SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

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

BILL: CS/SB 2128

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

SUBJECT: Public Medical Assistance Trust Fund; Task Force

DATE: April 17, 1999 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Carter	Wilson	HC	Favorable/CS
2.			FP	
3.				
4.				
5.				

I. Summary:

Committee Substitute for Senate Bill 2128 creates a 7-member task force to review the sources of funds deposited into the Public Medical Assistance Trust Fund (PMATF). The task force is to convene no later than August 1, 1999, for its first meeting, and must submit a report of its findings and recommendations, including any proposed legislation, to the President of the Senate, the Speaker of the House of Representatives, and the Governor by December 1, 1999. The Agency for Health Care Administration is designated to staff the task force and to provide the task force with technical assistance.

This bill creates one undesignated section of law.

II. Present Situation:

Chapter 395, F.S., delegates authority to the Agency for Health Care Administration (AHCA or agency) to license and regulate hospitals, ambulatory surgical centers, and mobile surgical facilities. Part IV of chapter 395, F.S., consisting of ss. 395.701 and 395.7015, F.S., 1998 Supplement, relates to the PMATF. Revenues collected from assessments on the specified health care providers under Part IV of chapter 395, F.S., are used to fund Medicaid-reimbursed hospital inpatient services. Through use of such trust fund moneys, the State is able to avoid use of general revenue to pay for Medicaid services provided to medically indigent State residents. According to AHCA, the assessments, combined with revenues from cigarette taxes and interest earnings are fully utilized each year in the General Appropriations Act.

Certain Specified Health Care Facilities are Subject to the PMATF Tax

Section 395.701, Florida Statutes, was originally enacted in 1984 to impose an assessment of 1.5 percent against the annual net operating revenue of each state-licensed hospital. Assessments are deposited into the PMATF. The Health Care Board, abolished in 1998, was empowered to fine or penalize hospitals that failed to comply with, or otherwise violate, the assessment payment

requirement, and to collect data from required reporting documents developed by the Board. Chapter 98-89, Laws of Florida (L.O.F.), abolished the Board. Enforcement authority relating to the assessment was transferred to AHCA.

Section 395.7015, F.S., 1998 Supplement, was originally codified in statute as s. 395.1015, F.S., as created by s. 177 of chapter 91-112, L.O.F., which for the first time extended PMATF assessments to four additional types of *freestanding* health care providers: clinical laboratories, ambulatory surgical centers, diagnostic imaging centers, and radiation therapy centers. As a result, more than 800 additional health care facilities were made subject to the PMATF assessment. Section 52 of chapter 92-289, L.O.F., redesignated s. 395.1015, F.S., as s. 395.7015, F.S. Administrative rule 59B-6.009(2), F.A.C., defines "freestanding" to mean that the health care entity bills and receives revenue which is not directly subject to the hospital PMATF assessment, and that the health care entity is not a department or other subdivision of a hospital.

Under s. 395.7015, F.S., 1998 Supplement, an annual assessment of 1.5 percent is imposed on the net operating revenues of ambulatory surgical centers and mobile surgical facilities, licensed under s. 395.003, F.S., 1998 Supplement; certain clinical laboratories, licensed under s. 483.091, F.S.; freestanding radiation therapy centers providing treatment through the use of radiation therapy machines that are registered under s. 404.22, F.S., 1998 Supplement; and diagnostic imaging centers that provide specialized services for the identification or determination of a disease through examination and also provide sophisticated radiological services which are rendered by physicians who meet certain specified state licensure credential requirements.

There are currently 329 diagnostic imaging centers and 215 clinical laboratories subject to the PMATF assessment. Of these, 151 diagnostic imaging centers and 87 clinical laboratories are physician owned. Physician-owned diagnostic imaging centers and clinical laboratories account for an estimated $3,297,340 in revenue for the PMATF for Fiscal Year 1999-2000 and Fiscal Year 2000-2001, separately.

How Is the PMATF Assessment Implemented?

An assessment of 1.5 percent against the annual net operating revenue of each health care entity that is subject to the PMATF tax is imposed by AHCA. Within four months (120 days) after the end of each health care entity's fiscal year, each such entity that is subject to the PMATF assessment must report its *actual experience* in the preceding calendar year based upon reports developed by the abolished Health Care Board. The agency, within six months of the end of the health care entity's fiscal year, must certify the amount of the assessment to each such entity based on its determination of the entity's net operating revenue. The assessment must be payable to and collected by the agency in equal quarterly amounts on or before the first day of each calendar quarter, beginning with the first full calendar quarter following the certification.

"Net operating revenue" is defined by paragraph 395.7015(1)(a), F.S., 1998 Supplement, and administrative rule 59B-6.009(5), F.A.C., to mean gross revenue less deductions from revenue. For health care entities using a cash basis of accounting, net operating revenue means the amount of gross revenue collected. Paragraph 395.7015(1)(b), F.S., 1998 Supplement, and administrative rule 59B-6.009(3), F.A.C., define "gross revenue" to mean the sum of daily service charges, ambulatory service charges, ancillary service charges, and other operating revenue. This amount

includes all revenue to the health care entity, excluding documented physician professional fees, revenues received for testing or analysis of samples received from outside the state or from product sales outside the state, and revenue unrelated to the operation of the health care entity as provided in administrative rules 59B-6.012 and 59B-6.013, F.A.C. Paragraph 395.7015(1)(c), F.S., 1998 Supplement, defines “deductions from revenue" to mean reductions from gross revenue resulting from inability to collect payment of charges. Such reductions include: bad debts; contractual adjustments; uncompensated care; administrative, courtesy, and policy discounts and adjustments; and other such revenue deductions, and includes the offset of restricted donations and grants for indigent care.

The Social Services Estimating Conference met on February 16, 1999, and adopted the following estimates for the PMATF for Fiscal Year 1999-2000:

PMATF
Estimates for Fiscal Year 1999-2000
(Source: Agency for Health Care Administration)

ESTIMATED REVENUES:	
Assessments on hospitals	$253,300,000
Assessments on other health care entities	9,200,000
Cigarette tax distribution to PMATF	118,300,000
Interest	3,000,000
Total Estimated Revenues	**$393,800,000**
ESTIMATED EXPENDITURES:	
Hospital Inpatient Services	$393,600,000
Administration	200,000
Total Estimated Expenditures	**$393,800,000**

Effect on the State of Exempting or Eliminating from Assessment Some, But Not All, Health Care Entities That Are Subject to the PMATF Tax

Chapter 98-192, L.O.F., codified as s. 395.7015, F.S., 1998 Supplement, provides an exemption from the assessment on hospital net operating revenues for outpatient radiation therapy services provided by a hospital and provides for the elimination of the assessment on freestanding radiation therapy centers. The exemption and elimination are both *contingent* upon AHCA receiving written confirmation from the federal Health Care Financing Administration (HCFA) that these changes to the law would not adversely affect the use of the remaining assessments as state match for the Medicaid program. According to the agency, it initiated efforts to obtain such confirmation on July 7, 1998, when it submitted a letter to HCFA requesting that HCFA confirm that the provisions of chapter 98-192, L.O.F., would have no impact on *the permissibility under federal rules of the remaining assessments*. On December 17, 1998, HCFA requested additional information from AHCA. The agency responded to HCFA’s request for additional information on

March 8, 1999. To date, the agency has not received HCFA's confirmation and, therefore, the assessment on the contingently exempted outpatient radiation therapy services and the contingently eliminated assessment on freestanding radiation therapy centers remain in effect.

Confirmation from HCFA that the exemption and elimination from the PMATF assessment, as enacted in 1998, is significant. Following is an explanation, provided by the agency, of what such confirmation means to the state.

Section 1903(w) of the Social Security Act specifies the treatment of revenues from provider-related donations and health care-related taxes in determining a state's medical assistance expenditures for which federal financial participation (match funds) are available. Title 42, part 433 of the Code of Federal Regulations (CFR) relates to health care-related provider taxes and donations. Section 42 CFR 433.55 defines a "health care-related tax" as a licensing fee, assessment, or other mandatory payment that is related to: (1) health care items or services; (2) the provision of, or the authority to provide, the health care items or services; or (3) the payment for the health care items or services.

Section 42 CFR 433.56 lists 19 separate classes of health care items or services for purposes of applying the provider donations and provider taxes provisions of federal rules. The classes are:

1. Inpatient hospital services;
2. Outpatient hospital services;
3. Nursing facility services (other than services of intermediate care facilities for the mentally retarded);
4. Intermediate care facility services for the mentally retarded and similar services furnished by community-based residences for the mentally retarded, under a waiver under section 1915(c) of the Act, in a state which, as of December 14, 1992, at lease 85 percent of such facilities were classified as ICF/MRs prior to the grant of the waiver;
5. Physician services;
6. Home health care services;
7. Outpatient prescription drugs;
8. Services of health maintenance organizations and health insuring organizations;
9. Ambulatory surgical center services, as described for the purposes of the Medicare program in s. 1832(a)(2)(F)(I) of the Social Security Act. These services are defined to include facility services only and do not include surgical procedures;
10. Dental services;
11. Podiatric services;
12. Chiropractic services;
13. Optometric/optician services;
14. Psychological services;
15. Therapist services, defined to include physical therapy, speech therapy, occupational therapy, respiratory therapy, audiological services, and rehabilitative specialist services;
16. Nursing services, defined to include all nursing services, including services of nurse midwives, nurse practitioners, and private duty nurses;
17. Laboratory and X-ray services, defined as services provided in a licensed, freestanding laboratory or X-ray facility (this definition does not include laboratory or X-ray services

provided in a physician's office, hospital inpatient department, or hospital outpatient department);

18. Emergency ambulance services; and
19. Other health care items and services not listed above on which the state has enacted a licensing or certification fee, subject to the following:
    (i) the fee must be broad based and uniform or the state must receive a waiver of these requirements;
    (ii) the payer of the fee cannot be held harmless; and
    (iii) the aggregate amount of the fee cannot exceed the state's estimated cost of operating the licensing or certification program.

Taxes that pertain to each class *must apply to all items and services within the class*, regardless of whether the items and services are furnished by or through a Medicaid-certified or licensed provider. Before calculating federal financial assistance, HCFA will deduct from a state's expenditures for medical assistance those funds from health care-related taxes received by a state or unit of local government if the taxes are not *permissible* health care-related taxes, as specified by federal law and federal regulations.

"*Health care-related taxes are permissible under federal regulation if the taxes are broad-based, uniformly imposed, and do not violate hold harmless provisions.*" A health care-related tax is considered broad based if the tax is imposed on at least all health care items or services in the class or providers of such items or services furnished by all non-federal, non-public providers in the state, and is imposed uniformly. A health care-related tax is considered uniformly imposed if it meets any one of the following:

- If the tax is a licensing fee or similar tax imposed on a class of health care services (or providers of those health care services), the tax is the same amount for every provider furnishing those items or services within the class.
- If the tax is a licensing fee or similar tax imposed on a class of health care services (or providers of those health care services), on the basis of the number of beds (licensed or otherwise) of the provider, the amount of the tax is the same for each bed of each provider of those items or services in the class.
- If the tax is imposed on provider revenue or receipts with respect to a class of items or services (or providers of those items or services), the tax is imposed at a uniform rate for all services (or providers of those items or services) in the class on all the gross revenues or receipts, or on net operating revenues relating to the provision of all items or services in the state, unit, or jurisdiction. Net operating revenue means gross charges of facilities less any deducted amounts for bad debts, charity care, and payer discounts.
- The tax is imposed on items or services on a basis other than those specified above, for example, an admission tax, and the states establishes to the satisfaction of the Secretary of the U.S. Department of Health and Human Services that the amount of the tax is the same for each provider of such items or services in the class.

The agency further explained that a tax imposed on a class of health care items or services *will not be considered to be imposed uniformly* if it meets either of the following criteria:

- The tax provides for credits, exclusions, or deductions which have as its purpose, or results in, the return to the providers of all, or a portion, of the tax paid, and it results, directly or indirectly, in a tax program in which the net impact of the tax and payments are not generally redistributive and the amount of the tax is directly correlated to the payments under the Medicaid program.
- The tax holds taxpayers harmless for the cost of the tax.

III. Effect of Proposed Changes:

The bill provides for the establishment of a 7-member task force to review sources of funds deposited into the PMATF, as created by s. 409.918, F.S. The President of the Senate is designated to appoint 2 members, a member of the Senate and a representative of a hospital subject to the PMATF assessment under s. 395.701, F.S., 1998 Supplement or s. 394.4786, F.S.; the Speaker of the House of Representatives is designated to appoint 2 members, a member of the House of Representatives and a representative of a health care entity that is subject to the PMATF assessment under s. 395.7015, F.S., 1998 Supplement; and the Governor is designated to appoint 3 members, the Director of AHCA, or his designee, a state-licensed physician, and a consumer with no employment or investment interest in any health care entity subject to the PMATF assessment and who is a representative of Florida TaxWatch. The Governor must designate the task force chairperson from among the members of the task force.

The task force must consider and make specific recommendations, and provide an analysis of the budgetary impact of any exemptions from, inclusions within, or modifications to existing PMATF assessments, concerning, but not limited to:

- Whether any provisions of PMATF laws should be revised;
- Whether annual PMATF assessments are equitably imposed;
- Whether additional exemptions from, or inclusions within, the assessments are justified;
- The extent to which federal law and regulations applicable to PMATF assessments allow state flexibility in modifying existing assessments; and
- The extent to which PMATF revenue could be increased by modifications of the PMATF assessments imposed under the following provisions of law: s. 210.20, F.S., 1998 Supplement, relating to the state’s cigarette tax revenues; s. 395.1041, F.S., 1998 Supplement, relating to hospital emergency services; s. 408.040, F.S., 1998 Supplement, relating to certain specific certificate-of-need activities pertaining to modification of a CON; and s. 408.08, F.S., 1998 Supplement, relating to certain health care providers, health care facilities, and health insurers that AHCA is authorized to conduct certain business transaction reviews.

Additionally, the bill directs AHCA to provide staff support and technical assistance to the task force, and requires the task force to convene no later than August 1, 1999, and report its findings and recommendations, including any proposed legislation, by December 1, 1999.

The provisions of the bill will take effect upon becoming law.

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 Article I, Subsections 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 Article III, Subsection 19(f) of the Florida Constitution.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Private-sector members of the task force may incur some costs incidental to travel-related expenses to meetings of the task force. The bill does not state how the cost of task force members will be covered.

C. Government Sector Impact:

The bill does not address who is responsible for the costs of the task force. It is unclear whether AHCA will cover the costs of the task force meetings, in addition to the costs of staff support and technical assistance.

VI. Technical Deficiencies:

Language should be added to the bill that clearly indicates how the costs of the task force are to be covered and by what entity or entities.

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.