SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

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

BILL: CS/SB 792

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

SUBJECT: Agency for Health Care Administration

DATE: April 5, 2001 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Liem	Wilson	HC	Favorable/CS
2.			GO	
3.			AHS	
4.			AP	
5.			RC	
6.				

I. Summary:

The Committee Substitute for SB 792 contains the Medicaid-related substantive provisions of the Appropriations Implementing Bill (SB 2002).

The bill reduces the income eligibility level for the elderly and disabled to 87.5 percent of the federal poverty level, makes Medicaid-eligible individuals who are insured eligible for Medicaid for purposes of paying health insurance premiums if the Agency for Health Care Administration (agency or AHCA) determines this to be cost-effective, and makes certain women eligible for cancer treatment. The agency is authorized to require prior authorization for nonemergency hospital inpatient admissions and for emergency and urgent-care admissions within 24 hours after admission. The bill removes the requirement that community mental health or substance abuse providers be licensed by the agency in order to be reimbursed for rehabilitative services. The agency is authorized to implement reimbursement and use management reforms for community mental health services. The bill limits reimbursement for intermediate nursing home services to persons who meet the nursing home level of care criteria as determined by the Department of Elderly Affairs CARES program and excludes reimbursement for services defined as general care in the Medicaid budget estimating process.

The bill deletes an exemption for counties contributing toward the cost of the special exception reimbursement for certain hospitals providing graduate medical education. The agency is prohibited from increasing nursing home reimbursements associated with changes of ownership filed on or after January 1, 2002. The bill specifies that, effective July 1, 2001, the cost of exempting certain hospitals from reimbursement ceilings and the cost of special Medicaid payments are not to be included in premiums paid to HMOs and prepaid health clinics. The bill requires competitive bidding for home health services, medical supplies and appliances, independent laboratory services, and prescribed drugs. The agency is authorized to competitively

procure transportation services or make changes to permit federal financing of transportation services at the service matching rate rather than the administrative matching rate. The agency may exclude providers not selected through the competitive bidding process from the Medicaid provider network. The bill deletes the requirement that Medicaid pay deductibles and coinsurance for nursing home and hospital outpatient Medicare part B services.

The bill modifies the formulas for calculating regular hospital disproportionate share payments and rural hospital disproportionate share payments. The Medicaid Pharmaceutical and Therapeutics Committee provisions are revised to conform to federal requirements and to develop a restricted-drug formulary. The agency may authorize exceptions to the restricted-drug formulary. Pursuant to the establishment of a restricted-drug formulary, the agency is authorized to negotiate supplemental rebates from manufacturers. The limit of four brand-name prescription drugs per month is extended to adult Medicaid recipients in nursing homes or other institutions. Reimbursements to pharmacies may be based on competitive bids in those counties with more than 35 Medicaid participating pharmacies.

The agency is authorized to contract with certain children's provider networks. The agency is required to disproportionately assign Medicaid-eligible children whose families do not select a provider to a children's network until the children's networks have sufficient numbers to be economically operated.

The bill requires the agency to develop and implement a pilot program to prevent Medicaid fraud and abuse in Medicaid-participating pharmacies by using a type of automated fingerprint imaging of Medicaid beneficiaries. The provisions relating to county contributions to Medicaid are revised to require county contributions for all Medicaid beneficiaries for inpatient hospitalization in excess of 11 days, rather than 12 days, but not in excess of 45 days. Counties are exempt from contributing toward certain new exemptions on inpatient ceilings and special Medicaid payments.

The bill amends ss. 409.904; 409.905; 409.906; 409.908; 409.911; 409.9116; 409.91195; 409.912; 409.9122; 409.913; and 409.915, F.S.

II. Present Situation:

Medicaid

Medicaid is a medical assistance program that pays for health care for the poor and disabled. The federal government, the state, and the counties jointly fund the program. The federal government, through law and regulations, has established extensive requirements for the Medicaid Program. The Agency for Health Care Administration (AHCA) is the single state agency responsible for the Florida Medicaid Program. The Department of Children and Family Services (DCFS) is responsible for determining Medicaid eligibility and managing Medicaid eligibility policy, with approval of any changes by AHCA.

The statutory provisions for the Medicaid Program appear in ss. 409.901 through 409.9205, F.S. Section 409.903, F.S., specifies categories of individuals who are required by federal law to be covered, if determined eligible, by the Medicaid Program (mandatory coverage groups). Section

409.904, F.S., specifies categories of individuals who the federal government gives state Medicaid programs the choice of covering (optional coverage groups).

Individuals who are elderly or disabled, whose incomes are under 100 percent of the Federal Poverty Level (FPL) 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. In the 1992 special session of the Legislature, proviso language in the amended General Appropriations Act reduced the Medicaid eligibility level for elderly and disabled persons from 100 percent FPL to 90 percent FPL.

Family Size	FPL	87.5% FPL	200% FPL
1	$ 8,590	$7,516.25	$17,180
2	$11,610	$10,158.75	$23,220
3	$14,630	$12,801.25	$29,260
4	$17,650	$15,365.00	$35,300

Payment of Health Insurance Premiums for Medicaid-eligible Persons When Cost-effective

The Bureau of Medicaid Third Party Liability (TPL) has determined that it is cost effective for the Medicaid program to pay for some recipients' premiums for private insurance coverage. This option has been used primarily when pharmacy benefits are available under a Medicare replacement plan. This bill authorizes the agency to pay for health insurance premiums if the payments are cost-effective. This authority was provided the agency through proviso language in previous years.

Medicaid Coverage for Women with Breast or Cervical Cancer

Medicaid coverage for women with breast or cervical cancer is not currently available for women whose income is above Medicaid's current levels to qualify for Medicaid coverage. The Breast and Cervical Cancer Screening Program was begun five years ago. It is a federally funded program administered through the Department of Health. There is no treatment component, only screening and limited diagnosis procedures. Women diagnosed with cancer have to find their own treatment through volunteer providers and hospitals. It has been difficult to find treatment in a timely manner. Volunteer providers have been overwhelmed in treating uninsured citizens for various cancers. Some counties do not have access to cancer treatment within the county and thus currently cannot participate in the screening program.

The Breast and Cervical Cancer Prevention and Treatment Act of 2000 amends Title XIX of the Social Security Act to give states enhanced matching funds to provide Medicaid eligibility to a new group of individuals not previously eligible under the program. A woman whose eligibility is based on this new option is entitled to full Medicaid coverage; coverage is not limited to coverage for treatment of breast and cervical cancer. The federal matching rate for the new eligibility group is equal to the enhanced Federal Medical Assistance Percentage (FMAP) used in the State Children's Health Insurance Program (SCHIP).

Medicaid Prior Authorization of Hospital Admissions

The agency currently prior authorizes inpatient hospital admissions for patients with psychiatric and substance abuse diagnoses. There is no specific authority to prior authorize acute care in-patient hospital admissions. The agency currently contracts with a peer review organization for retrospective review of a sample (10-15%) of in-patient acute care hospital admissions. If in-patient days are denied, or if a stay is found to be medically unnecessary, the hospital is required to repay the agency for the cost of the denied days.

Community Mental Health Services

Currently, the Agency for Health Care Administration pays for medically necessary behavioral health care services primarily under a fee-for-service system, except in Area Six, where the Agency contracts with a prepaid mental health plan and Medicaid HMOs for a capitated system of care that includes inpatient and outpatient psychiatric hospital services, community mental health, mental health targeted case management, and psychiatric physician services. In addition, mental health inpatient and physician services are covered by Medicaid HMOs throughout the state. Medicaid covers a specific array of mental health and substance abuse treatment services authorized by chapter 409, Florida Statutes.

Medicaid Nursing Home Services

Medicaid pays for nursing facility services that are 24-hour-a-day nursing and rehabilitation services provided in a facility that is licensed and certified by the Agency for Health Care Administration to participate in the Medicaid program. A doctor of medicine or osteopathy must order the recipient's care and services. State Medicaid programs are required to cover "skilled nursing services." Coverage for "intermediate care" may be provided at the option of the state. The Florida Administrative Code (59G-4.180 F.A.C.) separates intermediate care services into two separate sub-levels of care: Intermediate II and I. Intermediate I service is extensive health related care and service required by an individual who is incapacitated mentally or physically. Intermediate II service is limited health-related care and services required by an individual who is mildly incapacitated or ill to a degree to require medical supervision. Individuals at Intermediate II level of care are ambulatory, with or without assistive devices, demonstrate independence in activities of daily living, and do not require the administration of psychotropic drugs on a daily or intermittent basis or exhibit periods of disruptive or disorganized behavior requiring 24-hour nursing supervision. The Department of Elderly Affairs, Comprehensive Assessment and Review for Long Term Care Services (CARES) teams recommend the level of care for required recipients age 21 and older. The Children's Medical Services, Children's Multidisciplinary Assessment Team (CMAT) recommends the level of care for recipients under the age of 21.

Reimbursement for Nursing Home Change of Ownership

Nursing homes that undergo an unrelated party change of ownership are currently allowed to receive a rate increase in the operating and patient care components of the per diem rate attributable to the change.

Medicaid Hospital Reimbursement

Medicaid reimburses hospitals for inpatient and outpatient services based on an approved Medicaid Reimbursement Plan. There are separate plans for inpatient services and outpatient services. The plans guide the Agency for Health Care Administration in the setting of facility specific per diem rates based on each facility's cost report. Hospitals are required to submit annual financial cost reports to the agency. The reports are prepared in accordance with the cost finding of Title XVIII (Medicare) principles of reimbursement except as modified by the hospital reimbursement plans. Per diem rates are prospective or interim, and are based on historical cost adjusted for inflation. Interim rates are based on budgeted costs and subject to an annual cost settlement. Medicaid payment is considered payment in full for covered services.

In the 1980s and early 1990s, Medicaid expenditures were increasing at double-digit rates. The Legislature authorized the implementation of cost control measures to slow the rate of growth.

An inpatient variable cost-based reimbursement ceiling is established for each county. General hospitals are subject to the limitation on the variable cost per diem ceiling and will receive a per diem for which the variable cost component will be set at the lower of the variable cost rate for the hospital or the cost-based county ceiling. Statutorily defined teaching hospitals, specialty hospitals, and rural hospitals are exempt from the inpatient variable cost-based ceiling.

The target rate system for hospital inpatient per diem rates is used to limit the growth in the cost-based county ceiling and facility specific per diem between state fiscal years. The target ceilings are adjusted each July based on the prior January rate semester's ceilings and facility specific per diem multiplied times the allowable rate of increase.

The outpatient cost-based county reimbursement ceiling for variable costs per occasion of service is established for each county. The cost-based county ceilings apply to all hospitals as a limitation on the variable costs per occasion of service that a hospital will be paid. Hospitals will receive the lower of the hospital's occasion of service rate or the cost-based county ceiling. Rural and specialty psychiatric hospitals are exempt from this ceiling.

A target rate system for hospital outpatient rates is used to limit the growth in the cost-based county ceiling and facility specific rates between rate semesters. The target ceilings are adjusted each January and July based on the prior rate semester's county ceilings and facility specific rates times the allowable rate of increase.

Federal regulations (42 CFR §447.272 and 42 CFR §447.332) provide that in the aggregate, payments to a group of health care facilities (for example hospitals) by a Medicaid agency may not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles. The upper payment limit (UPL) does not apply to disproportionate hospital payment adjustments made to hospitals as DSH payments have separate federal limitations. Furthermore, the methodology used in estimating the UPL must rely on data collected for services rendered on a fee-for-service basis. Rates such as those used for health maintenance organizations cannot be included in the calculation.

Recent rule changes issued by the U. S. Department of Health and Human Services create three separate UPLs: one for state-owned or operated facilities, one for non-state government owned or operated facilities and one for private hospitals. The new rule sets forth provisions for a UPL of 150 percent of the reasonable estimate of what would have been paid under Medicare payment principles for inpatient and outpatient hospital services provided in non-State government hospitals. The UPL limits for the other two classes of hospitals remain at 100 percent of Medicare.

The Agency was authorized in FY 2000-01 to eliminate the hospital inpatient and outpatient ceilings for teaching, specialty, and Community Hospital Education Program hospitals and to make special Medicaid payments to those hospitals that qualify under the disproportionate share hospital program. $254,303,272 was appropriated for these additional payments to hospitals. A transfer of $13,750,000 provided the state matching funds from the Board of Regents and $96,592,190 from counties to enable the agency to draw an additional $143,961,082 in federal Title XIX funds. An additional $750,000 was transferred from the Board of Regents to AHCA. $75,000 of this transfer is authorized to contract for services and cover the usual and customary expenses associated with the administration of the Community Hospital Education Council and the production of the annual report of graduate medical education. The remaining $675,000 is provided to assure that participating hospitals' benefit equals or exceeds the funds received in FY 1999-00 and that the participating hospitals with primary care internship and residency programs receive funding at no less than that provided in FY 1999-00.

Disproportionate Share Programs

In 1987, Congress included in the Omnibus Budget Reconciliation Act provisions pertaining to inpatient hospital reimbursement for hospitals serving a disproportionate share of low-income patients with special needs. Effective July 1, 1988, federal law mandated that each state provide special reimbursement to qualifying "disproportionate share" hospitals (DSH) provided that the hospitals meet certain conditions. Florida currently has eight distinct DSH programs authorized under chapter 409, F.S.: Regular Hospital; Regional Perinatal Intensive Care Centers; Teaching Hospitals; Mental Health Hospitals; Rural Hospitals; Primary Care Hospitals; Specialty Hospitals (TB), and Specialty Hospitals for Children.

Chapter 409, F.S., provides authority, qualifications for participation by hospitals, and reimbursement formulas for DSH payments. The Medicaid Hospital Inpatient Reimbursement Plans that, by reference, are incorporated in administrative rule, also include comprehensive explanations of how the DSH reimbursement is calculated and made for hospitals.

Medicaid Payment for Medicare Services for Dually-eligible Recipients

Medicare hospital insurance, referred to as Part A, provides coverage for inpatient hospital care, limited skilled nursing care, some home health services, some hospital outpatient services, and some other services. Medicare Supplemental Medical Insurance, referred to as Part B, provides basic health care coverage for services provided by doctors, suppliers, therapists, and other licensed health care providers.

Medicare imposes cost sharing expenses for Part A and Part B by requiring a deductible and coinsurance amount. These expenses are usually paid by the Medicare beneficiary or a supplemental insurance policy. For individuals who are eligible for both Medicare and Medicaid, Medicaid pays a portion of the deductible and coinsurance.

For skilled nursing facilities, Medicaid reimburses either the Part A skilled nursing facility coinsurance rate or the Medicaid per diem for the facility, whichever is less.

Currently, s. 409.908, F. S., provides that Medicaid payments for Medicare deductibles and coinsurance shall be based on Medicare allowable fees, not on a provider's billed charges, and that Medicaid will pay no portion of Medicare deductibles and coinsurance when payment that Medicare has made for the service equals or exceeds what Medicaid would have paid if it had been the sole payer. The combined payment of Medicare and Medicaid must not exceed the amount Medicaid would have paid had it been the sole payer.

Section 409.908, F.S., provides an exception for Medicaid payments for nursing home Medicare Part A coinsurance and for deductibles and coinsurance for nursing home Medicare Part B services. Currently, Medicaid payments for nursing home Medicare Part A coinsurance must be the lesser of the Medicare coinsurance amount or the Medicaid nursing home per diem. Medicaid must pay all deductibles and coinsurance for nursing home Medicare Part B services.

Section 409.908, F.S., also provides an exception for Medicaid payments for hospital outpatient Medicare Part B services. Currently, Medicaid must pay all deductibles and coinsurance for hospital outpatient Medicare Part B services.

These policies result in Medicaid often paying more for Medicare crossover payments than Medicaid would have paid for a Medicaid-only covered beneficiary. This bill proposes to delete the exceptions for nursing home and hospital outpatient Part B crossover payments, and make nursing home and hospital outpatient Medicare crossover payments subject to the limitations imposed on such payments for other services.

Home Health Services, Durable Medical Equipment and Supplies

Home health services are provided in a recipient's home or other authorized setting to promote, maintain or restore health or to minimize the effects of illness or disability. Home health agencies enrolled in Medicaid as home health providers are reimbursed for home health visit services, private duty nursing services and personal care services. Payment for each service is based on the lesser of the amount billed by the provider or the Medicaid established payment.

Durable medical equipment (DME) is equipment that can be used repeatedly, serves a medical purpose, and is appropriate for use in the patient's home. Medical supplies are medical or surgical items that are consumable, expendable, disposable or non-durable, and are appropriate for use in a patient's home. Medical necessity for DME or supplies must be documented by a prescription, a statement of medical necessity, a plan of care, or a hospital discharge plan. Medicaid reimbursement is the lower of the Medicaid fee or the provider's customary fee. The total amount reimbursed for rental payments for DME cannot exceed the established maximum allowed purchase fee.

Independent Laboratory Services

Independent laboratory services are clinical laboratory procedures performed in freestanding laboratory facilities. A doctor of medicine or osteopathy or other licensed health care practitioner authorized within the scope of practice to order clinical laboratory tests must authorize the services.

Medicaid reimburses for services rendered by licensed, Clinical Laboratory Improvements Act (CLIA) certified, Medicaid-participating independent laboratories. Medicaid does not reimburse hospitals, ambulatory surgical centers, federally qualified health centers, rural health clinics, or practitioners for services performed in their offices for independent laboratory services. Medicaid reimbursement is currently limited to the specific procedures that an independent laboratory facility has been certified under CLIA to provide. The frequency of some tests is also limited. Medicaid reimbursement for laboratory services is the maximum Medicaid fee or the provider's customary fee, whichever is lower.

Annually around 301,000 Medicaid eligible individuals use independent laboratory services. There are approximately 125 independent laboratory providers participating in the Medicaid program.

Private Duty Nursing Services

Private duty nursing services are medically necessary skilled nursing care services consistent with a recipient's medical condition. Private duty nursing services must be ordered by the attending physician, documented as medically necessary, provided by a registered nurse or a licensed practical nurse, and be consistent with the physician approved plan of care. Medicaid reimburses private duty nursing services for children under age 21 who have complex medical problems and who require more individual care than can be provided through a home health nurse visit. All private duty nursing services must be authorized by a Medicaid service authorization nurse prior to the delivery of services. Private duty nursing services are provided to around 1,500 children annually. Medicaid has about 118 participating providers of private duty nursing services. Only Medicaid enrolled home health agencies may be reimbursed for private duty nursing services. Recipients may choose their Medicaid home health agency provider.

Patient Transportation Services

Medicaid reimburses for transportation services provided by Medicaid-participating ambulances, non-emergency medical vehicles, taxicabs, private automobiles, multi-passenger vans and buses, and public and private organizations. To be reimbursed by Medicaid, the transportation must be for the purpose of transporting the recipient to or from a Medicaid covered service to receive medically necessary care. Transportation services are available only to eligible recipients who cannot obtain transportation on their own through any available means such as family, friends or community resources. All transportation, except for emergencies, must be prior authorized by Medicaid, be provided by an enrolled provider, and must be the least expensive and most appropriate method of transportation available in each situation. Medicaid does not reimburse private automobile transportation that is provided by the recipient. Transportation rates are negotiated by the area Medicaid offices with transportation providers and should be less than the

local carriers' usual and customary charges. Private volunteer automobile transportation is compensable at 20 cents per mile. Non-emergency medical carriers are reimbursed the published Medicaid fee, the carrier's customary fee, or an area-negotiated rate, whichever is lower. There is a $1 co-payment for transportation services for each one-way trip, unless the recipient is exempt from the co-payment.

Prescribed Drugs

The Florida Medicaid Program is the single largest purchaser of prescription drugs in the state. The program currently has a voluntary preferred drug list of medications with net pricing favorable to Medicaid. There is currently a four-brand-name drug per month limit and prior authorization requirements for a few specific drugs, but there are no formulary restrictions. Exemptions to the brand-name drug limit are contraceptives, insulin and diabetic supplies, drugs used to treat mental illness and antiretrovirals for HIV/AIDS. There is currently no limit on the number of generic prescriptions that may be received within a month. Prescribers may request exceptions for medically necessary prescriptions in excess of the four brand-name drug limit through the Therapeutic Consultation Program.

The majority of insurers have adopted drug formularies to aid in controlling their overall program costs (pharmacy, inpatient hospital, and outpatient services). These formularies involve a list of drugs that may be prescribed without prior authorization, with step therapy protocols and tiered co-payment requirements for the patient.

Competitive Bidding

Medicaid service providers are subject to an enrollment process that normally requires evidence of current licensure (which may or may not include a site visit of the facility), background checks of principals of the entity, and an executed provider agreement. Fee schedules are typically set at a percentage of the Medicare fee schedule for the same procedures. Any provider who meets the generic qualifications and agrees to accept reimbursement at the stated rates is allowed to participate in the Medicaid program. This process does not lend itself to price negotiations nor does it allow the agency to focus on the comparative quality of services rendered. The Medicaid program is charged with purchasing services in the most cost-effective manner by 409.912, F.S.

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 Alocking-in@ recipients who over utilize services of designated providers, or to Alock-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.

Children's Health Clinics

The National Center for Health Statistics study (2001) found that 44% of emergency department visits for a Medicaid population occur between 4:00 p.m. and 11:59 p.m. It is estimated that the development of after-hours urgent care centers could divert 65% of emergency department visits for Medicaid-eligible children (age 0-18).

Fingerprinting of Medicaid Drug Beneficiaries

There is currently no provision for fingerprinting of Medicaid beneficiaries for the purpose of preventing fraud and abuse of services.

County Contributions to Medicaid Costs

Counties currently contribute 35% of the cost of hospital inpatient care for their residents, beginning with the13th day through the 45th day, with noted categories of recipients excluded. The amounts received by the state for county billings are recorded as general revenue unallocated. This bill is proposing that counties' responsibility now begin after the 11th day of inpatient care.

Mandatory Enrollment in Managed Care

Section 409.9122(f), F.S., provides that when a Medicaid recipient who is not exempted from managed care enrollment does not choose a managed care plan or MediPass provider, the Agency must assign the recipient to a managed care plan or MediPass provider. Medicaid recipients subject to mandatory assignment but who fail to choose a provider must be assigned to managed care plans or provider service networks until an equal enrollment of 50 percent in MediPass and provider service networks and 50 percent in managed care plans is achieved. Current language provides that for the FY 1998-99 year only, once equal enrollment is achieved, the assignments must be divided in order to maintain an equal enrollment in MediPass and managed care plans. Thereafter, assignment of recipients who fail to make a choice shall be based proportionally on the preferences of recipients who made a choice in the previous period.

Section 409.9122(k), F.S., (which is repealed on July 1, 2001, unless re-authorized) provides that notwithstanding section 409.9122(f), and for FY 2000-01 only, when a Medicaid recipient does not choose a managed care plan or MediPass provider, the agency must assign the recipient to a managed care plan, except in those counties in which there are fewer than two managed care plans accepting Medicaid enrollees, in which case the assignment must be to a managed care plan or a MediPass provider. Paragraph (f) also provides that recipients in counties with fewer

than two managed care plans who fail to make a choice must be assigned to managed care plans until an equal enrollment of 50 percent in MediPass and provider service networks and 50 percent in managed care plans is achieved. Once equal enrollment is achieved, the assignments shall be divided in order to maintain equal enrollment in MediPass and managed care plans. Paragraph (k) also provides criteria that the Agency must take into account when making assignments.

III. Effect of Proposed Changes:

Section 1. Amends s. 409.904, F.S., relating to Medicaid optional payments for eligible persons, to reduce the maximum income level for Medicaid for aged or disabled individuals from 100 percent of FPL to 87.5 percent of FPL; allows the Medicaid program to pay the cost of health insurance premiums for Medicaid-eligible individuals if the agency determines that such payments are cost-effective; and extends Medicaid eligibility to women with incomes below 200 percent of FPL who are between the ages of 50 and 64 for cancer treatment pursuant to the federal Breast and Cervical Cancer Prevention and Treatment Act of 2000, who have been screened through the National Breast and Cervical Cancer Early Detection Program.

Section 2. Amends s. 409.905(5), F.S., relating to mandatory Medicaid services to allow Medicaid to prior-authorize all non-emergency hospital inpatient admissions and emergency and urgent care admissions within 24 hour of admission. Technical changes are also made.

Section 3. Amends s. 409.906(8) and (16), F.S., relating to optional Medicaid services, to remove the requirement that mental health or substance abuse providers be licensed by the agency in order to be reimbursed for rehabilitative services and to allow the agency, in the instance of community mental health services, to implement reimbursement and use management reforms to comply with limitations and directions in the General Appropriations Act, including prior authorization of treatment plans, prior authorization of services, enhanced use review programs for highly used services, and limits on services for those determined to be abusing their benefit coverage. The agency is prohibited from paying for 24-hour-a-day intermediate-level nursing home care for individuals who are otherwise eligible but who meet the definition of "general care" as used in the Medicaid budget estimating process.

Section 4. Amends s.409.908, F.S., relating to reimbursement of Medicaid providers, to delete language that exempts counties from contributing toward the cost of special exception reimbursement for hospitals that serve a disproportionate share of low-income people and provide graduate medical education. Rate increases to nursing homes associated with changes in ownership filed on or after January 1, 2002 are prohibited. This section prohibits the cost of exempting statutory teaching hospitals, specialty hospitals, and community hospital education program facilities from reimbursement ceilings and the cost of special Medicaid payments from being included in premiums paid to health maintenance organizations or prepaid health care plans. This section authorizes competitive bidding to be used as the basis for reimbursement of home health care services, medical supplies and appliances, and independent laboratory services. Currently reimbursement is the lesser of the amount billed or the agency's maximum allowable fee.

Medicaid payments of deductibles and coinsurance for nursing home and hospital inpatient Medicare Part B services are to be based on Medicaid fees, rather than Medicare fees. Reimbursement for prescribed drugs is to be based on competitive bidding. The agency is allowed to competitively procure transportation services or make other changes necessary to secure approval of federal waivers needed to permit the state to claim federal match at the services, rather than the administrative, matching rate.

Section 5. Amends s. 409.911, F.S., to modify the values for certain elements of the disproportionate share formula the agency is to use for distribution of funds for hospitals providing a disproportionate share of Medicaid or charity care by redefining "Base Medicaid per diem" as a facility's Medicaid per diem as of January 1, 1999, rather than the per diem in effect at the beginning of each state fiscal year; require the use of 1994 audited financial data, rather than most recent calendar year data; and modify the formula by which disproportionate share percentages are computed, for those hospitals that qualify for the hospital disproportionate share program.

Section 6. Amends 409.9116, F.S., to provide a method for calculating a preliminary payment amount and an adjusted total payment amount under the disproportionate share formula for rural hospitals.

Section 7. Amends s. 409.91195, F.S., to modify the purpose of the Medicaid Pharmaceutical and Therapeutics Committee to require that the committee develop a restricted-drug formulary as permitted by federal law; and to delete the membership requirements of the committee replacing them with a requirement that the committee be comprised of members as specified in federal law. The committee is to develop the restricted-drug formulary and may recommend additions and deletions to it so that the formulary achieves cost savings while providing medically appropriate drug therapies. The committee is to recommend for inclusion in the formulary drugs that have clinical advantages over other drugs in the formulary, drugs for which the agency has negotiated supplemental rebates and any drug presented to the committee by the agency. Provisions relating to the voluntary Medicaid preferred prescribed drug list are eliminated. The agency is authorized to negotiate supplemental rebates from manufacturers which offset a state expenditure, such as cash, disease management programs, drug donation programs, drug utilization control programs and other services or investments which guarantee savings to the Medicaid program. Reimbursement of drugs not on the formulary is subject to prior authorization by the agency, and the restricted-drug formulary is to be published and disseminated to all Medicaid providers.

Section 8. Amends s. 409.912, F.S., relating to cost-effective purchasing of health care, to allow the agency to contract for services from "children's provider networks" that provide care coordination and care management of Medicaid-eligible children. This provider type is not defined. The agency is permitted to provide private duty nursing services, transportation, independent laboratory services, durable medical equipment and supplies through competitive bidding. The agency is allowed to seek federal waivers necessary to competitively bid such services and is allowed to exclude providers not selected through the bidding process from the Medicaid provider network.

The agency is allowed to authorize exceptions to the restricted drug formulary. The agency is allowed to set prescribed drug prices based at average wholesale price less 13.25 percent or based on competitive bid in counties with more than 35 participating pharmacies. The requirement for the use of counterfeit-proof prescription pads is expanded to all prescribers who write prescriptions for Medicaid recipients. The agency is authorized to implement a restricted-drug formulary, and is authorized to negotiate supplemental manufacturer rebates of at least 10 percent of the average manufacturer price unless the federal or supplemental rebate exceeds 25 percent and the agency determines the product "competitive". The agency is allowed to determine that specific generic products are competitive at lower rebate percentages. The bill deletes the exemption of institutionalized adults and persons residing in nursing homes from the four name-brand drug limit contained in current statutes.

The bill removes a requirement that a prepaid contract with an extended provider organization not cost more than a managed care plan contract in the same agency region and a requirement that manufacturers of generic drugs that raise prices in excess of the consumer price index rebate the excess amount to the state.

Section 9. Amends subsection (2) of s. 409.9122, F.S., relating to mandatory Medicaid managed care enrollment, to direct the agency to disproportionately assign Medicaid-eligible children who have not made a choice of a managed care plan or MediPass, and who would have been assigned to MediPass, to the children's provider networks described in section 8 of the bill. The disproportionate assignment shall be made until the agency determines that the children's networks have sufficient numbers to be economically operated. The bill deletes language applicable in FY 2000-2001 only relating to ratios of mandatory assignment of recipients who fail to make a choice.

Section 10. Amends s. 409.913, F.S., relating to the oversight of the integrity of the Medicaid program, to direct the agency to develop and implement a pilot program to prevent Medicaid fraud and abuse in Medicaid-participating pharmacies by using a type of automated fingerprint imaging of Medicaid recipients. The agency is to ensure that fingerprint imaging is only to prevent fraud and abuse of pharmacy benefits by recipients and must be in compliance with state and federal disclosure requirements. The agency is to develop an implementation plan by October 1, 2001. The pilot is to begin in one or more areas of the state by April 1, 2002, and the agency must evaluate the pilot project to ensure its cost-effectiveness before statewide expansion. The agency shall request required federal waivers necessary for implementation.

Section 11. Amends s. 409.915, F.S., relating to county contributions to Medicaid, to change the point at which counties are required to begin payment for inpatient hospitalization days from the 13^{th} day of inpatient care to the 12^{th} day. Hospitalizations for both fee-for-service and health maintenance members are counted towards this day threshold. Counties are exempted from contributing toward the cost of new exemptions on inpatient ceilings for statutory teaching hospitals, specialty hospitals, and community hospital education program hospitals that came into effect July 1, 2000, and for special Medicaid payments that came into effect on or after July 1, 2000.

Section 12. Provides an effective date of July 1, 2001.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

Section 11 of the bill changes the point at which counties are required to begin payment for inpatient hospitalization days under Medicaid from the 13th day of inpatient care to the 12th day, having the effect of increasing county contributions to Medicaid. Article VII, s. 18, Florida Constitution, requires that no county or municipality shall be bound by any general law requiring such local government to spend funds or to take action requiring the expenditure of funds unless the legislature has formally determined in the bill that such law fulfills an important state interest and the bill must pass by at least a 2/3 vote of the membership of each house of the legislature.

SB 792 does not contain the required finding of an important state interest.

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 Art. I, s. 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 Art. III, s. 19(f) of the Florida Constitution.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill will decrease revenues to some categories of Medicaid providers

C. Government Sector Impact:

	Amount Year 1 (FY 01-02)	**Amount Year 2 (FY 02-03)**
Revenues:		
Federal Grants-Title XIX Medical Assistance Medical Care Trust Fund	($238,852,474)	($303,115,090)
Federal Grants-Title XIX Medicaid Administration Administrative Trust Fund.	$3,120,862	$7,100,362
Federal Grants-Refugee Assistance Refugee Assistance Trust Fund	($162,766)	($233,140)

Transfer of State Funds from Other Agencies		
Medical Care Trust Fund	($104,605)	$1,393,207
Transfer of Tobacco Settlement Funds		
Tobacco Settlement Trust Fund	($42,727)	($60,235)
Rebates		
Grants and Donations Trust Fund	$53,209,956	$70,209,859
Total Recurring Revenues	($182,831,854)	($224,705,037)

Section-by Section Fiscal Impact

Section 1. *Eliminate Full Coverage for Elderly and Disabled above 87.5% of FPL:*

General Revenue	($18,962,318)	($18,962,318)
Administrative Trust Fund	($205,638)	($205,638)
Grants and Donations Trust Fund	($5,507,103)	($5,507,103)
Medical Care Trust Fund	($38,128,712)	($38,128,712)
Total	($62,803,771)	($62,803,771)

Pay Individual's Health Insurance if Cost-effective:

No fiscal impact on the Agency. The provision is codifying Medicaid payment of insurance premiums for Medicaid eligible individuals when such payment is cost-effective which is the Agency's current policy.

Provide Coverage for Qualified Women with Breast or Cervical Cancer:

General Revenue	$3,932,445	$5,898,668
Medical Care Trust Fund	$8,960,817	$13,396,226
Total	$12,893,262	$19,294,894

Section 2. *Prior Authorization for Non-emergency Hospital Inpatient Admissions:*

General Revenue	($9,006,063)	($18,012,127)
Tobacco Settlement Trust Fund	($11,023)	($22,045)
Medical Care Trust Fund	($11,698,875)	($23,397,749)
Refugee Assistance Trust Fund	($30,586)	($61,173)
Total	($20,746,547)	($41,493,094)

Administrative Cost for Prior Authorization:

General Revenue	$2,000,000	$4,000,000
Administrative Trust Fund	$3,000,000	$6,000,000
Total	$5,000,000	$10,000,000

Assumes Implementation on January 1, 2002

Section 3. *Behavioral Health Reimbursement/Management of Care Reforms:*

General Revenue	($3,710,515)	($3,710,515)
Tobacco Settlement Trust Fund	($13,189)	($13,189)
Medical Care Trust Fund-Other State Funds	($603,876)	($603,876)
Medical Care Trust Fund	($5,635,599)	($5,635,599)
Refugee Assistance Trust Fund	($14,502)	($14,502)
Total	($9,977,681)	($9,977,681)

Eliminate "General Care" Level of Care Coverage in Nursing Home Program:

General Revenue	($1,949,984)	($7,799,938)
Medical Care Trust Fund (Other State Funds)	$499,271	$1,997,083
Medical Care Trust Fund	($1,880,430)	($7,521,726)
Total	($3,331,143)	($13,324,581)

Assumes Implementation on April 1, 2002

Section 4. *Eliminate Increases in Nursing Home Rates due to Changes in Ownership:*

General Revenue	($2,881,536)	($5,763,073)
Medical Care Trust Fund	($3,735,081)	($7,470,161)
Total	($6,616,617)	($13,233,234)

Assumes Implementation on January 1, 2002

Cost of Exempting Certain Hospitals from Reimbursement Ceilings Not Included in HMO/PHP Rates: No fiscal impact on the Agency. The provision is codifying the current exemption.

Implement Competitive Bidding for Home Health Services, Durable Medical Equipment and Supplies:

General Revenue	($520,635)	($694,180)
Tobacco Settlement Trust Fund	($1,170)	($1,560)
Medical Care Trust Fund	($736,952)	($982,602)
Refugee Assistance Trust Fund	($47,731)	($63,642)
Total	($1,306,488)	($1,741,984)

Assumes implementation on October 1, 2001.

Implement Competitive Bidding for Independent Laboratory Services:

General Revenue	($546,477)	($728,457)
Tobacco Settlement Trust Fund	($2,438)	($3,259)
Medical Care Trust Fund	($713,909)	($951,663)
Refugee Assistance Trust Fund	($10,799)	($14,397)
Total	($1,273,623)	($1,697,776)

Assumes implementation on October 1, 2001.

Limit Reimbursement for Nursing Home Medicare Part B Crossover Claims:

General Revenue	($1,763,917)	($1,763,917)
Medical Care Trust Fund	($2,286,409)	($2,286,409)
Total	($4,050,326)	($4,050,326)

Limit Reimbursement for Hospital Outpatient Medicare Part B Crossover Claims:

General Revenue	($25,786,590)	($25,786,590)
Medical Care Trust Fund	($33,424,867)	($33,424,867)
Total	($59,211,457)	($59,211,457)

Implement Competitive Bidding for Prescribed Drugs:

General Revenue	($13,581,956)	($18,141,021)
Tobacco Settlement Trust Fund	($13,998)	($18,964)
Medical Care Trust Fund	($17,636,979)	($23,557,806)
Refugee Assistance Trust Fund	($57,747)	($77,557)
Total	($31,290,680)	($41,795,348)

Assumes implementation on October 1, 2001.

Competitively Bid or Change Transportation Services:

General Revenue	($416,850)	($555,800)
Tobacco Settlement Trust Fund	($765)	($1,020)
Medical Care Trust Fund	($542,070)	($722,760)
Refugee Assistance Trust Fund	($1,341)	($1,788)
Total	($961,026)	($1,281,368)

Assumes implementation on October 1, 2001.

Section 5. *Modify Data and Formula for Regular DSH Program:* No fiscal impact on the Agency. Codifying the Agency's current policy prescribed by implementing bills in prior fiscal years.

Section 6. *Modify Formula for DSH/Rural Financial Assistance for Rural Hospitals:* No fiscal impact on the Agency. Codifying the Agency's current policy prescribed by implementing bills in prior fiscal years.

Section 7. *Establish a Restricted Drug Formulary/Supplemental Rebates:*

General Revenue	($79,647,821)	($106,197,095)
Grants and Donations Trust Fund	$50,999,708	$67,999,611
Medical Care Trust Fund	($119,429,218)	($159,238,957)
Total	($148,077,331)	($197,436,441)

Assumes implementation on October 1, 2001.

Authority to Contract for Negotiations for Supplemental Rebates:

General Revenue	($3,360,906)	($3,360,906)
Grants and Donations Trust Fund	$7,717,351	$7,717,351
Medical Care Trust Fund	($4,356,445)	($4,356,445)
Total	$0	$0

Section 8. *Implement Competitive Bidding for Private Duty Nursing Services:*

General Revenue	($2,265,115)	($3,020,777)
Tobacco Settlement Trust Fund	($144)	($198)
Medical Care Trust Fund	($2,936,391)	($3,916,019)
Refugee Assistance Trust Fund	($60)	($81)
Total	($5,201,710)	($6,937,075)

Assumes implementation on October 1, 2001.

Sections 8 and 9. *Children's Provider Networks:*

General Revenue	($644,540)	($859,387)
Medical Care Trust Fund	($835,460)	($1,113,947)
Total	($1,480,000)	($1,973,334)

Assumes implementation on October 1, 2001.

Section 9. *Mandatory Assignment to Achieve 50% HMO/PHP/50% MediPass:*

General Revenue	($2,936,168)	($2,936,168)
Medical Care Trust Fund	($3,805,894)	($3,805,894)
Total	($6,742,062)	($6,742,062)

Assumes target enrollment met by January 1, 2002.

Section 10. *Pilot Program for Automated Fingerprinting of Recipients of Medicaid Drugs:*

General Revenue	$218,000	$872,000
Administrative Trust Fund	$326,500	$1,306,000
Total	$544,500	$2,178,000

Assumes implementation on April 1, 2002.

Section 11. *Require County Contributions for Cost of Hospital Inpatient Day 12:* No direct fiscal impact on the Agency. The $6,470,068 in additional revenues from billing counties for 35% of the cost of an additional inpatient day is deposited to General Revenue Unallocated.

Note: The Senate General Appropriations Act reduces General Revenue in Medicaid by the $6,470,068. If this is not corrected, then Medicaid will need $6,470,068 in Medical Care Trust Fund Budget and retain $6,470,068 in county billing collections to pay for hospital inpatient services.

Exempt County Contributions for Certain Medicaid Reimbursement to Hospitals: No fiscal impact on the Agency. Codifying the Agency's current policy prescribed by implementing bills in prior fiscal years.

Total Recurring Expenditures:		
General Revenue	($161,830,946)	($207,521,601)
Administrative Trust Fund	$3,120,862	$7,100,362
Tobacco Settlement Trust Fund	($42,727)	($60,235)
Grants and Donations Trust Fund	$53,209,956	$70,209,859
Medical Care Trust Fund-Other State Funds	($104,605)	$1,393,207
Medical Care Trust Fund	($238,882,474)	($303,115,090)
Refugee Assistance Trust Fund	($162,766)	($233,140)
Total Recurring Expenditures:	**($344,692,700)**	**($432,226,638)**

VI. Technical Deficiencies:

Section 1 of the bill establishes an optional Medicaid eligibility category for women screened through the Federal Breast and Cervical Cancer Prevention and Treatment Act of 2000. The provisions in the bill are inconsistent with direction received by states from the federal Health Care Financing Administration regarding income caps for this group. The bill should be amended to delete this language.

Section 3 of the bill prohibits Medicaid from paying for 24-hour-a-day intermediate-level nursing home care for individuals who are otherwise eligible but who meet the definition of "general care" as used in the Medicaid budget estimating process. Neither Florida Statutes nor the Florida Administrative Code use this definition as a level of care that has to be met to receive nursing home services. The bill should be amended to clarify that Medicaid will no longer provide Intermediate level II care as defined in 59G-4.180 F.A.C.

VII. Related Issues:

None.

VIII. Amendments:

None.