

## Should Florida have a Healthcare Provider Services Assessment?

### Executive Summary

In tough economic times, policymakers are often forced to make tough decisions. With Florida's economy currently in the midst of a recession and the state suffering unprecedented fiscal difficulties, it is time for Florida policymakers to consider creating a Healthcare Provider Services Assessment (HPSA) in order to prevent reductions and ensure quality patient care. With the implementation of the HPSA, state coffers would increase and the state would be better positioned over the coming years to cover its annual Medicaid expense liabilities.<sup>1</sup> In the future as the state's economic and fiscal conditions improve, the assessment could possibly be dedicated to increasing funding for nursing homes (NH)—as a March 2004 Florida TaxWatch study found was necessary.

Recent cuts in Medicaid reimbursement rates to NHs have negative implications and prospects for the quality of care offered to residents. As a way of increasing revenues and offsetting the cuts to Medicaid providers over recent years, the Florida Health Care Association (FHCA) and its member NHs have recommended to the Legislature a proposal for a HPSA. The intended goal of the HPSA is to not only allow the Legislature to temporarily replace General Revenue (GR) with a business-supported revenue stream, but also buy back rate cuts of the past and prevent future cuts. **Without the adoption of a HPSA, there may be further cuts in funding to Medicaid service providers, resulting in a reduction of quality and services.**

**Upon review of the proposed policy, Florida TaxWatch endorses the immediate implementation of the Healthcare Provider Services Assessment in Florida.**

### Introduction

The impending rise in Medicaid is quickly becoming a tsunami that has the potential of washing away funding for other core services that the Legislature provides annually. Florida implemented the Medicaid program on January 1, 1970 and the Legislature has authorized additional services since then with a major expansion in 1989, when Congress mandated states to provide all Medicaid services allowable under the Social Security Act to children under the age of 21. Florida has the fourth largest state Medicaid enrollment and ranks fifth in spending. These funds, provided to practitioners and care facilities through state reimbursement and federally-matched dollars, are meant to enable these healthcare providers with financial support to remain open and cover the cost of services for patients that are economically disadvantaged

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<sup>1</sup> See 409.908 F.S. Reimbursement of Medicaid Providers

and unable to pay for the services themselves. Unfortunately, these funding mechanisms are not adequate to cover the costs of the services required to properly care for the elder population that reside in NHs.

The scope of the shortfall for NH services at the national level was recently clarified in an October 2008 study conducted by Elijay, LLC.<sup>2</sup> The report indicated that a mix of an increase in federal matching program participation and overall state budget revenue increases have coalesced to result in a lowering of the per-day NH Medicaid reimbursement rate shortfall from \$14.60 in 2003 to a projected \$12.48 in 2008. This shortfall represents the cost differential between actual cost of services provided and Medicaid reimbursement of said cost. Unfortunately the Elijay study follows these data with the fact that this trend is coming to an abrupt halt, as tax receipts from the first quarter of 2008 were 5.3% below the first quarter receipts of 2007, while Medicaid expenses for 2008 are projected to increase 6.3%, as unemployment and poverty rates rise due to an ailing economy--which leads to a rise in enrollment and expense growth.

The core of the increasingly difficult Florida Medicaid funding shortfall is rooted in three main issues: (1) the nearly 3.7 million uninsured Floridians; (2) the rapidly growing size of the aging population; and (3) the budget cuts that are being forced upon the legislature by a troubled economy and slumping revenues. It is widely accepted that Medicaid expenses are an unbalanced provision—that is, a small percent of the Medicaid population are responsible for a large percent of the Medicaid cost. For example, according to a Kaiser Family Foundation study, in Fiscal Year (FY) 2005 the elderly and disabled represented 29% of all Medicaid enrollments and 65.9% of Medicaid spending (\$9,212 and \$10,577 per person, respectively). In the next budget year, FY 2006, Medicaid payments for nursing home (NH) care alone were in excess of \$2 billion—more than half of total long-term care costs of over \$4 billion. Yet there is still a lack of funding to allow the reimbursement rate to equal the actual cost for these services.

The Florida Health Care Association (FHCA) and its member facilities have recommended to the Legislature the implementation of a healthcare provider services assessment (HPSA) to improve funding capacity to NHs throughout the state.

Florida TaxWatch (FTW) has been asked to analyze the possible economic impacts of a HCPA. This study focuses on said assessment to NHs in Florida, as they are defined in 400.021 F.S. The goal of this study is to determine what benefits and/or detriments will be experienced by Florida, and the impacts that this new fee will have on taxpayers, NHs, and the residents of these providers.

FTW promotes the maximization of earning federal dollars as a way to alleviate the burden placed on the state's taxpayers. Florida can accomplish this by implementing a program that assesses a fee to NHs that operate for the purposes of elderly, indigent, or disabled care. If proven successful, this assessment may have the potential of being translated to other health care providers, as outlined in federal law.

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<sup>2</sup> Elijay, LLC *A Report on Shortfalls in Medicaid Funding for Nursing Home Care*

We will examine, to the extent that information is available, the impact to the state of Florida of a HPSA on long-term care providers for eligible elderly Medicaid recipients in Floridian NHs and present a cost-benefit analysis of the implementation of such an assessment.

## Healthcare Provider Services Assessments in the United States

The federal government has come to understand the funding deficiencies that came to fruition during the first couple of decades following the enactment of the Medicaid program in 1965. Especially during economic downturns, states cannot afford to sustain a statewide public subsidy of vulnerable citizens' healthcare costs on their own. Medicare and the State Children's Health Insurance Program (SCHIP) aid in covering these costs, but the limited eligibility requirements resign states to a position that necessitates an additional source of funding to ensure the health and safety of their citizens through the Medicaid program. As an attempt to assist states in the Medicaid burden, the federal government has created an avenue of funding—the Healthcare Provider Services Assessment (HPSA)—through which states can increase their capacity for revenue generation internally, while matching these funds at the national level through the Federal Medical Assistance<sup>3</sup> Percentage (FMAP) rate. The FMAP will be discussed in greater detail later in this report.

The federal laws that describe the proposed assessment are found throughout Title 42 of the Code of Federal Regulations (CFR), §433.55 through §433.74.<sup>4</sup> This legislation is set up as a means to generate new funding that the federal government would match. Created during the Reagan administration, rules and regulations have been amended over the program's lifespan, but have been in place as a more precise presence since 1993.

As defined in 42 CFR, §433.55(a), the HPSA is "...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."

Other specific requirements for the HPSA include:

1. *must* place no less than 85% of the assessment burden for generated revenues on the shoulders of healthcare providers (no more than 15% of the cost can be passed on to the NH resident)
2. *must* include all services and items provided by the NH to their residents that would otherwise be taxed to the general public, for example food services
3. *must not* include criminal or civil penalty payments, unless those revenues were generated in lieu of the assessment
4. *must not* include healthcare insurance premiums and health maintenance organization (HMO) premiums paid to ensure coverage or enrollment for items or services provided
5. *must not* exceed 25% of the non-federal share of Medicaid expenditures

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<sup>3</sup> "Under federal law, the term 'medical assistance' is used to describe payment to providers for the costs of the 27 different categories of health and long-term care services that states are able to cover (with federal matching funds) under their Medicaid programs. Thus, the FMAP formula applies to the costs of almost all Medicaid-covered services for almost all Medicaid-eligible populations. The federal share of 'medical assistance' costs in each state varies inversely with state per capita income: the poorer the state in terms of per capita income, the higher the state's FMAP."

*The Medicaid Matching Formula: Policy Considerations and Options for Modification*, Vic Miller & Andy Schneider; September 2004

<http://www.aarp.org/research/assistance/medicaid/aresearch-import-918-2004-09.html>

<sup>4</sup> [http://www.access.gpo.gov/nara/cfr/waisidx\\_03/42cfr433\\_03.html](http://www.access.gpo.gov/nara/cfr/waisidx_03/42cfr433_03.html)

6. *must not* guarantee to those being assessed that the revenues would be returned to them

The language outlining the mandatory parameters that must be implemented to allow for the assessment is found in Title 42, §433.68 of the CFR, which states:

"...a State may receive, without a reduction in FFP [Federal Financial Participation], health care-related taxes if the following are met: (1) The taxes are broad-based... (2) The taxes are uniformly imposed throughout a jurisdiction...and (3) The tax program does not violate the hold harmless provisions..."

Services provided through NHs<sup>5</sup> are included within 42 CFR, §433.56 as one of nineteen possible services and providers specified to which this assessment may be applied.

Original CFR language allowed for up to a 6.0 percent assessment to be paid by eligible facilities, but has recently been amended (see federal statute PL 109-432) to limit this fee to 5.5 percent of an eligible provider's revenues until September 30, 2011, when the temporary ceiling is set to expire and revert to its previous limit. A number of states have enacted their assessment under a lower rate—2 or 3 percent—in initial stages of implementation, but adjusted them upwards over time after observing the positive and successful impacts of federal and state revenue generation.

States utilize a variety of options in their implementation of HPSAs.<sup>6</sup> In general, states have adopted four methods by which they have applied a HPSA; although, however it is accomplished, the amount cannot exceed the percentage limit to facility revenues. These four methods are:

1. Annual assessment per licensed bed: A flat rate applied to every non-exempted, licensed resident bed
2. Assessment per occupied bed: A flat fee per resident day, per occupied bed
3. Assessment per non-Medicare day: A flat fee applied to resident days not paid for by Medicare<sup>7</sup>
4. Assessment as a percent of revenue: A flat rate, applied to a facility's revenues

As of October 2008, eight states utilized method 1, eight states utilized method 2, twelve utilized method 3, and five utilized method four. Of these thirty-one states, twenty were either at or near the 5.5 percent federal limitation. Colorado recently approved a HPSA, but is not included in this analysis.

A key component of the HPSA is the option to include waivers within a state's enacting legislation. Florida-specific waivers will be discussed in greater detail in the next section, but federal regulations, which are overseen by the Center for Medicare and Medicaid Services (CMS)<sup>8</sup>, provide a framework with which states can modify individual exemptions, based on

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<sup>5</sup> According to the FHCA, **80% of all NH residents in Florida are Medicaid recipients**

<sup>6</sup> Joseph M. Lubarsky, CPA; President Eljay, LLC

<sup>7</sup> Medicare expenditures are not eligible for FFP match. According to FHCA, approximately 60% of NH entrants are discharged within 50 days (occupational/physical therapy) and a large number of these are Medicare days; of those in this category, there exists some overlap with Medicaid

<sup>8</sup> The mission of CMS is "to ensure effective, up-to-date health care coverage and to promote quality care for beneficiaries." CMS approves all provider assessment plans. CMS also determines eligibility and legality in granting permission to states to allow for waivers for some facilities. The guidelines and restrictions CMS uses to determine eligibility are very stringent and protective of the federal government and Medicare/Medicaid recipients.

their own economic, social, and facility conditions. There are a variety of waivers that focus on exemptions from the requirements in Title 42 CFR, §433.68. The bases and conditions for these waivers are outlined in Title 42 CFR, §433.72.

## **Florida Healthcare Provider Services Assessment**

Florida was the first state to enact an annual assessment in 1984 (see 395.701 F.S.). This assessment was created exclusively for hospitals and has been capped at 1.5% of annual net operating revenues. The funds generated by this fee are placed in the Public Medical Assistance Trust Fund (PMATF) and is used by the state to match hospitals for inpatient services. It is proposed that a methodology similar to that for hospitals be developed for NHs.

However, by the end of FY 2007, 43 other states and the District of Columbia<sup>9</sup> also had in place at least one form of a "Provider Tax," which is generally identified by states as a "fee" or "assessment." In terms of NH assessments, there are currently 32 states and the District of Columbia that have enacted this fee. **Without the adoption of a HPSA, there may be further cuts in funding to Medicaid service providers, resulting in a reduction of quality and services.**

When asked to predict the costs to the state for implementation and continuation of the HPSA, AHCA estimated the amount for start-up to be between \$500,000 and \$700,000 in administrative expenditures. This cost includes three to five new full time equivalent (FTE) employees. An upfront cost for information technology (IT) needs<sup>10</sup> of \$200,000 is also incorporate into this estimate. **The upfront cost of implementation would be recovered from the first federal reimbursement funds resulting from an increase in Medicaid spending and equates to a fraction of a penny of the Medicaid reimbursement rates to NHs—even at the high end of the AHCA estimate of \$700,000.**

### *Background on Florida's Medicaid Program*

On January 1, 1970, Florida initiated its Medicaid program and since then a variety of services and procedures have been added to the list of covered offerings throughout the state program's lifetime. Over the years, with expansion and growth of services and population, the budgeted amounts for Medicaid expenditures have grown to reach the current fiscal year's funding amount of \$15.6 billion<sup>11</sup>. This growth is due, in part to the state's expansion of offerings, but also the occurrence in 1989 the United States Congress mandated states to provide all Medicaid services allowable under the Social Security Act to anyone 21 years old and below, a significant expansion in both eligibility and expense. NH-specific funding formulas and guidelines are outlined in Florida Title XIX Long-Term Care Reimbursement Plan Version XXXIII, effective as of January 1, 2008.<sup>12</sup>

In order to receive reimbursement from the federal government, Florida—as is the case for all states—is required to submit a quarterly financial report consisting of eight forms in total (November 15, February 15, May 15, and August 15), which is known as the CMS-37, which

<sup>9</sup> <http://ncsl.org/programs/health/healthtaxes.htm>

<sup>10</sup> Development of electronic filing, submittal, and recording functions that would be added to current Medicaid programming

<sup>11</sup> Lines 182-241 of House Bill 5001

<sup>12</sup> [http://www.fdhc.state.fl.us/Medicaid/cost\\_reim/pdf/long\\_term\\_care\\_v33.pdf](http://www.fdhc.state.fl.us/Medicaid/cost_reim/pdf/long_term_care_v33.pdf)

includes estimates and underlying assumptions for two fiscal years (FYs)—current and budget FYs. The state is obligated to certify that requisite matching state and local funds are, or will be, available for the certified quarter for which the state is submitting information. These data supplied to CMS through the Medicaid Budget and Expenditure System (MBES) and is thusly analyzed by CMS. If the information is found to be valid, then CMS issues the state a grant award authorizing federal funding for the certified quarter.

[Florida] may submit a revised CMS-37 through the MBES if the state believes that the original request for federal funds is insufficient. The revised submission should include justifications for its request and recertify the data for the quarter in question. Following review and approval, CMS issues a supplemental grant award to the state of Florida for additional federal funds needed.<sup>13</sup>

In Sec.1902 [42 U.S.C. 1396a] (5), the federal government requires a state to assign the oversight, administration, and supervision of medical assistance programs to a single state agency. In Florida, the Agency for Health Care Administration (AHCA) develops and carries out policies related to the Medicaid program. A description of the services offered by the Florida Medicaid program can be found in the AHCA Medicaid Summary of Services, 2008-2009.<sup>14</sup> The Florida Department of Elder Affairs (FDEA) is responsible for establishing regulations for assisted living facilities, while AHCA is responsible for inspection, issuing licenses, and oversight.<sup>15</sup>

In **March of 2004, Florida TaxWatch released a report**<sup>16</sup> that discussed the status of proper NH Medicaid reimbursement rate funding. This report concluded that Medicaid reimbursement rate losses for NHs ranged from \$12.15 in 1999 to \$14.72 in 2004.<sup>17</sup> The reimbursable rates included those for resident care, operations, and property costs. These average per diem losses, costed out over the span of an entire year, resulted in an overall loss of over \$234 million for NHs in 2004 alone. The study concluded with these two comments:

- 1. The critical question, however, is “How long can high quality patient care be maintained henceforth if nursing homes are not adequately funded to meet the challenges they face?” Medicaid reimbursements need to match nursing homes’ actual costs, or quality care could suffer<sup>18</sup>**
- 2. Since Medicaid reimbursements are not growing as fast as the growth in Medicaid costs, the legislature and the industry should explore ways to further both increase reimbursements to needed levels as well as methods to reduce costs before quality of service to nursing home residents begins to suffer**

Unfortunately, these thoughts remain unanswered and the funding disparity and affordability of operations for NHs are still prominent issues that require a remedy. Using data compiled by

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<sup>13</sup> [http://www.cms.hhs.gov/MedicaidBudgetExpendSystem/03\\_CMS37.asp#TopOfPage](http://www.cms.hhs.gov/MedicaidBudgetExpendSystem/03_CMS37.asp#TopOfPage)

<sup>14</sup> [http://www.fdhc.state.fl.us/medicaid/pdf/files/SS\\_08\\_080701\\_SOS.pdf](http://www.fdhc.state.fl.us/medicaid/pdf/files/SS_08_080701_SOS.pdf)

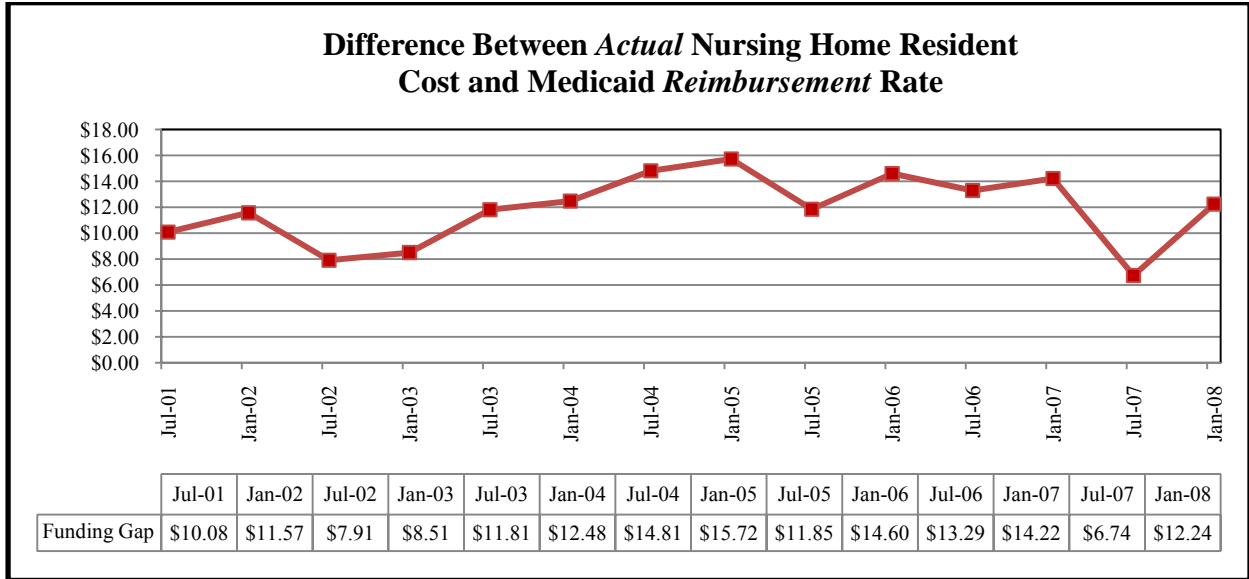
<sup>15</sup> <http://www.ahrq.gov/research/residentcare/rescare6.htm#fl> (For statutory delineation between agency responsibilities, see [Chapter 408 F.S.](#))

<sup>16</sup> <http://floridataxwatch.org/resources/pdf/FINALnursinghome.pdf>

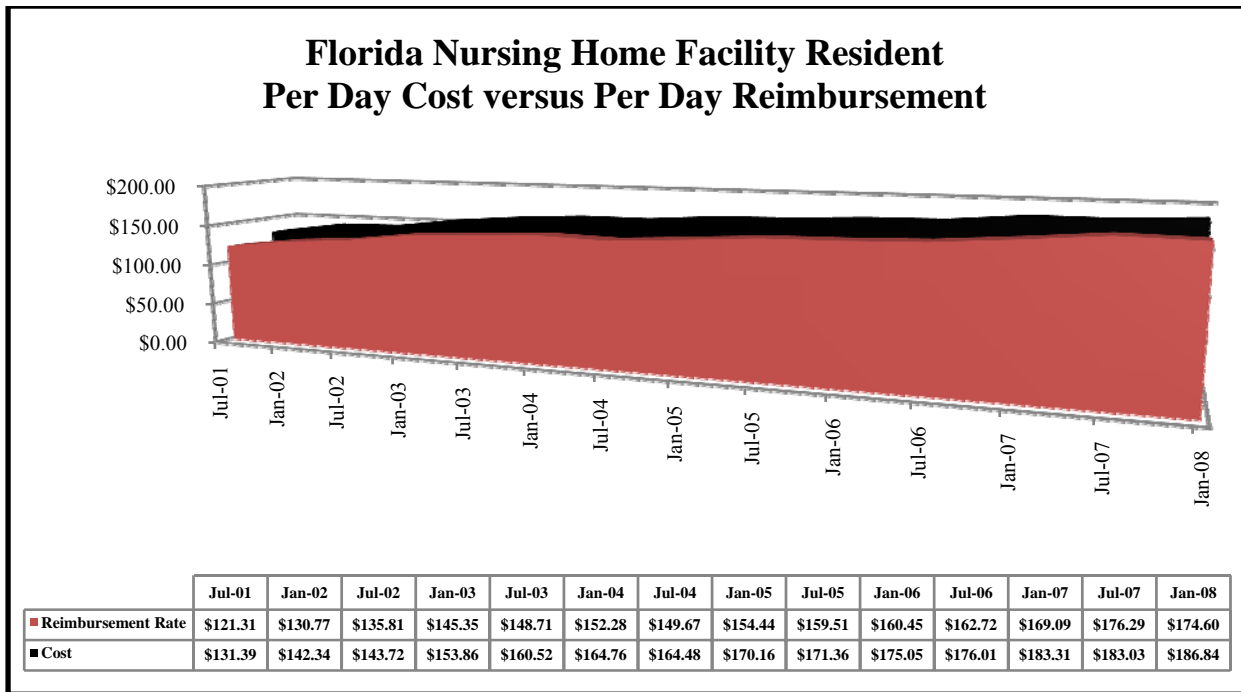
<sup>17</sup> Although the difference may seem small at first, multiply this amount by the number of residents in a NH by the number of days in a given year to determine annual financial loss impact on a NH

<sup>18</sup> See “Nursing Homes with Persistent High and Low Quality,” Medical Care Research and Review, Vol. 61, Issue 2, April, 2004, p. 89 for an interesting discussion of the requisite needs of NHs in order for them to be able to persistently maintain high quality care.

FHCA, using data supplied by AHCA<sup>19</sup>, Florida TaxWatch has obtained the following data to update a portion of our previous study:



Source: Florida Healthcare Association via Florida Agency for Health Care Administration Database



Source: Florida Healthcare Association via Florida Agency for Health Care Administration Database

<sup>19</sup> FHCA uses a weighted average based on rate setting data provided to them by AHCA. AHCA does not dispute FHCA data methodology.

## FMAP

Further complicating the funding shortfall is the federal match rate, which is determined using the (FMAP) formula. The FMAP formula is explained in federal statute and used to calculate each state's rate, which is based on the relationship between its per capita personal income and the national average per capita personal income over the span of three calendar years. The minimum FMAP rate is 50 percent (please see the following table for comparison of FMAP rates). The formula<sup>20</sup> can be expressed as follows:

$$FMAP = 100 \text{ Percent minus State Share}$$

$$\text{State Share} = 0.45 \times [\text{State per capita income}^2 / \text{U.S. per capita income}^2]$$

### FMAP Rates of Florida and Comparable States

	2004	2005	2006	2007	2008	2009
United States	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%
Texas	63.17%	60.87%	60.66%	60.78%	60.53%	59.44%
<b>Florida</b>	<b>61.88%</b>	<b>58.90%</b>	<b>58.89%</b>	<b>58.76%</b>	<b>56.83%</b>	<b>55.40%</b>
New York	52.95%	50.00%	50.00%	50.00%	50.00%	50.00%
California	52.95%	50.00%	50.00%	50.00%	50.00%	50.00%

Source: Kaiser Family Foundation <http://www.statehealthfacts.org/comparetable.jsp?ind=184&cat=4&sort=1049>

These rates have significant repercussions on state budgets. Though they are based on a state's per capita income—and hence (it is theorized) their citizens' ability to cover their own medical costs—FMAP rates often dictate to a large extent a state's ability to cover the costs for its low-income population. Depending upon the size of a state's Medicaid program, adjustments to the FMAP of only one fourth or one half of a percentage point can equate to an economic windfall or catastrophe of tens or hundreds of millions of dollars in matching federal funding.

As the demand grows for new sources of revenue at the state level due to recent economic conditions that have led to decreases in various tax revenues—sales taxes in particular in Florida—states have repeatedly turned to healthcare provider assessments as a way to increase their revenues and decrease the burden for Medicaid reimbursements that typically consume a large portion of any given state's overall budget expenditures. By 2004, 20 states had implemented an assessment on NH care providers, but by 2008 that number had grown to 32 plus the District of Columbia. Overall, provider taxes on NHs generate over \$4.0 billion in matching federal funds, and in the states affected, are used to reimburse an average of \$15 per patient day in allowable Medicaid NH costs.<sup>21</sup>

<sup>20</sup> The mathematical expression of this formula is:

$$FMAP_i = 1 - (.45 \times \sum(Y_{ni} + Y_{(n+1)i} + Y_{(n+2)i})^2 / \sum(Y_{nUS} + Y_{(n+1)US} + Y_{(n+2)US})^2)$$

Where  $FMAP_i$  = the FMAP of state  $i$ ,  $Y_{ni}$  = the per capita income of state  $i$  in year  $n$ , and  $Y_{nUS}$  = the average U.S. per capita income in year  $n$

<sup>21</sup> Eljay, LLC *A Report on Shortfalls in Medicaid Funding for Nursing Home Care*

During the last national economic crisis in FY 2003, most states were faced with severe revenue shortfalls. Similar to Florida's current situation, state revenues decreased at that time as a result of a weakened US economy. The National Conference of State Legislatures indicated that most states faced deficits in their FY 2003 and FY 2004 budgets. These funding shortfalls resulted in a reduction of spending, increases in revenues, or a combination of both in order to meet with balanced budget requirements. Medicaid, being one of the largest expenditures at the state level, was targeted.

In the report, *The Medicaid Matching Formula: Policy Considerations and Options for Modification*, by Vic Miller & Andy Schneider that was published in September of 2004, the authors outline the fiscal impacts of reductions in Medicaid spending as follows:

"Because the federal government shares in the cost of state Medicaid programs, states that need to reduce their own spending must cut Medicaid program spending by more than what they want to save in their own-source contributions. For example, to save \$1 of its own funds, a state with a 50 percent FMAP must reduce Medicaid spending by \$2. The providers that would have received the \$2 in Medicaid payments that are no longer spent for services to beneficiaries will experience a loss of \$2; the state will save \$1; and the federal government will save \$1. This effect is magnified in high-match states. To save \$1 of its own funds, a state with a 70 percent FMAP must reduce Medicaid spending by \$3.33. Providers will lose the full amount in Medicaid payments, and the federal government will save \$2.33. The loss of federal revenues has an impact not just on affected Medicaid providers in a state, but also on the state's economy as a whole. The withdrawal of federal Medicaid funds is more likely to weaken the state's economy than to revive it."

### *Assessment Dollar Inclusion into Reimbursement Funding Process*

The process for determining federal reimbursement for the HPSA and the process through which these dollars are to be included is complex and specific. The following section of this report has been included as an attempt to simplify these intricacies for the reader.

Many limitations on HPSA Federal Funding Participation (FFP) are written into Title 42, C.F.R., but a majority of them do not apply to the currently proposed Florida HPSA<sup>22</sup>. The applicable limitations are referenced in 42 C.F.R. §433.57 and generally refer to permissible provider-related donations and health care-related taxes. The provider-related donations are only limited if not considered to be "bona fide donations," as specified in 42 C.F.R. §433.54. The HPSA is only limited if it does not meet the guidelines and standards of uniformity and being broad-based. **Therefore, the FFP will not be negatively affected unless the funds do not adhere to federal requirements. These limitations should also be included in any enacting legislation that may be considered by the Florida Legislature.**

HPSA revenues eligible for FFP generally cannot exceed 25% of state/non-federal Medicaid expenditures.<sup>23</sup> For example, Florida's budgeted Medicaid expenditures for FY 2009 are \$15.6

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<sup>22</sup> Several limitations in Title 42 C.F.R. reference "transition periods," whose timelines expired prior to 1996 (e.g. §433.58 and §433.67)

<sup>23</sup> <http://ncsl.org/programs/health/healthtaxes.htm>

billion; therefore, the HPSA revenues eligible FFP limit is about \$3.9 billion. Also, as referenced previously, there is a temporary ceiling in place on the assessment. Currently the assessment cannot exceed 5.5 percent of a non-exempt NH's annual revenues. This moratorium will remain in place until the language in federal law is set to expire, or is renewed, in 2011. The previous maximum rate was set at 6 percent.

The complex process of financial transactions with the adoption of the HPSA lends itself to clarification. The transactions required to utilize the assessment is complicated, so the following explanation, example, and flow chart have been provided. To best illustrate the process, an example of "July Services" will be used.<sup>24</sup> (Please refer to the diagram on the next page, which correlates with the text):

In the end, the total number of transactions simply increases by one. Healthcare services rendered to residents by NHs on behalf of Medicaid (1) in July will be billed to the state (2) on August first. Upon receipt of the bill, the state will typically take five to ten business days (August 6<sup>th</sup> – 11<sup>th</sup>) to process the information and send a check to the NH (3a). The funds used to reimburse the NH are budgeted state funds (General Revenue and Medical Care Trust Funds). The financial information detailing the state dollars provided to NHs through Medicaid payments is sent to the federal government for reimbursement on expenditures (3.2). Therefore, the service is rendered and employees are paid prior to being reimbursed by the state.

Under the HPSA, this system would continue as it is, but one extra step and extra funding within multiple transactions would be included in the process. The one extra piece to the puzzle would fit in as the state is reimbursing the NH (3a). In other words, upon the receipt of payment from the state that includes the federal match, assessment, and Medicaid reimbursements, the NH would be "billed" by the state, in that the NH is required to pay an invoice each month and submit an accompanying form that details the financial transaction (3b).<sup>25</sup>

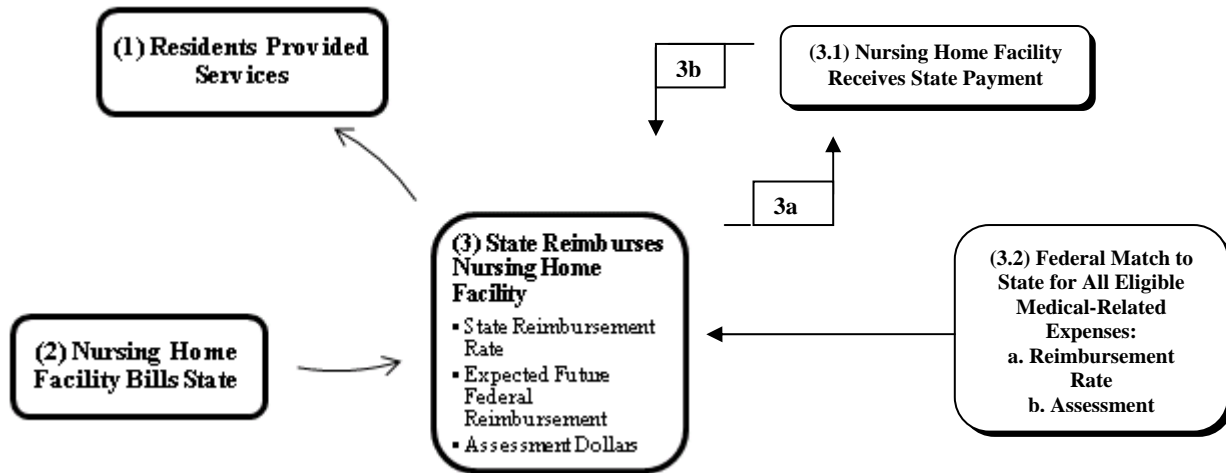
New revenues would be considered in multiple phases. First, the reimbursement to the NH would include assessment dollars for the month that was billed (in our example, the payment made on "August 6<sup>th</sup>" to the NH would include reimbursement for both services and the assessment for "July"). Second, the federal reimbursement transaction that is already in place would simply increase, as the pool of Medicaid dollars being distributed that are eligible for federal matching would have also increased.

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<sup>24</sup> Note: Specific dates are estimated and may vary based on facility.

<sup>25</sup> The reasoning behind the post-receipt NH reimbursement to the state is that prepayment would prohibit some NHs from being able to meet their monthly payroll responsibilities.

## Healthcare Provider Assessment Financial Flow Chart



For example:

If it costs \$1 per day per resident (eligible reimbursement only), then—in a 30-day month—the reimbursement amount will be \$30. This \$30 is then billed to the state. Assuming a full reimbursement<sup>26</sup>, the state then adds to its reimbursement total the amount of the expected assessment returns (5.5 percent of \$30 is \$1.65) for the purposes of the federal match. In this example, the federal match (FMAP rate of 56.83%) will be \$17.99. Without the additional HPSA, the federal match would only be \$17.05. Upon receipt of payment from the state that would total \$32.49 (\$30 + \$1.65 + \$0.84), the NH would then send payment of \$1.65 back to the state. After subtracting administrative costs<sup>27</sup>, the net gain of the assessment for a NH would be about \$0.84 per resident per month.

For every additional eligible resident in this example, after the deduction of administrative costs, **the state earns** approximately an extra \$0.03 per day (or \$0.84 per month). Multiplied out over time and number of eligible patient days, the new revenues generated by the state, at an assessment rate of 4 percent, have the potential to offset some or all of the FY 2009 suggested \$82 million cut to NH general revenue funding. Depending on the specifics of the model, the HPSA may allow general revenue savings in excess of \$125 million.

It is important to caution and to note that this revenue source is limited, in that the revenue assessment is capped at 5.5 percent. The HPSA should only be used to the extent necessary, during difficult economic times that may lead to rate reductions. **The assessment should only be set to its maximum allowable level if absolutely necessary.**

Among the variety of concerns voiced by proponents of the HPSA, the issue of guaranteed funding is often an area of discussion. Part of the federal requirements of the state HPSA is that

<sup>26</sup> Typical reimbursement does not cover complete costs; formula for reimbursement rate determination outlined in Florida Title XIX Long-Term Care Reimbursement Plan Version XXXIII, effective as of January 1, 2008

<sup>27</sup> For purposes of this example, administrative costs will be estimated at \$0.10 per resident per month

the matching dollars generated by this new revenue source cannot be promised to the facilities from which they originated (sometimes referred to as "Granny Grants"). However, CMS recently proposed a rule that would require these funds would be expressly directed towards those public NHs that are experiencing the Medicaid reimbursement losses that were described (with accompanying chart) previously in this report. In part, this rule change is aimed at guaranteeing that these matching dollars do not allow states to offset reductions in general revenues (GR) with new funds and create an avenue through which GR dollars that were previously spent on Medicaid reimbursement would be reappropriated for other uses. In effect, an infusion of new dollars might lead to a reduction in GR and would provide for the reduction or maintaining of Medicaid reimbursement rate levels that have led to shortfalls in NH funding. Congress placed a suspension on the possible implementation of this rule until April of 2009.<sup>28</sup>

### *Waivers*

One of the most complex elements of the HPSA is the option to implement waivers. An advantage for Florida is that a number of states, such as California, have already gone through the CMS approval process for waivers and the state can imitate and borrow from language, specifications, and responses already experienced by others.<sup>29</sup> Colorado's waiver system, with a few adjustments, is proposed to be used as the basis for Florida's model.<sup>30</sup>

These waivers are meant to allow for exemptions from the broad-based<sup>31</sup> and uniformity<sup>32</sup> requirements and are only applicable if the result of the exemption is generally redistributive. The broad-based requirement waiver is meant to exclude specific NHs, while the waiver of uniformity is meant to allow the state to charge variable tax rates. However, the hold harmless<sup>33</sup> provisions related to payer-burden still apply.<sup>34</sup> Either can be implemented or, as is proposed for Florida, a combination of the two waivers is also acceptable, if approved by CMS.

### *Hold Harmless in Florida*

The proposed HPSA is aimed at reducing the impact of increasing Medicaid costs to taxpayers and resulting reductions in funding for NHs. The federal law requires that a state cannot hold its citizens harmless. More specifically, it cannot hold those citizens that are assessed through this new revenue generating mechanism harmless. Therefore, **the HPSA is not an added cost to most of Florida's citizens**. Rather, its burden will fall solely upon those receiving the benefit.

According to the FHCA, there are currently 678 NH healthcare providers licensed by AHCA throughout the state. Using complex mathematical models and formulas, it has been determined that only five of these NHs will not receive an economic benefit from the HPSA. The federal law requires that there must be no less than one health care provider that incurs no economic benefit from the assessment. In addition to the five facilities that will receive no economic

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<sup>28</sup> Elijay, LLC *A Report on Shortfalls in Medicaid Funding for Nursing Home Care*

<sup>29</sup> Begin with 67 Florida NHs; All of which have been approved by CMS in other states (e.g. Continuing Care Retirement Communities (CCRCs))

<sup>30</sup> Florida Healthcare Association

<sup>31</sup> Broad-Based: 1) Must be redistributive; 2) Percent of HPSA paid through Medicaid days under waiver program must be no higher than under a broad-based HPSA (e.g. If Florida Medicaid represents 60% of total patient days, Medicaid's portion of HPSA cannot exceed 60%)

<sup>32</sup> Uniformity: 1) Must be redistributive; 2) Test of uniformity is statistical

<sup>33</sup> The mathematical slope of distribution between public and private NHs must not be less than before the HPSA.

<sup>34</sup> Joseph M. Lubarsky, CPA; President Elijay, LLC

benefit, there are another five facilities that will be impacted less by the cost to them for the assessment than they would have incurred under Medicaid funding reductions that will be reversed through the revenues generated by the HPSA. **Therefore, of the 678 NHs in Florida, over 99% will benefit from the enactment of a Healthcare Provider Services Assessment.**

A vital caveat must be written into any legislation that may be drafted on behalf of residents of the negatively impacted facilities. It must be acknowledged that there exists the potential that residents' room rates may go up with the increased cost to facilities (in an attempt to recoup possible revenue losses) and it is estimated that the cost passed down to each resident will equate to approximately an extra 4 to 6 percent for those facilities that do not recoup the assessment through their Medicaid rates. Approached with this realization, it is important to include in statutory language that a restriction for no direct pass-through of the assessment be placed by facilities on their residents.

### *Penalties for Non-Compliance*

As with any revenue generating activity, there arises the possibility that some entities liable for payment may not fully comply with legally outlined remittance requirements. One of the concerns voiced to the FHCA during implementation and strategy discussions with AHCA was the ability to impose penalties for those found to be in non-compliance. Penalty options for the Legislature to consider as it writes implementing and statutory language include, but may not be limited to:

- Imposing interest on overdue payments
- Withholding of future Medicaid reimbursements or other state funding for facilities until they are found by AHCA to be in full compliance
- Allow AHCA the authority to revoke or suspend the license of non-compliant facilities

### **Conclusion**

In good economic years, the HPSA may not be an optimal option, but in years of economic downturn the assessment may be a necessary evil to prevent reductions and ensure quality patient care. With the implementation of the HPSA, state coffers would increase and the state would be better positioned over the coming years to cover its annual Medicaid expense liabilities.

Recent cuts in Medicaid reimbursement rates to NHs have negative implications and prospects for the quality and extent of care services offered to providers' residents. As a way of increasing revenues and offsetting the cuts to Medicaid providers over recent years, the Florida Health Care Association (FHCA) and its member NHs have brought forth to the Legislature a proposal for a HPSA. The intended goal of the HPSA is to not only allow the Legislature to temporarily replace General Revenue (GR) with a business-supported revenue stream, but also buy back rate cuts of the past and prevent future cuts in the future. **Without the adoption of a HPSA, there may be further cuts in funding to Medicaid service providers, resulting in a reduction of quality and services.**

The HPSA would only effect a select group of individuals—residents of NHs. Also, based on preliminary findings of a model created by the FHCA in the image of other states' assessments already in place, the methodology and waivers will reduce the impact even further to this select group of Floridians. **The upfront cost of implementation would be recovered from the first federal reimbursement funds resulting from an increase in Medicaid spending and equates to a fraction of a penny of the Medicaid reimbursement rates to NHs—even at the high end of the AHCA estimate of \$700,000.**

It is important to caution and to note that this revenue source is limited, in that the revenue assessment is capped at 5.5 percent. The HPSA should only be used to the extent necessary, during difficult economic times that may lead to rate reductions. **The assessment should only be set to its maximum allowable level if absolutely necessary.**

**Upon review of the proposed policy, Florida TaxWatch fully endorses and supports the implementation of the Healthcare Provider Services Assessment.**

This *Special Report* was written by Ben Browning, Research Analyst

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Florida TaxWatch's research recommends productivity enhancements and explains the statewide impact of economic and tax and spend policies and practices on citizens and businesses. Florida TaxWatch has worked diligently and effectively to help state government shape responsible fiscal and public policy that adds value and benefit to taxpayers.

This diligence has yielded impressive results: in its first two decades alone, policymakers and government employees implemented three-fourths of Florida TaxWatch's cost-saving recommendations, saving the taxpayers of Florida more than \$6.2 billion -- approximately \$1,067 in added value for every Florida family, according to an independent assessment by Florida State University.

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