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:	PCS for SB 8-A
INTRODUCER:	Committee on Health and Human Services Appropriations and Senator Peaden
SUBJECT:	Health Care
DATE:	January 6, 2009 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Peters	Peters	HA	**Pre-meeting**
2.				
3.				
4.				
5.				
6.				

I. Summary:

The bill reduces Medicaid pharmacy ingredient price reimbursement for the Average Wholesale Price (AWP) component of pharmacy pricing from to AWP minus 18.4 percent and reduces the Wholesale Acquisition Cost (WAC) component of pharmacy pricing to WAC plus 2.75 percent.

This provision implements a budget reduction in the Medicaid Prescribed Drug Program of $1.5 million in General Revenue and a reduction of $70,938 in Tobacco Settlement Trust Funds in Fiscal Year 2008-09 and a $3.0 million General Revenue reduction in Fiscal Year 2009-10.

The bill also requires the Agency for Health Care Administration to calculate and assess a quality assessment on health care items or services provided by nursing facilities. The assessment would generate $43.9 million and drawn down $54.7 million in Medicaid matching funds to buy-back reductions to Nursing Home and Hospice reimbursement rates in Fiscal Year 2008-09, effective May 1, 2009 and $219.5 million and drawn down $273.3 million in Medicaid matching funds in Fiscal Year 2009-10.

This bill amends ss. 409.908 and 409.912, Florida Statutes.

The bill creates s. 409.9082, Florida Statutes.

II. Present Situation:

Medicaid Prescribed Drug Program

Florida provides prescription drug coverage as part of its Medicaid program. For outpatient services, Medicaid pays for most prescription drugs and selected over-the-counter medicines.

Florida's Medicaid program pays pharmacies the lower of two costs: (1) what it estimates pharmacies pay for drugs (referred to as acquisition costs) plus a $4.23 dispensing fee, or (2) the pharmacy's usual and customary price for the drug. AHCA's prescription drug pricing algorithm first selects the lowest estimated acquisition cost and adds the dispensing fee. The algorithm then compares this price to the pharmacy's usual and customary price and pays the lower of these prices. AHCA estimates acquisition costs using two nationally published prices, the Average Wholesale Price (AWP) and the Wholesale Acquisition Cost (WAC); and two maximum prices, the federal upper limit (FUL) and the state maximum allowable cost (SMAC).

The AWP resembles a list price, or sticker price, and does not reflect what pharmacies are actually paying the wholesalers for the drug after volume discounts or rebates. Therefore, Florida, as do other states, tries to arrive at the pharmacy's EAC by applying a fixed discount percentage to the published AWP's (currently AWP minus 16.4 percent). To further provide the most accurate estimate of the pharmacy's acquisition cost, Florida, as do many other states, utilizes published WAC pricing plus a fixed percentage to reflect the wholesaler's mark-up to the pharmacy (currently WAC plus 4.75 percent).

Health Care Assessments

Currently, 43 states impose provider assessments on at least one category of health care providers.[1] Assessments are most frequently imposed on nursing homes, but other entities such as hospitals, intermediate care facilities, and health maintenance organizations are assessed as well. Federal regulations define 19 separate classes of health care services and providers as eligible for assessment programs.[2] Florida currently has one provider assessment in place for hospital inpatient and outpatient services more commonly known as the Public Medical Assistance Trust Fund (PMATF) as specified in s. 395.701, Florida Statutes.

Generally, states implement provider assessments to generate revenue to support their Medicaid programs, using funds raised through the assessment to draw down federal matching funds. Provider assessments are often used to give rate increases to providers when state general revenue funds are not available, or to create funding for payments intended to help achieve specific programmatic goals, such as improved quality of care. States often redirect a portion of the assessment proceeds away from the providers paying the assessment and use the funds for either other health related purposes or general state expenses. Federal rules prohibit states from making payments to providers that are directly correlated to the amount of assessment paid, so some redistribution among providers is expected, regardless of any redirection of funds to the state.

All provider assessment programs must be approved by the federal government. In order to receive federal approval, a provider assessment program must comply with the federal Medicaid

[1] Health Management Associates. "Provider Tax Issues-Prepared for: Kansas Health Policy Authority Medicaid Transformation Committee." September 16, 2008.
[2] 42 CFR 433.56

Voluntary Contribution and Provider Specific Tax Amendments of 1991 and federal regulations under 42 CFR 433.54-74. Typically, revenue from an assessment will be deemed acceptable to the federal Centers for Medicare and Medicaid Services (CMS) as legitimate state match if it meets the following criteria:

- The assessment is broad based;
- The assessment is applied uniformly;
- The assessed entity is not held harmless for the assessment paid; and
- The assessment is less than 5.5 percent of industry's net patient revenue.

A health care related assessment is considered broad based if the assessment is imposed on at least all health care items or services within a class of providers. Some states have excluded or "carved out" certain classes of providers from the assessment in an effort to mitigate the redistribution of money that occurs within assessment programs. Federal regulations allow certain groups of providers to be legitimately exempted from a provider assessment if the state can demonstrate that the assessment is generally redistributive. A provider assessment is considered to be uniformly imposed if a state can demonstrate that the assessment is applied on the same basis at the same rate for each provider. An assessment is not uniformly imposed if it permits credits, deductions, or exclusions that result in returning all or part of the assessment. Most assessments are based on a flat amount per day or licensed bed and are considered uniform, but other assessment bases such as net revenue would also fulfill this requirement.

States are prohibited from establishing programs that would have the effect of offsetting or reducing the impact of the assessment on providers. This prohibition is called the "hold harmless" provision. The three main components of the federal law governing hold harmless are as follows:

- Providing a direct or indirect payment, in addition to any Medicaid payments, to providers paying the assessment and the amount of such payment is positively correlated either to the amount of the assessment or to the difference between the amount of the assessment and the amount of the payment under the Medicaid state plan.

- Making all or any portion of the Medicaid payments to the assessed provider vary only with the amount of the total assessment paid.

- Imposing the assessment includes a guarantee to hold the assessed provider harmless for any portion of the cost of the assessment.

Nothing prohibits the state from utilizing assessment revenue to finance Medicaid payments as long as it does not create a violation of provider assessment regulations. Regardless of whether the payment enhancements are financed entirely by assessment funding or a blend of general revenue funds and assessment monies, CMS will evaluate the changes to determine whether or not a hold harmless situation exists.

The federal government effectively limits the amount of money raised through provider assessments by imposing additional and significantly more onerous requirements on assessment

programs if the assessment exceeds 5.5 percent of aggregate net patient revenue for the class of providers. Until recently, the cap was 6 percent, but the ceiling was reduced under the Deficit Reduction Act (DRA) of 2005.

For provider assessment plans that meet the federal tests, a state plan amendment is submitted to CMS. Waivers may be pursued for states seeking to implement a plan that does not meet one or more of the federal requirements. While CMS carefully scrutinizes state plan amendment requests and may take months to approve one, the approval process is generally less cumbersome for an amendment than a waiver.

III. Effect of Proposed Changes:

Section 1 amends s. 409.908 (14), F.S., to reduce the Average Wholesale Price (AWP) component of pharmacy pricing from AWP minus 16.4 percent to AWP minus 18.4 percent and reduce the Wholesale Acquisition Cost (WAC) component of pharmacy pricing from WAC plus 4.75 percent to WAC plus 2.75 percent.

Section 2 amends s. 409.912 (39), F.S., to reduce the Average Wholesale Price (AWP) component of pharmacy pricing from AWP minus 16.4 percent to AWP minus 18.4 percent and reduce the Wholesale Acquisition Cost (WAC) component of pharmacy pricing from WAC plus 4.75 percent to WAC plus 2.75 percent.

Section 3 creates s. 409.9082, relating to the Nursing Facility Quality Assessments.

Subsection (1) creates definitions necessary for the administration of this section. Definitions outline the facilities that are required to pay assessments, key terms relating to calculating the assessments, and the trust funds relevant to this section.

Subsection (2) provides for the calculation of assessments by the Agency for Health Care Administration, effective May 1, 2009, outlines the purpose of the Nursing Home Quality Assessment, provides that the assessment shall not exceed 5 percent of the total aggregate net patient service revenue of assessed facilities, and provides for provider notification requirements.

Subsection (3) states that the quality assessment shall be calculated and paid on a per-resident day basis, and that the assessment rate shall be the same amount for each affected facility.

Subsection (4) directs the Agency for Health Care Administration to seek a federal waiver for the administration of the Nursing Home Quality Assessment program, outlines providers to be exempted from the program and provides that assessments should be lowered for certain high volume facilities.

Subsection (5) directs that the collection of this assessment shall begin no sooner than ten days after the Agency's initial payment of the Medicaid rates containing the elements prescribed in subsection (9).

Subsection (6) provides that if the waiver is not approved by federal CMS, then all assessments shall be returned to the nursing facilities (less any amounts expended by the Agency for purposes of implementation of this section) and collection of the assessments shall be discontinued.

Subsection (7) provides that the assessments shall be collected on a monthly basis and provides for a timeline for collection and reporting.

Subsection (8) provides the Agency with rule making authority regarding this section.

Subsection (9) provides that the monies collected through this assessment and distributed into the Agency's grants and donations trust fund shall be used for: a pass through to reimburse the Medicaid share of the quality assessments as a Medicaid allowable cost, an increase in nursing facility rates as needed to bring the rate up to the level of the January 1, 2008 nursing facility rate, and increases to nursing facility rates to bring the facilities Medicaid rate to the level of the rate for fiscal year 2008-2009 as outlined in the approved state plan in effect on December 31, 2007.

Subsection (10) provides that all provisions of this section will be null and void if the federal waiver or Medicaid state plan amendment is not approved, or the weighted average rate to nursing facilities fall below the rate in effect on June 30, 2008.

Subsection (11) provides that if the section does not become operative, all monies are returned on a pro rate basis to the nursing facilities.

Subsection (12) provides for sanctions against facilities for not paying timely assessments.

Subsection (13) provides that nursing facilities may not create a separate line item charge to pass through the costs of the assessments to residents.

Subsection (14) provides that monies collected relating to this assessment shall not revert to the state general revenue fund or any other fund at any time.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The pharmaceutical industry will receive reduced Medicaid pharmacy ingredient price reimbursement. The Nursing Home and Hospice providers will be able to restore the reductions to the reimbursement rates through the quality assessments.

C. Government Sector Impact:

	FY 2008-09	**FY 2009-10**
Pharmacy Ingredient Cost Adjustment		
General Revenue Fund	($1,521,435)	($3,049,310)
Tobacco Settlement Trust Fund	($ 70,938)	
Medical Care Trust Fund	($2,003,094)	($3,837,364)
Total	**($3,595,467)**	**($6,886,994)**
Nursing Home Quality Assessments		
Nursing Homes		
Grants and Donations Trust Fund	$42,337,476	$211,687,378
Medical Care Trust Fund	$52,717,476	$ 263,587,381
Total	$95,054,952	$475,274,758
Hospice		
Grants and Donations Trust Fund	$1,554,141	$ 7,770,704
Medical Care Trust Fund	$1,935,174	$ 9,675,869
Total	$3,489,315	$17,446,573
TOTAL		
Grants and Donations Trust Fund	$43,891,616	$219,458,082
Medical Care Trust Fund	$54,652,650	$273,263,250
Total	**$98,544,266**	**$492,721,332**

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.)

None.

B. Amendments:

None.