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HOUSE OF REPRESENTATIVES

FISCAL RESPONSIBILITY COUNCIL ANALYSIS

BILL #: HB 75B (PCB FRC 01-16B)

RELATING TO: Health Care

SPONSOR(S): Fiscal Responsibility Council & Representative Murman

TIED BILL(S):

ORIGINATING COMMITTEE(S)/COUNCIL(S)/COMMITTEE(S) OF REFERENCE:

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I. SUMMARY:

This bill makes a number of changes pertaining to the Medicaid program in the Agency for Health Care Administration (AHCA). These statutory changes implement Medicaid program funding decisions included in PCB FRC 01-02B for Health and Human Services Appropriations. Specifically, the bill:

- Eliminates the requirement for Medicaid recipients to receive one-on-one counseling regarding choice among health care provider options.
- Eliminates the optional Medicaid Expansion Designated by SOBRA – Aged and Disabled (MEDS-AD) Program.
- Expands the Pharmaceutical Expense Assistance Program to include Elderly and Disabled individuals no longer receiving Medicaid services under the MEDS-AD Program.
- Eliminates adult coverage under the optional Medically Needy program.
- Provides for a cap on the number of contracted Medicaid nursing home beds.
- Eliminates optional Medicaid coverage for adult dental, visual and hearing services.
- Reduces the number of state paid days for hospital inpatient services.
- Authorizes utilization of mail order pharmacy services for maintenance drugs.
- Limits the existing Pharmaceutical Expense Assistance Program to current enrollment.
- Provides additional authority and statutory changes to enhance fraud and abuse prevention and recovery efforts.
- Increases county participation for nursing home care.
- Establishes dispensing fee incentives for pharmacy services.
- Eliminates statutory requirements for nursing home consumer satisfaction surveys, the Florida Center on Nursing, and the Nursing Home "Up or Out" program.

This bill requires a 2/3 vote of each house of the Legislature in order to bind counties, pursuant to Article VII, Section 18(a) of the Florida Constitution. See section IV of this analysis.

The budget impact for FY 2001-02 of the various reduction decisions included in this bill total ($168.6) million in General Revenue and ($238.3) million in trust funds, and the projected revenue impact is $28.6 million to the General Revenue Fund.

II. SUBSTANTIVE ANALYSIS:

A. DOES THE BILL SUPPORT THE FOLLOWING PRINCIPLES:

1.	Less Government	Yes [X]	No []	N/A []
2.	Lower Taxes	Yes []	No []	N/A [X]
3.	Individual Freedom	Yes []	No []	N/A [X]
4.	Personal Responsibility	Yes [X]	No []	N/A []
5.	Family Empowerment	Yes []	No []	N/A [X]

For any principle that received a "no" above, please explain:

B. PRESENT SITUATION:

Medicaid Aged and Disabled (MEDS –AD) Program

Certain aged and disabled persons who have income and assets over the current standards for the Supplemental Security Income program, but who have income at or below 90 percent of the federal poverty level and assets no greater than $5,000 for an individual and $6,000 for a couple, are currently eligible for Medicaid coverage at the option of the state.

The current monthly income standard for extending Medicaid eligibility to elderly and disabled persons under this program is $645 for an individual or $871 for a couple. This standard is at 90 percent of the 2001 federal poverty level of $716 for an individual or $968 for a couple. The Supplemental Security Income (SSI) income standard for 2001 is $530 for an individual and $796 for a couple, or 74 percent and 82 percent of the federal poverty level respectively.

Medicaid is required to provide Medicare 'buy-in' coverage for aged and disabled individuals who are Medicare beneficiaries. Therefore, if Medicaid coverage is eliminated for persons eligible under the criteria for the Elderly and Disabled (MEDS-AD) program, those who are eligible for Medicare will continue to have Medicaid coverage for Medicare premiums, deductibles and coinsurance.

Medically Needy Program

The Medically Needy program is an optional program under Medicaid that primarily covers persons who have experienced a catastrophic illness and either have no health insurance, or have exhausted their benefits. The program provides Medicaid coverage for those persons who qualify categorically for Medicaid except that their income or assets are greater than the level allowed under other Medicaid programs. There is no limit to the monthly income an individual can have, but to be eligible for Medicaid to pay for care, the individual must incur enough medical bills to offset his or her income to the income level that would qualify the individual for the Medically Needy program.

About two-thirds of the individuals eligible for the Medically Needy program are in the TANF-related group. The TANF-related group is primarily families with higher incomes who have undergone an illness or injury with substantial medical cost that would reduce their incomes down to the income standard. For example, a family of four would have to incur medical bills that, if deducted from their income, would reduce their income to $364 per month. The income eligibility standard of $364 per

month for a family of four is about one-fourth of the 2001 federal poverty level of $1,471 per month for a family of four.

The Supplemental Security Income (SSI) related group is usually without Medicare or other forms of insurance and primarily receives services for critical needs relating to AIDS, cancer, organ transplants, and other catastrophic illness. These individuals must incur medical bills that, if deducted from their income, would reduce their income to $180 per month for an individual or $241 per month for a family of two. This monthly income standard is about one-fourth of the 2001 federal poverty level for an individual ($716 per month) or for a family of two ($968 per month).

Eligibility is determined based on medical and pharmacy bills presented to the Department of Children and Family Services. Once determined eligible, the state reimburses providers based on the current Medicaid reimbursement rates. Individuals do not actually "spend down" to the above income standards in order to qualify for the program.

Adult Dental, Visual and Hearing Services

Medicaid covers adult dental services rendered by licensed, Medicaid participating dentists. Medicaid reimbursable adult dental services are provided to beneficiaries' 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.

Prescription Drugs

The Medicaid program reimburses licensed, Medicaid-participating pharmacies for drugs dispensed to Medicaid eligible individuals. A health care professional licensed to prescribe drugs must prescribe the drugs. Medicaid pays an estimated $943.8 million annually for maintenance drugs for recipients. If the Agency is authorized to contract with a mail order pharmacy provider, the Agency estimates that around ten percent of the maintenance drugs would be dispensed through the mail order pharmacy provider. The Agency projects that savings of 4.25 percent over our current reimbursement amount could be realized through the use of a contracted mail order pharmacy service. The annual savings is estimated to be over $4 million.

Pharmaceutical Expense Assistance Program

Created by the 2000 Legislature, the Prescription Affordability Act for Seniors provides a catastrophic pharmaceutical expense assistance program for certain individuals.

Eligibility for the program is limited to Florida residents age 65 and over who qualify for limited assistance under the Medicaid program as a result of being dually eligible for Medicaid and Medicare but whose limited benefit does not provide prescription drug coverage.

Medications covered are those covered under the Medicaid program. The program requires a ten-percent co-insurance payment by enrollees and is limited to a maximum payment by Medicaid of $80 per month per enrollee.

For the six months during FY 2000-2001 the program was operational an average of 6,818 individuals utilized the program. The average cost of the program per recipient per month was $57.06. Only 40 percent of the eligible individuals utilizing the program each month use the maximum $80 subsidy per month.

County contributions to Medicaid

Currently, s. 409.915, F.S., requires that counties contribute 35 percent of the total Medicaid costs for days 11 through 45 of an inpatient hospitalization for a Medicaid recipient for both HMO members and fee-for-service beneficiaries.

Section 409.915, F.S., also requires counties to contribute to the state share of the Medicaid cost of providing nursing home or intermediate facilities care. Counties must pay 35 percent of the total cost for Medicaid payments for nursing home or intermediate care facilities care in excess of $170 per month, except that the cost of skilled nursing care for children under age 21 is excluded from county participation. County financial participation for nursing home or intermediate care is further limited to no more than $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. Prior to the implementation of the Medicaid program, counties were paying for nursing home care for many of their low-income residents. The implementation of Medicaid gave Florida the opportunity to draw down federal dollars using the counties' contributions as a portion of the state match.

The required county financial participation in the Medicaid cost of providing nursing home and intermediate facilities care has not kept pace with the total increases experienced by the Medicaid program for these services. The average Medicaid monthly cost per person for nursing facilities has increased substantially each year while the $55 limit per person per month for the county contribution has remained constant. 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 for s. 409.915, F.S., are deposited into the General Revenue Fund unallocated.

Medicaid nursing home "Up or Out" program

The 2001 Legislature provided for a Medicaid "Up-or-Out" Quality of Care Program. Section 400.148, F.S., requires the Agency to develop a pilot project in selected counties to demonstrate the effect of assigning skilled and trained medical personnel to ensure the quality of care, safety, and continuity of care for long-stay Medicaid recipients in the highest-scoring nursing homes in the Florida Nursing Home Guide. The Agency is authorized to begin the pilot project in the highest-scoring homes in counties where such services are immediately available. The Agency is required to report to the Legislature on January 1 of each year of the pilot project an assessment of the program and a proposal for expansion of the program to additional facilities.

The Agency has not entered into any contracts for services for this program.

Center for Nursing

Section 409.0195, F.S., establishes a center to address issues of supply and demand for nursing, including issues of recruitment, retention and utilization of nurse workforce resources.

Nursing home consumer satisfaction survey

Section 400.0225, F.S., establishes 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.

C. EFFECT OF PROPOSED CHANGES:

See SECTION-BY-SECTION ANALYSIS.

D. SECTION-BY-SECTION ANALYSIS:

Section 1: Amends s. 409.903, F.S., relating to mandatory payments and eligibility for elderly and disabled. Eliminates reference to additional optional coverage.

Section 2: Amends s. 409.904, F.S., relating to optional payments for eligible persons. Eliminates optional coverage for elderly and disabled persons eligible under the Medicaid Aged and Disabled (MEDS –AD) Program.

Eliminates Medicaid coverage for adults eligible for Medicaid through the Medically Needy program. Pregnant women will continue to receive prenatal and delivery services under the Medically Needy program, and children will continue to be covered under the Medically Needy program.

Modifies language relating to payments for services of a licensed nursing facility to allow the imposition of a limit on the number of nursing home beds available in the state. Freezes the number of beds a nursing facility has available for Medicaid recipients based on the number of Medicaid residents in the nursing facility on January 1, 2002. Subsequent to this date, allows a nursing facility to accept a new Medicaid admission only if an existing Medicaid resident leaves the facility. Allows exceptions to this policy in circumstances when access to long-term care beds is an issue. Based on passage of this provision average monthly caseloads for 2001-02 will level off to 47,362, for a decrease of 138. Average caseloads for 2002-03 will decrease by 994. Funds are provided in the supplemental appropriations bill so that individuals not able to enter the nursing facility would receive services under the Home and Community-Based Waiver.

Section 3. Amends s. 409.905, F.S., relating to mandatory Medicaid nursing facility services to reflect the limit on contracted Medicaid beds.

Section 4. Amends s. 409.906, F.S., relating to optional Medicaid services. Eliminates adult denture services as an optional service. Restricts eligibility for hearing and visual services to people under age 21.

Modifies language relating to payments for intermediate care services to reflect the limit on contracted Medicaid beds.

Authorizes the use of mail order pharmacy services for dispensing drugs.

Section 5. Amends s. 409.9065, F.S., relating to the Pharmaceutical Expense Assistance Program. A new eligibility group is added for those individuals age 65 or older or disabled adults age 21 and older with incomes above the Supplemental Security Income level but below 90 percent of the federal poverty level. Modifies the current program to limit enrollment levels to those authorized by the Legislature in appropriation.

Section 6. Effective upon this bill becoming law, amends s. 409.907, F.S., relating to Medicaid provider agreements to enhance fraud and abuse prevention and recovery efforts. Authorizes the agency to withhold payment to a provider for any pending claim if the provider is under active fraud or abuse investigation by the agency until the conclusion of the investigation, and requires completion of investigations in a timely manner. Authorizes the agency to require the submission of professional, business, and personal background information, and permit an onsite inspection of the provider's service location as conditions of initial and any required renewal applications. Provides for provider enrollment no earlier than the effective date of the approval of the provider application, rather than the date of application submission. Provides additional factors for consideration by the agency relative to the denial of a provider application, including the number of providers of the same type already enrolled in the same geographic area; and the credentials, experience, success and patient outcomes of the provider for the services for which it is making application to provide in the Medicaid program.

Section 7. Amends s. 409.908, F.S., relating to reimbursement of Medicaid providers. Conforms language to reflect the provision of hearing and visual services for children only. Authorizes incentives and dis-incentives in the payment of drug dispensing fees to enhance utilization of the preferred drug list. Changes current dispensing fee paid to pharmacists for filling a prescription from a flat rate of $4.23 by increasing the dispensing fee by 50 cents to $4.73 for preferred drugs and reducing the dispensing fee by 50 cents to $3.73 for non-preferred drugs.

Sections 8 and 9. Amend ss. 409.912 and 409.9122, F.S., to eliminate the current requirement for enrollment choice counseling for MediPass or managed care plans.

Section 10. Effective upon becoming law, amends s. 409.913, F.S., relating to oversight of the integrity of the Medicaid program to allow the imposition of liens against provider assets, including, but not limited to, financial assets and real property, not to exceed the amount of the fine or recovery sought, and other remedies as permitted by law to affect the recovery of a fine or overpayment. Eliminates the current $15,000 cap on recovered costs to entitle the agency to recover from the provider all investigative, legal and expert witness costs.

Section 11. Amends s. 409.915, F.S., relating to county contributions to Medicaid. Changes the period for which counties pay 35% of the costs for inpatient hospitalization from days 11 through 45 to days 10 through 45. Increases the current cap on county contributions for nursing home or intermediate facilities care to $140 per month per person, which equates to 4% of the average cost of care.

Section 12. Amends s. 400.071, F.S., relating to application for a nursing home license to conform to the elimination of the nursing home consumer satisfaction surveys

Section 13. Amends s. 400.191, F.S., to conform to the elimination of nursing home consumer satisfaction surveys.

Section 14. Amends s. 400.23, F.S., to conform to the elimination of nursing home consumer satisfaction surveys.

Section 15. Amends s. 400.235, F.S., relating to nursing home quality and licensure status. Conforms to the elimination of nursing home consumer satisfaction surveys.

Section 16. Amends s. 409.8132, F.S., relating to MediKids program component to reflect the elimination of mandatory choice counseling.

Section 17. Amends s. 409.815, F.S., relating to health benefits coverage to correct a cross reference.

Section 18. Provides that this act fulfills an important state interest.

Section 19. Repeals s. 400.0225, F.S., establishing the nursing home consumer satisfaction surveys; s. 400.148, F.S. establishing the Medicaid "Up or Out" Quality of Care Contract Management Program; and ss. 464.0195 through 464.0197, F.S., establishing the Florida Center for Nursing.

Section 20. Except as otherwise provided herein, provides that this act shall take effect January 1, 2002.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

General Revenue Unallocated	**FY 2001-02**	**FY 2002-03**
Increased county billing for Hospital Inpatient	$ 4,109,421	$ 8,218,841
Increased county billing for Nursing Home Care	$24,442,260	$48,884,520

2. Expenditures:

	FY 2001-02			FY 2002-03		
	GENERAL REVENUE	TOBACCO SETTLEMENT TF	OTHER TF	GENERAL REVENUE	TOBACCO SETTLEMENT TF	OTHER TF
Eliminate MEDS A/D and provide coverage through state-only pharmacy assistance program	(83,471,250)	32,183,687	(129,630,059)	(156,116,958)	32,183,687	
Cover only children and pregnant women in the Medically Needy Program	(45,182,048)	-	(68,632,974)	(111,404,364)		(173,177,284)
Eliminate the AIDS Care Waiver	(23,746,250)		(30,762,279)	(51,224,132)		(66,359,039)
Reduce Prescription Program for Seniors	-	(22,224,000)	-		(22,224,000)	
Eliminate Center for Nursing	(100,000)	-	(100,000)			
Eliminate nursing home consumer satisfaction survey	(500,000)	-		(500,000)		

Eliminate Nursing Home 'Up or Out' Program	(1,500,000)	-	(1,500,000)	(1,500,000)		(1,500,000)
Nursing home cap on beds	(2,282,208)	-	(2,981,573)	(18,321,337)		(23,913,453)
Mail order pharmacy for drugs	(436,922)	-	(565,883)	(1,747,689)		(2,263,531)
Eliminate Choice Counseling Contract 12/31/01	(1,348,042)	-	(1,348,043)	(2,696,085)		(2,696,086)
Eliminate Adult Dental, Hearing and Visual	(2,805,121)	(500,000)	(4,413,403)	(11,403,662)	(2,000,000)	(17,848,400)
Pharmacy dispensing fee incentives	(1,722,003)	-	(2,230,265)	(3,444,007)		(4,460,530)
Increased fraud and abuse activities	(5,500,000)	-	(5,500,000)	(11,000,000)		(11,000,000)
TOTAL	**(168,593,844)**	**9,459,687**	**(247,664,479)**	**(369,358,234)**	**7,959,687**	**(303,218,323)**

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

N/A

2. Expenditures:

	FY 2001-02	**FY 2002-03**
Increased county billing for Hospital Inpatient	$ 4,109,421	$ 8,218,841
Increased county billing for Nursing Home Care	$24,442,260	$48,884,520

The elimination of eligibility groups such as the MEDS A-D and the Medically Needy program for adults may place more burden on local governments for the cost of indigent care.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The elimination of the MEDS A-D program and the Medically Needy program may result in more uncompensated care for hospitals.

D. FISCAL COMMENTS:

None

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

This bill will require counties to spend approximately $28.6 million. Section 11, which amends s. 409.915, F.S., requires counties to pay 35% of the costs for inpatient hospitalization from days 10 through 45 and increases the current cap on county contributions for nursing home or intermediate facilities care to $140 per month per person.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

This bill does not reduce the authority that counties or municipalities have to raise revenues in the aggregate.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

This bill does not reduce the percentage of a state tax shared with counties or municipalities.

V. COMMENTS:

A. CONSTITUTIONAL ISSUES:

None.

B. RULE-MAKING AUTHORITY:

None.

C. OTHER COMMENTS:

None.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

None

VII. SIGNATURES:

FISCAL RESPONSIBILITY COUNCIL:

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