,788,000) |
| *Adult Dental, Vision and Hearing Services* | | |
| General Revenue Fund | $7,163,298 | $14,326,596 |
| Medical Care Trust Fund | $10,265,652 | $20,531,303 |
| Refugee Assistance Trust Fund | $287,389 | $574,778 |
| | $17,716,339 | $35,432,677 |
| *Provider Network Management* | | |
| General Revenue Fund | ($10,775,000) | ($10,775,000) |
| Medical Care Trust Fund | ($15,441,545) | ($15,441,545) |
| Total Funds | ($25,216,545) | ($25,216,545) |

Nonrecurring Expenditures

| | |
|---|---|
| *Delay of nursing home staffing increase* | |
| General Revenue Fund | ($4,285,223) |
| Medical Care Trust Fund | ($6,141,110) |
| Total Funds | ($10,426,333) |

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None

2. Expenditures:

The change in the billing process for county contributions to nursing homes will result in the counties paying the previously disputed and unpaid contributions, but it does not increase the $55 per resident per day contribution.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

There are new fiscal consequences for the private sector. The savings achieved for some services will mean less money for some providers—hospitals, nursing homes, pharmacies, pharmaceutical manufacturers, private intermediate care facilities for the developmentally disabled, and others—while overall increased spending will mean increased payments.

Hospitals' assessments, which contribute revenue to the Public Medical Assistance Trust Fund, will be greater.

D. FISCAL COMMENTS:

None

## III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require municipalities or counties to spend funds or to take an action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenues.

2. Other:

None

B. RULE-MAKING AUTHORITY:

The Agency for Health Care Administration has sufficient rulemaking authority to carry out the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None

## IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES