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 2242

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

SUBJECT: Health Care/Medicaid

DATE: April 12, 2000 REVISED: _____ _____ _____ _____

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

I. Summary:

The Committee Substitute for Senate Bill 2242 increases the optional state supplementation rate by the federal cost-of-living adjustment provided the average state optional supplementation contribution does not increase; restores rule making authority to the Department of Children and Family Services (DCF) with respect to Medicaid eligibility determinations and clarifies responsibilities relating to this function; raises the cap on hospital outpatient services from $1,000 per year to $1,500 per year per Medicaid recipient; allows the transfer of general revenue funds from DCF to the Agency for Health Care Administration (AHCA or agency) to cover state match requirements which exceed the appropriated amount for targeted case management services; expands the maximum amount of a surety bond the agency may require of certain prospective or currently participating providers from $50,000 to the total amount billed by the provider during the current or most recent fiscal year; allows AHCA to deny a provider's application to become a Medicaid provider if the agency finds that, for any reason, the provider's participation could affect the efficient and effective administration of the program; requires AHCA to develop and implement a disproportionate share program for children's hospitals; requires transfer of unexpended funds appropriated to the Department of Elderly Affairs for the Assisted Living for the Elderly Medicaid waiver to be transferred to AHCA without a legislative appropriation for use by the agency to fund Medicaid-reimbursed nursing home care; authorizes university laboratory schools to participate in Medicaid certified school match funding; and permits AHCA to request a waiver to allow a pilot project to implement a system of care for ventilator-dependent patients.

The bill amends the following sections of Florida Statutes: 490.212; 409.901, 409.902, 409.903, 409.905, 409.906, 409.907, 409.908, 409.912, and 409.919: creates s. 409.9119, F.S., and two undesignated sections of law. The bill repeals paragraph (b) of subsection (4) of section 409.912, F.S.

II. Present Situation:

Optional State Supplementation

Optional State Supplementation (OSS) is a program administered by the Department of Children and Family Services (DCF) providing a cash supplementation to individuals who live in assisted living facilities, adult family care homes, family placements or other specialized living arrangements; and who are receiving Supplemental Security Income. The payment is the difference between the person's income and the maximum OSS rate the residential facility is allowed to charge. As the SSI payment to the individual increases based on federal cost-of-living increases, the department decreases the OSS payment to the individual.

Medicaid

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. Individuals who are elderly or disabled, whose incomes are under 100 percent of the Federal Poverty Level are an optional coverage group eligible for Medicaid under s. 409.904(1), F.S. Payments for services to individuals in the optional categories are subject to the availability of monies and any limitations established by the General Appropriations Act or chapter 216, F.S. Federal Supplemental Security Income (SSI) pays a cash benefit to individuals who are age 65 or older, or who are blind, or who have a disability and who have limited income and assets. Persons who qualify for SSI automatically qualify for Medicaid.

On July 1, 1993, the Medicaid program was transferred to AHCA from the former Department of Health and Rehabilitative Services. While AHCA is the single state agency responsible for the Medicaid program, the Department of Children and Family Services has retained the responsibility for receiving the applications for Medicaid and determining Medicaid eligibility through an interagency agreement with AHCA.

During the 1999 session of the Legislature, a reviser's bill changed the word "department," which referred to the Department of Children and Family Services, to the word "agency," which referred to the Agency for Health Care Administration, in s. 409.919, F.S., which provides statutory authority for rule making in the Medicaid program. As AHCA is the state agency responsible for Medicaid, this appeared to be a simple, noncontroversial change. However, the result of this revised wording was to remove DCF's rule making authority specific to Medicaid eligibility determinations.

The Department of Children and Family Services is currently involved in litigation about Medicaid-related disability determinations (Spencer v. Bush) and must have rule making authority for any policy changes stemming from this suit. Discussion regarding policy changes with plaintiffs is ongoing. Some agreements have been reached, and, as a result, policy statements have been issued that must be supported in rule. Without the proper rule making authority, any necessary rule amendments stemming from this suit cannot be promulgated.

Medicaid Eligibility for Supplemental Security Income Recipients

In an agreement between the Social Security Administration and AHCA, called a Section 1634 Agreement, the Social Security Administration has been authorized to perform the functions necessary to provide Medicaid eligibility to certain disabled, blind, or aged individuals who are determined eligible for Title XVI cash benefits. However, in 1999, this authorized process became required when a federal directive was issued providing that the Social Security Administration's determination of an individual's eligibility for Supplemental Security Income automatically qualified them for Medicaid. Current statutory language relative to the Medicaid program does not permit either the acceptance of the Social Security Administration applications nor their determination of eligibility for Supplemental Security Income as the determination of eligibility for Medicaid.

The Medicaid Outpatient Cap

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 hospital outpatient services to $1,000 per fiscal year per adult recipient except for renal dialysis services and for other exceptions made by AHCA. The exceptions are for services that can be safely performed in the hospital outpatient setting and are more cost-effective when done in the outpatient setting rather than in the inpatient setting.

The agency indicated that the last increase in the cap for hospital outpatient services occurred in 1987. Over the past thirteen years, the cost of medical care has risen substantially, while the level of reimbursement for hospitals providing outpatient care to adults who are eligible under Medicaid has not changed.

General Revenue Transfers Between Agencies

Targeted case management is a Medicaid service provided by the Department of Children and Family Services and Children's Medical Services of the Department of Health. In prior years, the General Appropriations Act has contained proviso requiring DCF to transfer general revenue as state match when the Adult Mental Health component of targeted case management exceeded amounts set in the act.

The Assisted Living for the Elderly (ALE) Waiver is a home and community-based services program that was implemented statewide on February 1, 1995, for nursing home certifiable recipients who reside in less-expensive assisted living facilities. The Department of Elderly Affairs operates the waiver, and Medicaid provides federal matching funds. The waiver includes case management and assisted living services. The Medicaid appropriation for the waiver is funded by federal funds and matching state general revenue funds appropriated directly to the Department of Elderly Affairs. Medicaid pays the waiver claims and bills the Department of Elderly Affairs for the state share of those claims.

Medicaid Provider Enrollment

Section 409.907(7) permits the agency to require, as a condition of participation in the Medicaid program, a surety bond not to exceed $50,000. The agency reports that currently it requires a $50,000 surety bond from only specific provider types, including durable medical equipment (DME) providers, home health agencies, home and community based providers who provide DME, physician groups and clinics where 50% or more of the practice is owned by non-physicians, specified transportation providers, and independent laboratories.

Section 1902 (a) (23) of the Social Security Act requires that (with the exception of programs under s. 1915 of the Act) Medicaid recipients must be allowed to receive services from any institution, agency or person qualified to perform the service who undertakes to provide the service. Implementing federal regulations at 42 CFR 431.51(b)(1)(i) and (ii) require that, absent a waiver, the state plan for Medicaid must provide that a recipient may obtain services from any provider that is qualified to furnish the services and is willing to furnish them to that recipient. 42 CFR 431.51(c) clarifies that these requirements do not prohibit the Medicaid agency from establishing fees, setting reasonable standards for providers, or restricting free choice under a waiver or, under certain conditions, for the purchase of medical devices, laboratory and x-ray services, or for the purpose of "locking-in" recipients who over utilize services of designated providers, or to "lock-out" providers who have abused the program. According to the Health Care Financing Administration, the state is allowed to determine its own provider standards, so long as such standards are reasonably related to the provider's ability to render care to recipients.

Subsection (9) of s. 409.907, F.S., requires the agency to either enroll a qualified provider, or deny a prospective provider's application if enrollment is not in the best interests of the program. The determination that enrollment is not in the best interests of the program must be based on grounds specified in subsection (10) of s. 409.907, F.S., which include:

- making false statements on the application;
- having been involuntarily excluded or terminated from participation in a Medicaid or insurance program;
- conviction of an offense related to delivery of goods or services under Medicaid or other health care or insurance program;
- conviction of offenses related to neglect or abuse of a patient;
- drug-related convictions;
- conviction of any crime punishable by imprisonment of a year or more which involves moral turpitude;
- conviction of obstructing or interfering with the investigation of any of the offenses listed in the subsection;
- violation of laws or rules governing Medicaid or any other health care or insurance program which resulted in sanctions;

- previous violations of standards related to professional licensure; and
- failure to pay a fine or overpayment by Medicaid.

The Medicaid Disproportionate Share Hospital Program

Federal law requires state Medicaid programs to "take into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs" when determining payment rates for inpatient hospital care. This requirement is referred to as the Medicaid disproportionate share hospital payment adjustment. Currently, under the Florida Medicaid program, there are seven separate programs specifically designed to provide enhanced Medicaid reimbursement for certain classes of hospitals rendering disproportionate levels of services to Medicaid recipients and indigent clients. While the federal government, via the Balanced Budget Act of 1997, has imposed limits on the total amount of each state's Medicaid budget which can flow through the disproportionate share program and specific limits on mental health disproportionate share, each state has the flexibility to array these expenditures as the state sees fit. One of the Governor's budget recommendations for fiscal year 2000-2001 is the creation of a children's hospital disproportionate share program.

Medicaid School Health Services Certified Match Program and Developmental Research Schools

Sections 236.0812, 409.9071, and 409.908(21), F.S., authorize the school districts to certify to the Florida Medicaid program their expenditures for school health services rendered to Medicaid eligible students; AHCA in turn certifies these amounts to the Health Care Financing Administration; and HCFA provides federal matching funds for these expenditures. As established annually as part of the General Appropriations Act, there is an annual expenditure cap of $50 million on such certifications under this program. For the current fiscal year, the Social Services Estimating Conference meeting of February 18, 2000, projected an expenditure of $37.8 million under this program.

Developmental research schools, as authorized under s. 228.053, F.S., may be established by a state university to serve as a vehicle for the conduct of research, demonstration, and evaluation regarding management, teaching, and learning as part of the participating university's curriculum. Currently, developmental research schools exist at Florida Agricultural and Mechanical University (FAMU), Florida State University (FSU), Florida Atlantic University (FAU), and University of Florida (UF). The number of students in attendance ranges from around 500 students at FAMU and FAU, to over 1,000 students at FSU and UF.

Because the requirements for the certified school match program target school districts, and because developmental research schools are organizationally part of the universities with which they are affiliated and not part of the respective school district, the developmental research schools have not been part of the Medicaid certified match program for school health services.

Waiver for Ventilator-dependent Individuals

There is currently no statutory authorization for reimbursement for respiratory services for adult Medicaid recipients. Hospitals, therefore, have great difficulty in discharging ventilator-dependent adults who live alone or who cannot access professional respiratory care. Placements in skilled nursing facilities are also difficult, since no supplemental reimbursement is available to these facilities for the extra care individuals on ventilators require. As a result, hospitals report that they are absorbing costs in excess of one million dollars annually for each ventilator- dependent person. At times, hospitals are able to establish an agreement with a nursing facility that allows the hospital to assist the nursing facility in the support of these patients, and at times ventilator-dependent individuals are relocated to other states, including Virginia, Maryland, and North Carolina.

Medicaid Managed Care Contracting

Paragraph (b) of subsection (4) of s. 409.912, F.S., exempts entities providing only Medicaid services on a prepaid basis from the HMO licensure requirements of part 1 of chapter 641, F.S. The Agency reports that this paragraph is no longer necessary or used, since all prepaid providers have the appropriate managed care licensure.

III. Effect of Proposed Changes:

Section 1. Amends subsection (6) of s. 409.212, F.S., to require that the OSS rate shall be increased by the federal cost-of-living adjustment, provided that the average state OSS contribution does not increase as a result.

Section 2. Amends subsections (3), (15), and (18) of s. 409.901, F.S., to: substitute “department” and the Social Security Administration for the agency as entities to which applications for medical assistance are submitted in the definitions for Medicaid applicant, Medicaid program and Medicaid recipient.

Section 3. Amends s. 409.902, F.S., to clarify that the Department of Children and Family Services is responsible for Medicaid eligibility determinations, including policy and rules and the agreement with the Social Security Administration for Medicaid eligibility determinations for SSI recipients.

Section 4. Amends s. 409.903, F.S., to clarify that the Department of Children and Family Services and the Social Security Administration, by contract with the Department, determine eligibility for Medicaid.

Section 5. Amends s. 409.905, F.S., to raise the cap on hospital outpatient services from $1,000 per year to $1,500 per year per recipient.

Section 6. Amends subsection (5) of s. 409.906, F.S., to allow the transfer of general revenue funds from the Department of Children and Family Services to the Agency for Health Care Administration to cover state match requirements when spending for targeted case management services exceeds the amount specified in the General Appropriations Act.

Section 7. Amends subsections (7), (9), and (10) of s. 409.907, F.S., pertaining to Medicaid provider conditions of participation, to broaden the ability of AHCA to designate other agencies to perform onsite inspections of Medicaid providers and to expand the maximum amount of a surety bond the agency may require of a prospective or currently participating provider which is reimbursed on a fee-for-service basis or fee schedule basis which is not cost-based from $50,000 to the total amount billed by the provider during the current or most recent calendar year, whichever is greater. For providers who are new to the program, the agency may base the surety bond on the provider's estimate of its first year billings. In the instance that the provider's actual first year billings exceed these estimates, the agency may require the provider to acquire an additional bond in an amount such that the aggregate amount of the surety bonds equals the amount billed by the provider. A provider's bond shall not exceed $50,000 if a physician or physician group licensed under chapters 458, 459, or 460 has a 50 percent or greater ownership interest in the provider, or if the provider is an assisted living facility licensed under chapter 400, Part III.

This section expands the grounds on which the agency may deny a provider's application to become a Medicaid provider to include if the agency finds that, for any reason, the provider's participation could affect the efficient and effective administration of the program, including the current availability of medical care, taking into consideration geographic location and reasonable travel time.

Section 8. Amends s. 409.908(1)(a), F.S., to increase the reimbursement limit for outpatient hospital services from $1,000 to $1,500 per recipient per year.

Section 9. Creates s. 409.9119, F.S., to require the agency to develop and implement a disproportionate share program for hospitals licensed as a children's hospital. Counties are exempt from contributing toward the cost of this special reimbursement. The section establishes a formula for calculating the additional payment for hospitals participating in the program; requires that hospitals must be in full compliance with applicable rules of the agency to receive payments under the section; and specifies that a hospital that is not in compliance for two or more consecutive quarters may not receive its share of the funds, which funds are redistributed to the remaining participating hospitals that are in compliance.

Section 10. Amends subsection (9) of s. 409.912, F.S., to require transfer of unexpended funds appropriated to the Department of Elderly Affairs for the Assisted Living for the Elderly Medicaid waiver to the Agency for Health Care Administration without a legislative appropriation. These funds are to be used by the agency to fund Medicaid-reimbursed nursing home care.
Section 11. Amends s. 409.919, F.S., to require the Department of Children and Family Services to adopt and accept transfer of any rules necessary to administer ss. 409.901-409.906, F.S., and other provisions necessary to the determination of Medicaid eligibility.

Section 12. Authorizes university laboratory schools to participate in Medicaid certified school match funding.

Section 13. Permits the Agency for Health Care Administration to request a waiver to allow a pilot project that would implement a system of care for ventilator-dependent patients which is to include a case management network of skilled nursing facilities aimed at transitioning ventilator-

dependent patients out of acute care facilities into skilled nursing facilities with the eventual goal of getting these individuals off of ventilators and into their own home. A patient is eligible for enrollment into the management program as soon as he or she goes on a ventilator. Each patient's benefits would be extended for 180 days to allow for placement in a skilled nursing facility. The purpose of the project is to allow the agency to evaluate a coordinated and focused system of care for these patients to determine the overall cost-effectiveness and improved outcomes for such patients. The Agency is required to submit a preliminary report six months after project implementation and a final report by February 15, 2002.

Section 14. Repeals paragraph (b) of subsection (4) of 409.912, F.S.**,** relating to exemption from the HMO licensure requirements of part 1 of chapter 641, F.S., for entities providing only Medicaid services on a prepaid basis.

Section 15. The effective date of the bill is 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 Section 24(a) of Article I 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, Section 19(f) of the Florida Constitution.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Increasing the cap on hospital outpatient services will benefit hospitals providing care to Medicaid recipients by decreasing uncompensated care.

Increasing the amount of a surety bond the agency can require may decrease the number of providers desiring enrollment in the Medicaid program.

Broadening the ability of the agency to refuse enrollment in the Medicaid program may mean

that some providers who would otherwise enroll in the program will not be allowed to do so.

Since overall disproportionate share payments are capped, creation of a children's hospital disproportionate share program will require a decrease in funds going to other types of disproportionate share facilities.

Developing a program to assist ventilator-dependent individuals will assist hospitals and nursing homes to move these individuals out of institutional care, decreasing the uncompensated care burden in these facilities.

C. Government Sector Impact:

The impact of increasing the OSS rate by the federal cost-of-living rate is unknown at this time.

The Department of Children and Family Services reports that there will be a significant economic impact to the department if the bill is not passed. For every policy made by the department for which it lacks rule making authority, the department is subject to litigation by any individual affected by the policy. Each of the 33 Medicaid related policy memorandums issued since July 1, 1999, represents a potential litigation risk for the department.

The agency estimates that the fiscal impact of increasing the cap on hospital outpatient care will be $17,361,227.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Amendments:

None.