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.)

Date: April 1, 1998 Revised: _____ _____ _____ _____

Subject: Public Assistance

	Analyst	Staff Director	Reference	Action
1.	Williams	Wilson	HC	Favorable/CS
2.	Eccles	Smith	WM	Favorable/CS
3.				
4.				
5.				

I. Summary:

Committee Substitute for Senate Bill 484 is the product of an interim project by the Committee on Health Care relating to Medicaid reform. The bill directs the Agency for Health Care Administration (AHCA) to transition to a case-mix reimbursement methodology for Medicaid nursing home services; authorizes AHCA to include disease management strategies in its health care utilization review strategies; authorizes AHCA to competitively negotiate home health services, including seeking any necessary federal waivers; extends from 60 days to 90 days the period of time during which a Medicaid recipient may voluntarily disenroll from a managed care plan or MediPass provider; deletes the requirement that Medicaid managed care plans have a specific ratio of Medicaid enrollees to commercial enrollees; specifies the distribution of recoveries from third party benefits in cases where the recovery is more than 200 percent of the amount of medical assistance provided by Medicaid, less any medical coverage paid or payable to Medicaid; requires certain third-party benefits received by a Medicaid recipient to be remitted to AHCA within 60 days after receipt of settlement proceeds; revises the order under which a probate claim may be made against the estate of a recipient of public assistance from a class 7 claim to a class 3 claim; and requires circuit courts to provide a copy of a report of decedents to AHCA when such report is provided to the Department of Revenue.

The bill amends the following sections of the Florida Statutes: 198.30, 409.908, 409.910, 409.912, 409.9122, and 414.28.

II. Present Situation:

Medicaid is a medical assistance program that pays for health care for the poor and disabled. The program is jointly funded by the federal government, the state, and the counties. The federal government, through law and regulations, has established extensive requirements for the Medicaid

Program. The Agency for Health Care Administration is the single state agency responsible for the Florida Medicaid Program. The statutory provisions for the Medicaid Program appear in ss. 409.901 through 409.9205, F.S. The state budget for the program for the current fiscal year is $6,913,956,870, and the program anticipates serving 1,490,047 clients this year.

Program eligibility and service coverage standards are specified in the Florida Statutes. The federal government requires state Medicaid programs to provide services to certain eligibility groups, some of which are required to be covered, specified in s. 409.903, F.S., and some of which are covered at the state's option, under s. 409.904, F.S. The federal government requires state Medicaid programs to provide payment for certain services as a condition of receiving federal funds. Section 409.905, F.S., specifies the mandated Medicaid services. The federal government has also agreed to participate financially in paying for certain other services under states' Medicaid programs, if a state elects to cover these "optional" services. Section 409.906, F.S., specifies those 22 optional Medicaid services which Florida has agreed to provide to Medicaid recipients. Section 409.908, F.S., provides the statutory requirements under which providers of Medicaid services are reimbursed. Section 409.910, F.S., specifies responsibility for payments on behalf of Medicaid-eligible persons when other parties are liable. Paragraph (f) of subsection (12) of section 409.910, F.S., establishes the distribution of recoveries in cases where the recovery is less than 200 percent of medical assistance provided by Medicaid less any medical coverage paid or payable to Medicaid. Section 409.912, F.S., relates to cost-effective purchasing of health care services under Medicaid. Section 409.9122, F.S., relates to Medicaid managed care.

Florida's Medicaid Program has had an estate recovery program since the early 1980's as part of public assistance benefit recovery efforts. Prior to transfer of the Medicaid Program from the former Department of Health and Rehabilitative Services (HRS) to AHCA in 1993, estate recovery activities were handled by HRS district legal staff. In response to federal law changes and in an effort to generally strengthen the recovery efforts, AHCA established its own estate recovery program in 1995, and approximately $9 million have been recovered since that date via a contract with private attorneys working on a contingency fee basis. Section 414.28, F.S., specifies that public assistance payments, including Medicaid, constitute public debts by the recipient. Following the death of a public assistance recipient, the state is authorized to file a claim against the estate of a public assistance recipient for the amount of public assistance received. Under this section, such claims are considered a class 7 claim under s. 733.707(1)(g), F.S., relating to the order of payment of probate claims. Class 7 claims are those "debts acquired after death by the continuation of the decedent's business, in accordance with s. 733.612(22), F.S., but only to the extent of the assets of that business." As such, class 7 seems to be an incorrect class of claims for public assistance debts. Class 3 claims are those debts and taxes with preference under federal law. Since public assistance funding is partially derived from federal sources, class 3 seems the more appropriate level of such claims. Section 198.30, F.S., requires circuit court judges to provide to the Department of Revenue certain estate information.

The Medicaid reform project (Interim Project Report 97-P-34) focused on those Medicaid issues which were the subject of recent federal Medicaid law changes, or of ongoing concern to the

legislature from either a funding or policy perspective. The report offered several recommendations for specific actions to be taken. These recommendations addressed:

- Disproportionate share funding ceilings imposed by the federal Balanced Budget Act of 1997, and the resulting need for reductions in Florida's disproportionate share funding levels (to be addressed as part of the budgeting process).
- Nursing home reimbursement methodology, and consideration of moving to a case-mix reimbursement approach. Medicare is moving to a case-mix reimbursement approach effective July 1, 1998.
- Managed care provisions, specifically the period of time during which a Medicaid recipient may change managed care providers after having selected a managed care provider (current Florida law says 60 days; revised federal law says 90 days); and repeal of the federal requirement that Medicaid managed care entities have one commercial enrollee for each three Medicaid enrollees (the "75-25" rule).
- Need for state regulation of durable medical equipment providers as a Medicaid fraud related issue. The question to be addressed is whether this is best accomplished by state licensure requirements, or by a less-intensive regulatory approach such as some type of registration process. (Senate Bill 294 addresses this issue.)
- AHCA has included in its legislative package a proposal to strengthen its estate recovery efforts by: requiring the clerks of the court to provide AHCA with a copy of a report the clerks currently submit to the Department of Revenue detailing opened estates; clarifying that claims filed relating to public assistance debt be class 3, rather than class 7 claims; requiring the estate's personal representative to serve a copy of the notice of administration to AHCA; and requiring attorneys to remit payments to AHCA as required by s. 409.910, F.S., within 30 days after settlement.
- While the legislature has imposed in excess of $500 million in reductions in the Medicaid Program over the past 4 years, no real assessment of these funding reductions has been performed. AHCA, working through the Medicaid Estimating Conference process, should determine the extent to which these reductions have been realized.
- As authorized in the General Appropriations Act (GAA) for fiscal year 1997-98, AHCA is implementing disease management initiatives for asthma, diabetes, HIV/AIDS, and hemophilia. Indications are that five percent of Medicaid recipients account for 50 percent of program expenditures. AHCA should recommend to the legislature other diseases for which these mechanisms might be appropriate.
- The GAA for 1997-98 directed AHCA to pursue competitive negotiation of home health, durable medical equipment, and imaging services. Federal regulations require that a specific waiver is necessary to competitively bid home health services. AHCA included a specific request for authority in its legislative package.
- The federal Balanced Budget Act of 1997 modified provisions relating to cross-over payment policies for those recipients who are dually eligible for Medicare and Medicaid to indicate that the Medicaid payment rate for any such service is the maximum amount that should be paid. This should be clarified in the Florida Statutes.

III. Effect of Proposed Changes:

Section 1. Amends s. 409.908, F.S., relating to Medicaid reimbursement, to direct AHCA to establish a case-mix reimbursement methodology for nursing homes by July 1, 1999; to specify how AHCA is to develop the case-mix reimbursement methodology; and to prescribe guidelines for Medicaid payment of Medicare deductibles and coinsurance.

Section 2. Amends s. 409.912, F.S., relating to cost-effective purchasing of services under Medicaid to repeal a prohibition on specified contracts and eliminate a redundant provision; to specifically authorize AHCA to include disease management initiatives in its health care utilization review strategies; and to specifically authorize AHCA to competitively negotiate home health services, including seeking any needed federal waivers.

Section 3. Amends s. 409.9122, F.S., relating to Medicaid managed care, to: clarify which state agencies are involved in making Medicaid managed care or MediPass enrollees aware of their managed care enrollment options; increase from 60 days to 90 days the time period during which a Medicaid recipient may voluntarily change his or her mind about a selected managed care provider; and delete reference to any ratio of commercial enrollees to Medicaid enrollees in managed care plans.

Section 4. Amends s. 409.910, F.S., relating to Medicaid third-party liability, to specify the distribution of recoveries from third party benefits in cases where the recovery is more than 200 percent of the amount of medical assistance provided by Medicaid, less any medical coverage paid or payable to Medicaid; and to require that certain third-party benefits received by a Medicaid recipient be remitted to AHCA within 60 days after receipt of settlement proceeds.

Section 5. Amends s. 414.28, F.S., relating to public assistance payments constituting debts of the recipient, to specify that claims made against the estate of a public assistance recipient be considered class 3 rather than class 7 claims under s. 733.707, F.S., relating to order of payment of claims under probate proceedings.

Section 6. Amends s. 198.30, F.S., relating to the decedent information that circuit courts must furnish to the Department of Revenue, to require that this same information be submitted to AHCA by the circuit courts.

Section 7. Amends s. 154.504, F.S., to prohibit the use of copayments as compensation by health care providers.

Section 8. Creates s. 381.0022, F.S., to authorize the Department of Health and the Department of Children and Family Services to share confidential information on public health clients who are served by both departments.

Section 9. Creates s. 402.115, F.S., to authorize the Department of Health and the Department of Children and Family Services to share confidential information on public assistance clients who are served by both departments.

Section 10. Amends s. 414.028, F.S., to provide for a representative of a county health department or Healthy Start Coalition to serve as a nonvoting member of the local WAGES coalition.

Section 11. Amends s. 766.101, F.S., to redefine the term "medical review committee" to include a committee of the Department of Health.

Section 12. Amends s.383.04, F.S., to require the prophylactic to be used for the eyes of infants to be approved by the Committee on Infectious Diseases of the American Academy of Pediatrics.

Section 13. Repeals 383.05, F.S., to eliminate a requirement for the Department of Health to prepare prophylactic solution, disallowed by s. 383.04, F.S., for free distribution.

Section 14. Provides for a July 1, 1998, effective date.

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:

Those nursing homes serving Medicaid clients should see a more equitable reimbursement based on the acuity levels of the patients.

See the Government Sector Impact statement below for additional details.

C. Government Sector Impact:

While the transition to a nursing home case-mix reimbursement methodology can be accomplished in a cost-neutral manner, AHCA has included in its Legislative Budget Request an item totaling $20 million (of which $9 million is general revenue) for fiscal year 1998-99 for a 2.85 percent reimbursement rate increase for nursing homes. Since this amount is for a 6-month period, beginning January 1, 1999, this amount will annualize at $40 million for fiscal year 1999-2000. The House Appropriations Bill has funded this issue at $6.1 million in general revenue and $7.7 million trust. The Senate Appropriations Bill does not include a funding provision for this reimbursement policy. This matter will be worked out as part of the budgeting process.

The disease management initiatives that were approved as part of the General Appropriations Act for 1997-98 were estimated to generate approximately $4.2 million in savings for the current year. The bill grants AHCA specific statutory authority for these initiatives. As a corollary, AHCA is seeking $175,000 in expense funds as part of its 1998-99 Legislative Budget Request to be used to refine the prototype disease management model for Medicaid recipients with HIV/AIDS.

The competitive negotiation initiative for home health services that was approved as part of the General Appropriations Act for 1997-98 was estimated to generate approximately $3.0 million is savings for the current year. The bill grants AHCA specific statutory authority for this competitive negotiation.

During fiscal year 1996-97, AHCA collected $12.2 million under s. 409.910, F.S. An AHCA analysis of a sample of cases closed with collection during the first half of fiscal year 1997-98 indicated that 12 percent of the cases (which accounted for 13 percent of the money collected) were recovered under the formula provision of 409.910, F.S. That is, the settlement was less than 200 percent of the Medicaid claim. That means that 87 percent (or $10.61 million of the 1996-97 collections) of recoveries are not related to the existing formula with the under-200 percent threshold. Under the proposed revision, the amount recovered would be reduced by 25 percent plus the Medicaid share of costs. As a result, Medicaid would recover less than $7.96 million as compared to $10.61 million for those cases with settlements in excess of 200 percent of the Medicaid lien. Based on the AHCA analysis, the fiscal impact is estimated to be in excess of $2.65 million per year that AHCA will not recover.

The agency is unable to provide any estimate of the revenue that might be generated from the enhanced estate recovery activities that may result from this bill.

The requirement that court clerks submit decedent information to AHCA will have a minimum, but unknown, fiscal impact on the circuit courts.

VI. Technical Deficiencies:

None.

VII. Related Issues:

For additional information regarding the interim project upon which this bill is based, the reader should see the Florida Senate Interim Project Report 97-P-34, October 1997, entitled “Medicaid Reform.”

VIII. Amendments:

None.