The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Health and Human Services Appropriations Committee

BILL: CS/SB 1852

INTRODUCER: Committee on Health and Human Services Appropriations and Senator Peaden

SUBJECT: Health Care

DATE: March 3, 2008 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Dull	Peters	HA	**Fav/CS**
2.				
3.				
4.				
5.				
6.				

Please see Section VIII. for Additional Information:

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

I. Summary:

The bill eliminates automatic price level increases, which would otherwise be included in the Medicaid budget adjustments for Fiscal Year 2008-09. The bill requires the Agency for Health Care Administration to limit Medicaid reimbursement in an amount necessary so that the statewide weighted average rate equals the statewide average rate from the preceding rate semester beginning July 1, 2008, for the following providers: inpatient hospitals, outpatient hospitals, nursing homes, county health departments and community intermediate care facilities for the developmentally disabled; and to apply the effect of the reductions to the reimbursement rates for prepaid health plans and nursing home diversion providers.

This bill amends section 409.908, Florida Statutes.

II. Present Situation:

Section 409.908 of the Florida Statutes requires the Agency for Health Care Administration to incorporate into rule, the methodologies that are used to reimburse Medicaid providers in accordance with state and federal law.

Hospital Inpatient Services Reimbursement
Medicaid reimburses for inpatient hospital services prospectively based on cost-reported, per diem rates that are subject to caps. Teaching, specialty, and community health education hospitals and other qualifying hospitals are exempted from the caps contingent upon counties contributing to the state's share of the cost of the exemption.

To calculate the reimbursement rate, the agency requires each provider to submit an annual report of its prior year Medicaid costs ("a cost report"). Utilizing this information, the agency then calculates the providers average daily cost of services provided to Medicaid recipients for the reported year. The costs are inflated using a nationally published medical inflation factor to adjust the providers historical average cost into an amount that can be used to reimburse the provider for the upcoming period subject to certain limitations that are built into the methodology. This per-diem rate is used to reimburse the provider for services delivered to Medicaid recipients for the rate semester period (July 1st to December 31st; and January 1st to June 30th). The agency repeats this process every six months utilizing the most recent cost report information submitted by the provider and the most recent inflation trends in order to provide the most accurate estimate of the providers current average daily cost of providing services to Medicaid recipients. Further details of the reimbursement plan are explained in the Florida Medicaid (Title XIX) Inpatient Hospital Reimbursement Plan. The plan is available on the Agency for Health Care Administration website at http://ahca.myflorida.com/Medicaid.

Hospital Outpatient Services Reimbursement
Medicaid reimburses for outpatient hospital services prospectively based on cost-reported per diem rates that are subject to caps. Teaching, specialty, and community health education hospitals and other qualifying hospitals are exempted from the caps, contingent upon counties contributing to the state's share of the cost of the exemption.

To calculate the reimbursement rate, the agency requires each provider to submit an annual report of its prior year Medicaid costs ("a cost report"). Utilizing this information, the agency then calculates the providers average cost of services provided to Medicaid recipients for the reported year. The costs are inflated using a nationally published medical inflation factor to adjust the providers historical average cost into an amount that can be used to reimburse the provider for the upcoming period subject to certain limitations that are built into the methodology. This per-diem rate is used to reimburse the provider for services delivered to Medicaid recipients for the rate semester period (July 1st to December 31st; and January 1st to June 30th). The agency repeats this process every six months utilizing the most recent cost report information submitted by the provider and the most recent inflation trends in order to provide the most accurate estimate of the providers current average cost of providing services to Medicaid recipients. Further details of the reimbursement plan are explained in the Florida Medicaid (Title XIX) Outpatient Hospital Reimbursement Plan. The plan is available on the Agency for Health Care Administration website at http://ahca.myflorida.com/Medicaid.

Nursing Homes
Medicaid nursing facility reimbursement is made in accordance with the Florida Medicaid (Title XIX) Long-Term Care Reimbursement Plan. A summary of the reimbursement methodology is included in the following paragraph. A detailed explanation is available in the Medicaid Title

XIX Long-Term Care Reimbursement Plan on the agency website at: http://ahca.myflorida.com/Medicaid.

Each nursing home provider is required to submit an annual report of its prior year Medicaid costs ("a cost report") to the agency each year no later than five months after the end of the provider's fiscal year. Utilizing this information, the agency then calculates the provider's average cost of services for the following five cost components: Operating, Direct Patient Care, Indirect Patient Care, Property, and Return on Equity. The costs are inflated using a nationally published medical inflation factor to adjust the providers historical average cost into an amount that can be used to reimburse the provider for the upcoming period subject to certain limitations that are built into the methodology. The agency combines the five cost components into one facility specific per-diem reimbursement rate. The rate is used to reimburse the provider for services delivered to Medicaid recipients for each rate semester period (July 1st to December 31st; and January 1st to June 30th). The agency repeats this process every six months utilizing the most recent cost report information submitted by the provider and the most recent inflation trends in order to provide the most accurate estimate of the providers current average cost of providing services to Medicaid recipients. Since the methodology is based on average cost, there is no difference in reimbursement rates for recipients with skilled or intermediate levels of care. Rural swing-bed providers receive the average statewide nursing-facility rate. Hospital-based skilled nursing units receive the average nursing-facility rate for the county in which the hospital is located. Supplemental reimbursement is available for approved recipients who have AIDS or are medically-fragile children 20 years of age or younger. Prior authorization is required for a supplemental reimbursement.

Community Intermediate Care Facilities for the Developmentally Disabled
Community Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) facilities are reimbursed by Medicaid using a cost based reimbursement methodology that results in a per diem (daily) rate for each ICF/DD for each level care provided. The ICF/DD reimbursement levels are categorized in two groups: 1) a reimbursement rate for a Level of need 7 client base; and 2) a reimbursement rate for a Level of need 8 and 9 client base. A detailed explanation is available in the Medicaid Title XIX Intermediate Care Facility for the Mentally Retarded and Developmentally Disabled, Not Publicly Owned, Not Publicly Operated Reimbursement Plan on the agency website at: http://ahca.myflorida.com/Medicaid.

County Health Departments
County Health Departments (CHD)'s are reimbursed by Medicaid using a cost based reimbursement methodology that creates a facility specific encounter rate. Each CHD is required to submit detail costs for its entire reporting year, making appropriate adjustments as required by the County Health Department reimbursement plan. Details of the reimbursement plan can be found on the agency's website at: http://ahca.myflorida.com/Medicaid.

The following services are reimbursed through the facility specific encounter reimbursement rate:

- Adult health screening services
- Child Health Check-Up
- Dental services

- Family planning services
- Medical primary care
- Registered nurse services

Prepaid Health Plan Reimbursement

Prepaid Health Plans or Health Maintenance Organizations (HMO)'s managed care providers are reimbursed based on capitation payments calculated for the applicable contract year. Currently, the Agency for Health Care Administration as the administrating agency, is responsible for calculating the capitation payment rates for reimbursement to the HMO managed care plans. The agency's methodology is established through the administrative rule process (Rule 59G-8.100; F.A.C). The methodology can be summarized as follows:

- The capitation payment is the fixed amount paid monthly by the agency to an HMO for each enrolled HMO member to provide covered services needed by each member during the month as specified in each contract.
- The agency uses two years of certain historical expenditure data (excluding some fees and payments as described in the rule) from the Medicaid fee-for-service program for the same services the HMO is responsible for delivering.
- These data are then categorized into "rate cells" by age, gender, eligibility group, geographic region and are forecasted to the applicable year using inflation factors adopted by the legislature in the Social Services Estimating Conference. Once forecasted to the applicable year, these expenditure data are adjusted to reflect policy changes adopted by the legislature. It is important to note that Federal rules do not allow Medicaid managed care payments to exceed what would have been paid to providers under Medicaid fee-for-service. Therefore any policy changes that may affect fee-for-service expenditures in the applicable year must be accounted for in the capitation rates (i.e. reduction in fee-for-service Hospital Inpatient reimbursement rates. Hospital inpatient expenditures are a major component of HMO capitation rates).
- After the adjustment for policy issues, the agency applies a discount factor and a trend adjustment to each rate cell. The discount factor ranges from 0% to 8% and varies by rate cell depending on the geographic region and eligibility category.
- Upon completion, the rates are reviewed and certified by an independent actuarial firm. Upon actuarial certification, and confirmation by CMS, the agency will begin reimbursing HMOs the monthly capitation payment for each recipient enrolled in the plan.
- In the Medicaid Reform counties, a similar methodology is used as listed above, with the added criteria of risk adjustment based on recipient health status.

Nursing Home Diversion

Nursing Home Diversion (NHD) providers are reimbursed at a monthly capitated rate for each plan member. The methodology used in setting the NHD capitation rates is very complex but can be summarized as follows:

- The agency calculates estimated Fee-For-Service costs for Aged and Disabled (ADA) and Assisted Living (ALE) waiver recipients with a minimum of 50% of their experience in the community (versus being a nursing home resident), who also meet eligibility criteria for the Nursing Home Diversion program;

- Adjusts the Home and Community Based Services data for different service expectations between the Waiver programs and the Diversion program;
- Calculates a Statewide Assessment Rating Factor (ARF) to address health status differences;
- Divides the cost per eligible in each district by the statewide ARF to obtain a normalized rate;
- Adjusts for incurred but not reported (IBNR) claims and third party liability (TPL) recoveries;
- Multiplies the normalized rate by the ARF for the capitated plans in that district; and Adds the Nursing Home Factor (NHF) to adjust for the cost of nursing home stays based on the number of years of operation of the diversion plans in that district.
- Upon completion, the rates are reviewed and certified by and independent actuarial firm. Upon actuarial certification, and confirmation by CMS, the agency will begin reimbursing NHD providers the monthly capitation payment for each recipient enrolled in the plan.

Complete details of the NHD capitation rate methodology can be found on the Department of Elder Affairs Website at: http://elderaffairs.state.fl.us/english/diversion/Report18NHD092006-082007.pdf)

III. Effect of Proposed Changes:

Section 1. Adds subsection (23) to section 409.908, F.S., to limit Medicaid reimbursement in an amount necessary so that the statewide weighted average rate equals the statewide average rate from the preceding rate semester beginning July 1, 2008, for the following providers: inpatient hospitals, outpatient hospitals, nursing homes, county health departments and community intermediate care facilities for the developmentally disabled; and to apply the effect of the reductions to the reimbursement rates for prepaid health plans and nursing home diversion providers.

Section 2. Provides the act to take effect upon becoming a law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Statewide average Medicaid reimbursement rates for hospital, nursing home, county health departments, prepaid health plans, nursing home diversion, and intermediate care facilities for the developmentally disabled providers will not increase above the June 30, 2008 levels.

C. Government Sector Impact:

The table below provides a summary of the fiscal impact of the bill. Column A reflects the Fiscal Year 2008-09 expenditure estimates that include price level and workload estimates per the February 27, 2008 Social Services Estimating Conference for Medicaid Expenditures. Column B reflects the estimated expenditures based on freezing the provider rates at the statewide average as indicated in the bill.

Medicaid Service Type	FY 08-09 EXPENDITURE ESTIMATE BEFORE REIMBURSEMENT RATE FREEZE*	FY 08-09 EXPENDITURE ESTIMATE AFTER REIMBURSEMENT RATE FREEZE	DIFFERENCE
	A	B	C
HOSPITAL INPATIENT SERVICES			
TOTAL COST	$2,186,635,769	$2,095,284,620	($91,351,149)
TOTAL GENERAL REVENUE	$180,480,043	$139,836,447	($40,643,596)
TOTAL MEDICAL CARE TRUST FUND	$1,191,676,127	$1,141,048,407	($50,627,720)
TOTAL REFUGEE ASSISTANCE TF	$2,054,406	$1,974,573	($79,833)
TOTAL PUBLIC MEDICAL ASSIST TF	$506,570,000	$506,570,000	$0
TOTAL GRANTS AND DONATIONS TF	$278,515,253	$278,515,253	$0
TOTAL OTHER STATE FUNDS	$27,339,940	$27,339,940	$0
NURSING HOMES			
TOTAL COST	$2,541,235,795	$2,401,911,754	($139,324,041)
TOTAL GENERAL REVENUE	$1,123,543,888	$1,061,488,960	($62,054,928)
TOTAL MEDICAL CARE TRUST FUND	$1,412,869,372	$1,335,600,259	($77,269,113)
TOTAL GRANTS AND DONATIONS TF	$4,822,535	$4,822,535	$0
HOSPITAL OUTPATIENT SERVICES			
TOTAL COST	$605,193,192	$578,798,039	($26,395,153)
TOTAL GENERAL REVENUE	$211,383,459	$199,657,578	($11,725,881)
TOTAL MEDICAL CARE TRUST FUND	$334,986,361	$320,382,221	($14,604,140)
TOTAL REFUGEE ASSISTANCE TF	$1,230,182	$1,165,050	($65,132)
TOTAL GRANTS AND DONATIONS TF	$57,593,190	$57,593,190	$0

Medicaid Service Type	FY 08-09 EXPENDITURE ESTIMATE BEFORE REIMBURSEMENT RATE FREEZE*	FY 08-09 EXPENDITURE ESTIMATE AFTER REIMBURSEMENT RATE FREEZE	DIFFERENCE
CLINIC SERVICES			
TOTAL COST	$114,261,476	$103,874,067	($10,387,409)
TOTAL GENERAL REVENUE	$50,492,349	$45,902,135	($4,590,214)
TOTAL MEDICAL CARE TRUST FUND	$62,884,238	$57,167,487	($5,716,751)
TOTAL REFUGEE ASSISTANCE TF	$884,889	$804,445	($80,444)
ICF-DD COMMUNITY			
TOTAL COST	$246,293,249	$240,132,993	($6,160,256)
TOTAL GENERAL REVENUE	$109,699,013	$106,955,235	($2,743,778)
TOTAL MEDICAL CARE TRUST FUND	$136,594,236	$133,177,758	($3,416,478)
CAPITATED NURSING HOME DIVERSION			
TOTAL COST	$244,520,061	$243,119,631	($1,400,430)
TOTAL GENERAL REVENUE	$109,050,981	$108,426,418	($624,563)
TOTAL MEDICAL CARE TRUST FUND	$135,469,080	$134,693,213	($775,867)
PREPAID HEALTH PLAN			
TOTAL COST	$2,476,677,302	$2,435,683,217	($40,994,085)
TOTAL GENERAL REVENUE	$1,095,320,532	$1,077,190,732	($18,129,800)
TOTAL MEDICAL CARE TRUST FUND	$1,364,150,911	$1,341,571,418	($22,579,493)
TOTAL REFUGEE ASSISTANCE TF	$17,205,859	$16,921,067	($284,792)
GRAND TOTAL	$8,414,816,844	$8,098,804,321	($316,012,523)
TOTAL GENERAL REVENUE	$2,879,970,265	$2,739,457,505	($140,512,760)
TOTAL MEDICAL CARE TRUST FUND	$4,638,630,325	$4,463,640,763	($174,989,562)
TOTAL REFUGEE ASSISTANCE TF	$21,375,336	$20,865,135	($510,201)
TOTAL PUBLIC MEDICAL ASSIST TF	$506,570,000	$506,570,000	$0
TOTAL OTHER STATE FUNDS	$27,339,940	$27,339,940	$0
TOTAL GRANTS & DONATIONS TF	$340,930,978	$340,930,978	$0

* Expenditure estimates adopted at the February 27, 2008 Social Services Estimating Conference for Medicaid Expenditures.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

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

Requires the Agency for Health Care Administration to limit Medicaid reimbursement in an amount necessary so that the statewide weighted average rate equals the statewide average rate from the preceding rate semester beginning July 1, 2008, for the following providers: inpatient hospitals, outpatient hospitals, nursing homes, county health departments and community intermediate care facilities for the developmentally disabled; and to apply the effect of the reductions to the reimbursement rates for prepaid health plans and nursing home diversion providers.

B. Amendments:

None.