

# 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/CS/SB 954

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

SUBJECT: Public Medical Assistance Trust Fund Assessments/Hospital Outpatient Services

DATE: April 25, 2000 REVISED: \_\_\_\_\_

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	<u>Munroe</u>	<u>Wilson</u>	<u>HC</u>	<u>Favorable/CS</u>
2.	_____	<u>Hadi</u>	<u>FP</u>	<u>Withdrawn</u>
3.	<u>Keating</u>	<u>Wood</u>	_____	<u>Favorable/CS</u>
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____

## I. Summary:

Committee Substitute for Committee Substitute for Senate Bill 954 implements the recommendations of the Public Medical Assistance Trust Fund (PMATF) Task Force created by section 192 of chapter 99-397, Laws of Florida, by: specifying legislative findings; reducing the annual PMATF assessment on net operating revenues attributed to hospital outpatient services, ambulatory surgical centers, clinical laboratories, and diagnostic-imaging centers from 1.5% to 1%; increasing from \$1,000 to \$1,500 the expenditure cap imposed annually on MedAccess and Medicaid payments for hospital outpatient services; and providing appropriations in unspecified amounts to the Agency for Health Care Administration to replace the funds lost due to the elimination of the assessment imposed on hospitals and other health care entities and to fund the increase in the expenditure cap for hospital outpatient services.

The bill authorizes the Agency for Health Care Administration to contract with and to reimburse an entity located in Pasco County or Pinellas County that provides in-home physician services to Medicaid recipients with degenerative neurological diseases to test the cost-effectiveness of enhanced home-based medical care. This provision repeals on July 1, 2002.

The bill requires the Department of Health's Volunteer Health Care Provider Program to conduct a survey and publish a report annually on the uncompensated care for which health providers receive no reimbursement.

This bill amends sections 395.701, 395.7015, 408.904, 409.905, 409.908, and 409.912, Florida Statutes.

## 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., relates to the Public Medical Assistance Trust Fund (PMATF) which is created in s. 409.918, F.S. 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.

### ***Specified Health Care Facilities are Subject to the PMATF Assessment***

Section 395.701, F.S., was originally enacted in 1984 to impose an assessment of 1.5 percent against the annual net operating revenue of each state-licensed hospital. The funds generated through the assessment were to be used to expand Medicaid coverage and equalize the financial burden of indigent health care among hospitals. Assessments are deposited into the PMATF. The Health Care Board was empowered to fine or penalize hospitals that failed to comply with, or otherwise violated, the assessment payment requirement. Chapter 98-89, Laws of Florida (L.O.F.) abolished the Board. Enforcement authority relating to the assessment was transferred to AHCA. There are currently 256 hospitals subject to the PMATF assessment according to AHCA.

Section 395.7015, F.S., was originally codified in statute as s. 395.1015, F.S., as created by s. 177 of ch. 91-112, L.O.F., which for the first time extended PMATF assessments to four additional types of health care providers: clinical laboratories, ambulatory surgical centers, diagnostic imaging centers, and freestanding radiation therapy centers. As a result, more than 800 additional health care facilities were made subject to the PMATF assessment. Section 52 of ch. 92-289, L.O.F., redesignated s. 395.1015, F.S., as s. 395.7015, F.S. Administrative rule 59B-6.009(2), Florida Administrative Code (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., an annual assessment of 1.5 percent was imposed on the net operating revenues of ambulatory surgical centers and mobile surgical facilities, licensed under s. 395.003, F.S.; 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.; 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. Chapter 98-192, L.O.F., exempted hospital outpatient radiation therapy services from the assessment and repealed the assessment on freestanding radiation therapy centers, contingent on the receipt of federal confirmation that these changes would not adversely affect the use of the remaining assessments as state match for the Medicaid program. According to AHCA, there are currently 382 diagnostic imaging centers, 254 ambulatory surgical centers, and 345 clinical laboratories subject to the PMATF assessment.

### ***How Is the PMATF Assessment Implemented?***

The agency imposes an assessment of 1.5 percent against the annual net operating revenue of each health care entity that is subject to the PMATF assessment. Within four months (120 days) after the end of each health care entity's fiscal year, each 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., 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. Section 395.7015(1)(b), F.S., 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., 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.

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

Chapter 98-192, L.O.F., codified as s. 395.7015, F.S., 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 AHCA, 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. Prior to the 1999 Regular Legislative Session, the agency had 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 remained in effect.

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

Section 3 of chapter 99-356, L.O.F., modified the contingent effective date enacted in 1998 for the removal of the annual PMATF assessment on outpatient radiation therapy services and

freestanding radiation therapy centers. If HCFA notifies AHCA, in writing, between April 15, 1999, and November 15, 1999, that the removal of the assessment violates federal regulations, then the removal of the assessment is repealed. The repeal would only take effect upon the date that the Secretary of State receives notification from AHCA of the federal determination. Before ch. 99-356, L.O.F., took effect (July 1, 1999), AHCA received confirmation on May 28, 1999 from HCFA that the changes would not adversely affect the use of the remaining assessments as state match for the Medicaid program and the exemption and elimination of the PMATF assessment were subsequently implemented retroactive to July 1, 1998.

### ***Public Medical Assistance Trust Fund Task Force***

Section 192, ch. 99-397, L.O.F., provided 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 task force had to consider and make specific recommendations to the Legislature, 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.

The task force completed a report by December 1, 1999, of its findings and recommendations which includes proposed legislation. The PMATF task force report included thirteen findings and seven recommendations:

- The State should work toward repeal of the PMATF assessment, if the lost revenue is replaced from another source.
- Such repeal should occur in stages.
- Phase one should be implemented in Fiscal Year 2000-2001 by repealing the assessment on: ambulatory surgical centers; diagnostic imaging centers; clinical laboratories; and hospital-based outpatient services.
- The State should seek approval from federal authorities for exemption of hospital outpatient services to ensure federal financial participation is not jeopardized.
- The \$85 million in revenue lost through the phase one repeal should be replaced in order to maintain the federal financial participation.

- The replacement funds should come from tobacco funds or whatever other revenue source the Legislature finds appropriate. Tobacco funds represent a particularly appropriate funding sources because of the health-related nature of the settlement.
- The annual cap on hospital outpatient services for adults under the Medicaid program should be raised from \$1,000 to \$2,000.

### ***Annual Cap on Hospital Outpatient Services for Adults***

Sections 408.90 - 408.908, F.S., create the MedAccess program to offer basic, affordable health care services to those Floridians who have not had access to the private health insurance market. Section 408.904, F.S., sets the benefits that are to be provided under the program. Under this section, hospital outpatient services are capped at \$1,000 per calendar year per member. The MedAccess program has not been funded and has never been implemented.

Section 409.905(6), F.S., requires AHCA to pay for preventive, diagnostic, therapeutic, or palliative care and other services provided to a Medicaid recipient in the outpatient portion of a hospital. Payment is limited to \$1,000 per state fiscal year per adult recipient. Section 409.908(1)(a), F.S., limits Medicaid reimbursement for outpatient services to \$1,000 per fiscal year per adult recipient except for renal dialysis services and for other exceptions made by AHCA. The agency has listed the criteria for the exceptions in administrative rule 59G-4.160(5), F.A.C. The criteria for the exceptions made by the agency are for services that may be safely performed in the outpatient setting and are more cost-effective when done in the outpatient setting rather than in the inpatient setting.

### ***Medicaid Cost-Effective Purchasing***

Section 409.912, F.S., requires AHCA to purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. The agency must maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies to facilitate the cost-effective purchase of a case-managed continuum of care. The agency must also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high cost services. The agency is authorized to enter into agreements with any public or private entity on a prepaid or fixed-sum basis for the provision of health care services to Medicaid recipients.

## **III. Effect of Proposed Changes:**

The bill implements the recommendations of the PMATF Task Force. The bill specifies legislative findings regarding the PMATF.

**Section 1.** Amends s. 395.701(2), F.S., reducing the annual assessment on net operating revenues attributed to hospital out patient services from 1.5% to 1.0%.

**Section 2.** Amends s. 395.7015(2)(a), F.S., reducing the annual assessment on net operating revenues attributed to ambulatory surgical centers, clinical laboratories, and diagnostic-imaging centers from 1.5% to 1%.

**Section 3.** Amends s. 408.904 (2)(c), F.S., relating to benefits covered by the MedAccess program, to increase the annual reimbursement limit on hospital outpatient services for persons covered by the MedAccess program from \$1,000 to \$1,500 per calendar year per member.

**Section 4.** Amends s. 409.905(6), F.S., relating to mandatory Medicaid program services, to increase the annual reimbursement limit on hospital outpatient services for adults covered by the Medicaid program from \$1,000 to \$1,500 per state fiscal year per recipient.

**Section 5.** Amends s. 409.908(1)(a), F.S., relating to Medicaid program reimbursement of providers, to increase the Medicaid reimbursement limit for hospital outpatient services provided to covered adults from \$1,000 to \$1,500 per state fiscal year per recipient.

**Section 6.** Amends s. 409.912(3)(e), F.S., relating to requirements for AHCA to make cost-effective purchasing of health care goods and services for Medicaid recipients, to authorize AHCA to contract with and to reimburse an entity located in Pasco County or Pinellas County that provides in-home physician services to Medicaid recipients with degenerative neurological diseases to test the cost-effectiveness of enhanced home-based medical care. The amendment to this section by the bill repeals on July 1, 2002.

**Section 7.** Requires the Department of Health's Volunteer Health Care Provider Program to conduct a survey and publish a report annually on the uncompensated care for which health providers receive no reimbursement.

**Section 8.** Directs the Legislature to appropriate each year from the General Revenue Fund to the PMATF an amount sufficient to replace the funds lost due to the reduction by this act in the assessment on hospitals under s. 395.701, F.S., and the reduction by this act in the assessment on health care entities under current s. 395.7015, F.S., and to maintain federal financial participation.

**Section 9.** Appropriates the sum of \$28.3 million from the General Revenue Fund to the Agency for Health Care Administration for the purpose of implementing this act. However, such appropriation shall be reduced by an amount equal to any similar appropriation for the same purpose which is contained in other legislation adopted during the 2000 legislative session and which become law.

**Section 10.** Provides an effective date of July 1, 2000.

#### **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:

The bill reduces revenues to the Public Medical Assistance Trust Fund (PMATF) in fiscal year 2000-01 by \$28.3 million. The bill appropriates \$28.3 million from the General Revenue Fund to the PMATF to replace the reduction in revenues. Further, the bill directs the Legislature to make an annual appropriation to the PMATF to replace the reduction in revenues as a result of this act.

B. Private Sector Impact:

In fiscal year 2000-01, hospitals will save an estimated \$28.3 million in hospital assessment fees as a result of this act.

C. Government Sector Impact:

The Social Services Estimating Conference met on February 18, 2000, and adopted the following estimates for the PMATF for Fiscal Year 2000-2001:

**PMATF**  
**Estimates for Fiscal Year 2000-2001**  
*(Source: Agency for Health Care Administration)*

ESTIMATED REVENUES:

Assessments on hospitals	\$248,800,000
Assessments on other health care entities	15,500,000
Cigarette tax distribution to PMATF	113,500,000
Interest	2,700,000
<b>Total Estimated Revenues</b>	<b>\$380,500,000</b>

ESTIMATED EXPENDITURES:

Hospital Inpatient Services	\$380,300,000
Administration	200,000
<b>Total Estimated Expenditures</b>	<b>\$380,500,000</b>

The increase in the annual cap on hospital outpatient services from \$1,000 to \$2,000 will result in Medicaid reimbursement for hospital outpatient services to increase by an estimated \$26,895,782 (\$11,667,390 from Florida and \$15,228,392 from the federal government) per year according to AHCA.

Under the provisions of the bill, the Agency for Health Care Administration estimates that it will need \$26,895,782 (\$11,667,390 from Florida and \$15,228,392 from the federal government) to fund the increase in the annual cap on hospital outpatient services plus \$84,959,000 to replace the revenue shortfall due to the reduction in annual assessments on net operating revenue which will not be collected and deposited in the PMATF totaling \$111,854,782.

**VI. Technical Deficiencies:**

None.

**VII. Related Issues:**

None.

**VIII. Amendments:**

None.

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

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