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 26-B

SPONSOR: Committee on Appropriations and Senator Silver

SUBJECT: Agency for Health Care Administration

DATE: October 23, 2001 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Peters	Revell	AP	Favorable/CS
2.				
3.				
4.				
5.				
6.				

I. Summary:

The Committee Substitute implements the following provisions of the General Appropriations Bill for FY 2001-02 (SB 2B):

- Eliminates Medicaid coverage for pregnant women with incomes between 150 percent and 185 percent of the federal poverty level effective July 1, 2002.
- Eliminates the Ticket-to-Work program that was authorized to establish a buy-in program allowing certain disabled individuals who are able to work to purchase Medicaid coverage effective January 1, 2002.
- Eliminates coverage for adults (with the exception of pregnant women) under the Medically Needy program effective July 1, 2002.
- Eliminates coverage for Adult Dental, Visual and Hearing Services effective July 1, 2002.
- Requires generic drug substitution for adults in the Medically Needy program from January 1, 2002 through June 30, 2002.
- Authorizes the use of mail order pharmacy services for dispensing drugs effective January 1, 2002.
- Limits the Pharmaceutical Expense Assistance Program to the annual appropriation in the General Appropriations Act and authorizes the Agency for Health Care Administration to develop waiting lists based on application dates to be used in enrolling individuals in unfilled enrollment slots effective January 1, 2002.
- Makes enhancements to expand fraud and abuse recoveries by the Agency for Health Care Administration effective upon the bill becoming a law.
- Eliminates the State Financial Assistance Program for rural hospitals effective January 1, 2002.

- Modifies Medicaid pharmacy reimbursement to the average wholesale price (AWP) less 15 percent effective January 1, 2002.
- Strengthens the sanctions that may be imposed to recover fines or overpayments and allows agency recovery of costs associated with recoveries effective upon the bill becoming a law.
- Increases county contributions related to Medicaid-funded nursing home services effective April 1, 2002.
- Authorizes a variable dispensing fee for dispensing of preferred-drug-list products to provide an increase of 50 cents for dispensing of a Medicaid preferred-drug-list product and a 50 cent reduction for the dispensing of a Medicaid product not included in the preferred-drug-list effective January 1, 2002.
- Deletes a requirement for consumer satisfaction surveys for nursing home services and related requirements effective January 1, 2002.
- Repeals requirements for the Medicaid "Up or Out" quality of care contract management program in nursing homes effective January 1, 2002.

This bill amends ss. 400.071, 400.191; 400.235; 409.815; 409.903; 409.904; 409.906; 409.9065; 409.907; 409.908; 409.9116; 409.912; 409.913; and 409.915, F.S.

This bill repeals ss. 400.0225; 400.148; and 409.904(11), F.S.

II. Present Situation:

The 2001 Florida Legislature passed SB 2000 the General Appropriations Act for FY 2001-2002 and was signed into law on June 15, 2001. As a result of estimated shortfalls in revenue for FY 2001-2002 a special session of the Florida Legislature was called to address the reduction in projected revenues.

Medicaid and the Medically Needy Program

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. States are required to cover certain groups of individuals under Medicaid, other groups may be covered at the state's option. Likewise, certain core services are required to be covered in the Medicaid program; other services may be covered at the state's option. The Agency for Health Care Administration (AHCA or Agency) 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). Sections 409.905

specifies the services the state is required to cover by federal law; ss. 409.906, F.S., specifies the federally optional services Florida's Medicaid Program covers.

Florida has extended Medicaid coverage to pregnant women who have incomes at or below 185 per cent of FPL. A pregnant woman who applies for eligibility for Medicaid through a qualified Medicaid provider must also be offered the opportunity, subject to federal rules, to be made presumptively eligible for the Medicaid Program. The prenatal care provided to the pregnant women under this program helps in reducing bad birth outcomes. Upon birth the newborn qualifies for Medicaid and any medical costs for treating the newborn is paid by Medicaid

Individuals who are elderly or disabled, whose incomes are under 100 percent of the Federal Poverty Level (FPL) are an optional coverage group made 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 which is the current eligibility standard.

The federal Medicaid law establishes a Medically Needy eligibility category that allows states to provide Medicaid to families and individuals who have more income than allowed for Medicaid eligibility under the other mandatory or optional categorical eligibility groups described in the Social Security Act, but who have significant health care expenses. The federal Omnibus Budget Reconciliation Act (OBRA) of 1981 amended the Social Security Act to allow states more flexibility in defining the term "Medically Needy" and permitted states to vary Medicaid services by eligibility group.

To become eligible for the Medically Needy Program, an individual must meet the categorical criteria for Medicaid, that is, be a low-income family with children; a caretaker relative or parent of a dependent child; a pregnant woman; a dependent child; or be aged, blind or disabled; and have incurred catastrophic medical expenses to the extent that income, after medical costs are deducted in the month in question, is reduced to $180 ($241 for a couple), and have assets which do not exceed $5,000 ($6,000 for a couple). Income and asset levels increase with family size. At the point in time each month that incurred medical expenses exceed the amount necessary to reduce gross income to $180, the individual becomes eligible for Medicaid for the remainder of that month only. A person eligible for the Medically Needy Program is eligible for all Medicaid services with the exception of services in a skilled nursing facility or an intermediate care facility for the developmentally disabled, and home and community-based services.

The "Ticket to Work and Work Incentives Improvement Act of 1999"

In CS/CS/SB 792, the 2001 Legislature established a Medicaid buy-in program pursuant to the "Ticket to Work and Work Incentives Act of 1999" for persons who are between the ages of 16 and 64, are disabled, and who have assets, income and resources up to and including 250 percent of the federal poverty level. The Agency for Health Care Administration was authorized to seek a federal grant, demonstration project or waiver to implement a Medicaid buy-in program or other programs to assist individuals with disabilities in gaining employment. The General Appropriations Act for FY 2001-2002 provided funding for this program to begin effective April 1, 2002.

Optional Adult Dental, Visual and Hearing Services

Medicaid currently covers adult dental services rendered by licensed, Medicaid participating dentists. Medicaid-reimbursable adult dental services are provided to recipients age 21 and older. Services include diagnostic examinations for denture services; radiographs necessary for dentures; extractions and other surgical procedures essential to the preparation of the mouth for dentures; oral prophylaxis; and emergency extractions and abscess treatment to alleviate pain or infection.

Medicaid covers hearing services rendered by licensed, Medicaid participating otolaryngologists, otologists, audiologists, and hearing aid specialist. Hearing services include cochlear implants, diagnostic testing, hearing aids, hearing aid evaluations, hearing aid fitting and dispensing, and hearing aid repairs and accessories.

Medicaid covers visual services rendered by licensed, Medicaid participating ophthalmologists, optometrists, and opticians. Medicaid reimbursable services include eyeglasses, eyeglass repairs and prosthetic eyes and contact lenses.

The annual caseload for dental services is 57,981; the annual caseload for visual services is 123,493; and the annual caseload for hearing is 8,764 individuals.

The Pharmaceutical Expense Assistance Program

The Prescription Affordability Act for Seniors," enacted in the 2000 Session of the Legislature, created a pharmaceutical expense assistance program for individuals who qualify for limited assistance under Medicaid as a result of being dually eligible for both Medicaid and Medicare and whose limited assistance or Medicare coverage does not include pharmacy benefits. Eligible individuals are Florida residents who are 65 years of age or older, have incomes between 90 and 120 percent of the federal poverty level, are not enrolled in a Medicare health maintenance organization that provides a pharmacy benefit, and request to be enrolled in the program. Medications covered under this program are those covered under the Medicaid Program. Monthly benefit payments are limited to $80 per program participant. Participants are required to make a 10 percent coinsurance payment for each prescription purchased through the program. The act appropriated $15 million from the General Revenue Fund to the Agency for Health Care Administration to implement the pharmaceutical expense assistance program for the first six month of operation beginning January 1, 2001. Additionally, $250,000 is appropriated from the General Revenue Fund to the agency to administer the program. Rebates collected from drug manufacturers under this program are to be used to help finance the program.

Fraud and Abuse in Medicaid

Section 409.920(2)(a-f), F.S., makes it unlawful to engage in certain activities for the purpose of falsely procuring Medicaid benefits. Like other healthcare insurance programs, Medicaid is vulnerable to abusive and fraudulent practices of providers. These practices can take several forms. For example, providers may sometimes over-bill because of simple errors, with no intent to increase their income. In other instances, providers may bill Medicaid for healthcare services that are not fraud and, when warranted, provides its findings to state attorneys for possible criminal action.

An October, 2001 report by the Office of Program Policy and Governmental Accountability recommended that the agency improve its efforts to detect and deter Medicaid provider fraud and abuse and its methods of assessing the effectiveness of program integrity functions.

County Contributions to Medicaid

Counties are currently required to participate in 35 percent of the total cost of Medicaid payments for nursing home and intermediate care facilities care in excess of $170 per month, with the exception that a county's contribution may not exceed $55 per month per person. The county participation for nursing home or intermediate facilities payments has not been increased since the Medicaid Program was implemented in Florida in 1970.

Consumer Satisfaction Surveys in Nursing Homes

Section 400.0225, F.S. requires consumer satisfaction surveys of nursing homes. The Agency is required to report the results of the surveys in consumer information materials prepared by the Agency and distributed to the public. Due to the amount of anticipated costs and workload, the Agency has been unable to contract with an outside entity to perform the survey at the current funding level. Section 400.191(2)(a), F.S., requires that consumer satisfaction surveys be posted in nursing facilities. Section 400.235 establishes the Gold Seal Program and includes a requirement that Gold Seal Facilities participate consistently in the consumer satisfaction process.

Medicaid "Up-or-Out" Pilot Project

CS/CS/CS 1202 required the agency to develop a pilot project to manage the medical and supportive care needs of residents in nursing homes in selected counties. The project is to ensure the quality of care of residents by placing skilled and trained medical personnel in highest scoring nursing homes in the Florida Nursing Home Guide, subject to an appropriation. The project is to be modeled after Medicare-approved demonstration projects. The agency is required to report to the Legislature and Governor and assess the program and submit a proposal for expansion to additional facilities. The bill specifies several criteria for the project. The agency is authorized to provide this service through contract. The Agency has not entered into any contracts for services for this program.

III. Effect of Proposed Changes:

Section 1: Amends s. 409.903 (5) , F.S, to eliminate Medicaid coverage for pregnant women with incomes between 150 percent and 185 percent of the federal poverty level effective July 1, 2002. The program will continue to be funded with nonrecurring funds through June 30, 2002. There will be approximately 5,150 women that will lose coverage from the elimination of this program. Children under age 1 with family incomes at or below 185% of the federal poverty level will continue to receive coverage.

Section 2: Repeals s. 409.904 (11), eliminating Medicaid coverage for disabled individuals transitioning to work effective January 1, 2002. The program would have served an estimated 1,500 working disabled individuals. This is the "Ticker to Work" program passed by the 2001 Legislature.

Section 3: Amends s. 409.904 (2) and (5), F. S., to eliminate Medicaid coverage for adults eligible for Medicaid through the Medically Needy Program with the exception of pregnant women and children under the age of 1 effective July 1, 2002. The program will continue to be funded with nonrecurring funds through June 30, 2002. Coverage for the Medically Needy Program is not available to presumptively eligible pregnant women. Around 8,900 children and 37,600 adults are covered at least for a portion of a year under the program. Children will continue to receive coverage, and an estimated 1,300 pregnant women will continue to receive prenatal and delivery services under the Medically Needy program. An estimated 19,243 adults would lose full coverage. Also reduces eligibility for a postpartum women living in a family with income from 185 percent of poverty to 150 percent of poverty to receive family planning services for 24 months following a pregnancy paid for by Medicaid.

Section 4: Amends s. 409.906 (1), (12), and (23), F.S., to eliminate Medicaid coverage for dental, visual and hearing services for adults effective July 1, 2002.

Section 5: Amends s. 409.906 (20), F.S., to authorize the Agency to use mail order pharmacy services for dispensing drugs effective January 1, 2002. Medicaid pays an estimated $943.8 million annually for maintenance drugs for recipients. By authorizing the Agency to contract with a mail order pharmacy provider, the Agency estimates that ten percent of the maintenance drugs would be dispensed through the mail order pharmacy provider. The Agency projects that savings of 4.25 per cent over the current reimbursement amount could be realized through the use of a contracted mail order pharmacy service. Additionally, pharmacies are required to dispense generic drug products for adults eligible under the Medically Needy Program from January 1, 2002 through June 30, 2002.

Section 6: Amends s. 409.9065(3) and (5), F.S., to limit the Pharmaceutical Expense Assistance Program to the annual appropriation in the General Appropriations Act and authorizes the Agency to develop waiting lists based on application dates to be used in enrolling individuals in unfilled enrollment slots effective January 1, 2002. For the six months during FY 2000-01 the program was operational and an average of 6,818 individuals utilized the program. The average cost of the program per recipient was $57.06. Only 40 percent of the eligible individuals each month utilizing the program use the maximum $80 subsidy per month. The program is currently funded at $30 million. The program is being reduced by $22.5 million which leaves $7.5 million to serve an estimated 10,953 elder individuals.

Section 7: Amends s. 409.907(5)(a), (7) and (9), F.S., to allow the Agency to withhold payment to a provider for a pended claim until the conclusion of the timely investigation, when a provider is under an active fraud or abuse investigation by the agency and imposes additional requirements on providers with respect to the submission of information for an initial and any required renewal applications. Provider enrollment is effective as of the date of the approved provider application. Provider applications may be denied if there are sufficient provider types already enrolled in the same geographic area and if the credentials, experience, success, and patient outcomes of the provider. This section is effective upon becoming law.

Section 8: Amends s. 409.9116, F.S., relating to the disproportionate share/financial assistance program. The state funded Rural Hospital Financial Assistance Program (RFAP) is eliminated January 1, 2002. The RFAP provides funding to rural hospitals that are not eligible under the

federal guidelines to receive disproportionate share program payments. Currently there are three rural hospitals that do no qualify for disproportionate share payments under the federal guidelines because they do not meet the obstetrical certification requirements: Calhoun General, Gadsden Community Hospital, and Trinity Community Hospital (Hamilton County).

The elimination of this program will result in the loss of approximately $215,000 annually to each of the three hospitals. Additionally, funds under this program are also paid to the remaining twenty-five hospitals to make up for shortfalls in their disproportionate share payments due to total payment limits. On average each of the hospitals, with one exception receive approximately $20,000 annually. One hospital (Gulf Pines) receives approximately $171,000 in RFAP funds due to their disproportionate share limit.

Section 9: Amends s. 409.912 (37)(a), F.S., relating to cost-effective purchasing of health care to require that Medicaid reimbursement to pharmacies for Medicaid prescribed drugs be set at the average wholesale price (AWP) less 15 percent, effective January 1, 2002. The current reimbursement is set at the average wholesale price less 13.25 percent. All of the 3,700 pharmacies participating in the Medicaid Program that would be affected.

Section 10: Amends s. 409.913 (15) and (22)(a), F.S., to strengthen the sanctions that the Agency may impose on providers including imposition of liens against provider assets (including financial assets and real property), not to exceed the amount of the fine or recovery sought and other remedies as permitted by law to effect the recovery of a fine or overpayment. Authorizes the Agency to recover all investigative, legal, and expert witness costs if the agency's findings were not contested by the provider, or if contested, the agency ultimately prevailed. Currently, recovery of these costs is limited to $15,000. This section is effective upon becoming law.

Section 11: Amends s. 409,215 (2), F.S., to provide for an increase in the statutorily mandated contribution that counties are required to make for nursing home and intermediate care facilities. The bill increases the limitation to $90 per person (an increase of $35 per person) effective April 1, 2002. The county billing limit as a percent of the average Medicaid cost per person per month went from over 10 percent in FY 1978-79 to under 2 percent by FY 2000-01. Revenues collected from counties under the provisions of s. 409.915, Florida Statutes are deposited into the General Revenue Fund Unallocated.

Section 12: Provides that the Legislature determines and declares that this act fulfills an important state interest.

Section 13: Amends s. 409.908 (14), F.S., to require an increase of 50 cents in the Medicaid dispensing fee for dispensing of preferred-drug-list-product and a decrease of 50 cents in the Medicaid dispensing fee for dispensing of a non preferred-drug-list-product effective January 1, 2002. It is anticipated that this will result in a 10% increase in formulary compliance resulting in a 10% increase in supplemental rebates. The current dispensing fee paid to pharmacists is a flat $4.23 regardless if the drug is on the formulary.

Section 14: Repeals s. 400.0225, F.S. requiring consumer satisfaction surveys of nursing homes effective January 1, 2002. Current law established a formal mechanism for assessing consumer satisfaction in nursing homes. The Agency is required to report the results of the surveys in

consumer information materials prepared by the Agency and distributed to the public. Due to the amount of anticipated costs and workload, the Agency has been unable to contract with an outside entity to perform the survey at the current funding level

Section 15: Amends s. 400.191(2)(a), F.S., to remove a provision requiring posting results of consumer satisfaction surveys.

Section 16: Amends s. 400.235 (5)(c) to eliminate a provision related to participation in the consumer satisfaction process for Gold Seal facilities

Section 17: Repeals s. 400.148, F.S., the Medicaid "Up-or-Out" quality of care contract management program for nursing homes effective January 1, 2002

Section 18: Amends s. 400.071 (8), F.S., to eliminates a nursing home licensure requirement for participation in consumer satisfaction measurement process.

Section 19: Amends s. 409.815, F.S., to conform a cross reference related to children's dental services.

Section 20: Provides for an effective date of January 1, 2002 except as otherwise specifically provided in the act.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The bill modifies county contributions to Medicaid for nursing home services. 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.

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 elimination of the Medically Needy program for adults will decrease revenues to a variety of health care providers including hospitals, pharmacies and physicians. Elimination of dental, visual and hearing services for adults in Medicaid will decrease revenues to these providers. The reduction in Medicaid reimbursement for pharmacies will decrease revenues to pharmacies. The use of mail-order pharmacies will decrease revenues for local pharmacies. Restrictions on provider enrollment will adversely affect revenues for providers not selected for participation in the Medicaid program.

C. Government Sector Impact:

	FTE	FY 2001-02	FY 2002-03
Revenues:			
Section 11			
Increase County Contributions for Nursing Homes		$5,032,230	$20,128,920
A. Non-Recurring			
Section 7 and 10			
Expand Fraud and Abuse Recoupment - Administrative			
State		($52,332)	
Federal		($52,332)	
Total		($104,664)	

	FTE	FY 2001-02	FY 2002-03
Section 1			
Reduce Coverage for Pregnant Women from 185% to 150% of FPL			
State		$7,318,932	
Federal		$9,486,889	
Total		$16,805,821	
Section 3			
Eliminate Adult Coverage in the Medically Needy Program			
State		$55,702,182	
Federal		$72,201,796	
Total		$127,903,978	
Section 4			
Eliminate Adult Dental, Visual, and Hearing Services			
State		$6,590,242	
Federal		$8,826,806	
Total		$15,417,048	
TOTAL NON-RECURRING			
State		$69,559,024	
Federal		$90,463,159	
Total		$160,022,183	

B. Recurring

Section 1			
Reduce Coverage for Pregnant Women from 185% to 150% of FPL			
State		($7,318,932)	($14,637,864)
Federal		($9,865,028)	($19,730,056)
Total		($17,183,960)	($34,367,920)

	FTE	FY 2001-02	FY 2002-03
Section 2			
Eliminate the Ticket-to-Work Program			
State		($789,121)	($3,156,484)
Federal		($1,143,326)	($4,573,304)
Total		($1,932,447)	($7,729,788)
Section 3			
Eliminate Adult Coverage in the Medically Needy Program			
State		($41,790,232)	($111,404,364)
Federal		($68,555,816)	($173,177,284)
Total		($110,346,048)	($284,581,648)
Section 4			
Eliminate Adult Dental, Visual, and Hearing Services			
State		($6,590,242)	($13,180,484)
Federal		($8,826,806)	($17,653,612)
Total		($15,417,048)	($30,834,096)
Section 5			
Implement Mail Order Pharmacy Services for Maintenance Drugs			
State		($436,922)	($1,747,689)
Federal		($565,883)	($2,263,531)
Total		($1,002,805)	($4,011,220)
Section 6			
Reduce Pharmaceutical Expense Assistance Program			
State		($22,500,000)	($22,500,000)
Federal			
Total		($22,500,000)	($22,500,000)

	FTE	FY 2001-02	FY 2002-03
Section 7 and 10			
Expand Fraud and Abuse Recoupment			
State		($6,250,000)	($12,500,000)
Federal		($8,036,510)	($16,073,020)
Total		($14,286,510)	($28,573,020)
Administrative			
State		$1,280,760	$2,456,854
Federal		$1,324,717	$2,544,766
Total	26.0	$2,605,477	$5,001,620
Section 8			
Eliminate State Rural Financial Assistance Program			
State		($600,000)	($1,200,000)
Federal		($14,944)	($29,888)
Total		($614,944)	($1,229,888)
Section 9			
Reduce Ingredient Cost of Drugs to AWP - 15%			
State		($4,564,640)	($9,129,280)
Federal		($5,946,724)	($11,893,448)
Total		($10,511,364)	($21,022,728)
Section 12			
Implement a Variable Dispensing Fee (Incentives) for Prescribed Drugs			
State		($1,722,003)	($3,444,006)
Federal		($2,230,265)	($4,460,530)
Total		($3,952,268)	($7,904,536)
Section 14, 15, 16, and 18			
Eliminate Nursing Home Consumer Satisfaction Survey			
State		($500,000)	($500,000)
Federal			
Total		($500,000)	($500,000)

	FTE	FY 2001-02	FY 2002-03
Section 17 Eliminate Nursing Home Up-or-Out Program			
State		($1,500,000)	($1,500,000)
Federal		($1,500,000)	($1,500,000)
Total		($3,000,000)	($3,000,000)
TOTAL RECURRING			
State		($93,281,332)	($192,443,317)
Federal		($105,360,585)	($248,809,907)
Total		($198,641,917)	($441,253,224)

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Amendments:

None.