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 42C

SPONSOR: Committee on Appropriations and Senator Silver

SUBJECT: Agency for Health Care Administration, Medicaid

DATE: November 28, 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 2C):

- 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 July 1, 2002.
- Reduces the income standard for the Elderly and Disabled (MEDS/AD) Program from 90% to 89% of poverty 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.
- Limits coverage for certain Project AIDS Care Waiver services effective January 1, 2002.
- Authorizes the use of mail order pharmacy services for dispensing drugs effective January 1, 2002.
- Revises eligibility for the Pharmaceutical Expense Assistance Program to lower the income criteria from 90% to 89% of poverty, limits the program to the annual appropriation in the General Appropriations Act, and authorizes the Agency to develop waiting lists for enrolling individuals in unfilled enrollment slots effective January 1, 2002.
- Makes enhancements to expand fraud and abuse initiatives and recoveries by the Agency for Health Care Administration effective upon the bill becoming a law.
- Modifies Medicaid pharmacy reimbursement to the average wholesale price (AWP) less 13.75 percent effective January 1, 2002.

- Authorizes the Agency to expand its current mail-order-pharmacy diabetes-supply program to include all generic and brand-name drugs used by Medicaid patients with diabetes and expands access to home delivery of pharmacy products.
- Eliminates Agency choice counseling requirements to contact and provide choice counseling to Medicaid recipients subject to mandatory managed care enrollment and defines "managed care plans".
- Authorizes a variable dispensing fee for dispensing of preferred-drug-list products to provide an increase of 50 cents for the 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.

This bill amends ss. 400.071; 400.179; 400.191; 400.235; 409.815; 409.904; 409.906; 409.9065; 409.907; 409.908; 409.912; 409.9122; and 409.913, F.S.

This bill repeals ss. 400.0225; 400.148; 409.904(11); and 414.41(4), 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 percent 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.

Medicaid Aged and Disabled (MEDS –AD) Program
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 of the federal poverty level (FPL) to 90 percent FPL.

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.

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 medically necessary, for expensive procedures when less costly alternatives are available, or for services that were not actually rendered as a means of increasing their income. The Agency must develop procedures for referring cases of suspected fraud to the state's Medicaid Fraud Control Unit (MFCU) located in the Department of Legal Affairs. The MFCU conducts investigations of suspected 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.

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.

III. Effect of Proposed Changes:

Section 1: Repeals s. 409.904 (11), F.S., to eliminate Medicaid coverage for disabled individuals transitioning to work effective July 1, 2002. The program was estimated to serve 1,500 working disabled individuals. This is the "Ticket to Work" program passed by the 2001 Legislature and funded effective April 1, 2002.

Section 2: Amends 409.904 (1) , F.S., to reduce the income standard for the Elderly and Disabled (MEDS/AD) Program from 90% to 89% of poverty effective January 1, 2002.

Section 3: Amends s. 409.904 (2), F.S., to eliminate Medicaid coverage for adults eligible through the Medically Needy Program with the exception of pregnant women effective July 1, 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.

Section 4: Amends s. 409.906 (1), (12), and (23), F.S., to eliminate Medicaid coverage for Adult Dental, Visual and Hearing services effective July 1, 2002.

Section 5: Amends s. 409.906 (13) and (20), F.S., to authorize the Agency to limit or eliminate coverage for certain Project AIDS Care Waiver services to comply with limitations in the General Appropriations Act and authorizes 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.

Section 6: Amends s. 409.9065(2), (3) and (5), F.S., to revise eligibility for the Pharmaceutical Expense Assistance Program by lowering the income standard for the elderly from 90% to 89% of poverty, to limit enrollment levels in the program to the annual appropriation in the General Appropriations Act, and to authorize 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 that the program was operational, 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 used 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(7) and (9), F.S., to allow the Agency to impose additional requirements on providers with respect to the submission of information for an initial and any required renewal applications; to require that the Agency be notified of any current or pending bankruptcy filing; to revise the effective date of provider enrollment to the date of the approved provider application; and to deny provider applications if there are sufficient provider types already enrolled in the same geographic area and based on the credentials, experience, success, and patient outcomes of the provider. This section is effective upon becoming law.

Section 8: 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 13.75 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 would be affected.

Additionally, the Agency is authorized to expand home delivery of pharmacy products by expanding its current mail-order-pharmacy diabetes-supply program to include all generic and brand-name drugs used by Medicaid patients with diabetes. Recipients in the program may obtain non-diabetes drugs on a voluntary basis. The Agency is also authorized to offer home delivery pharmacy products to any Medicaid recipient with diabetes on a voluntary basis provided that the provider accept current mail-order diabetes-supply reimbursement rates and offers equivalent levels of patient education and support services. The Agency is authorized to apply for and implement any necessary federal waivers.

Section 9: Amends s. 409,9122 (2), F.S., to eliminate the current requirement for contacting a Medicaid recipient and providing choice counseling for MediPass or managed care plans for recipients subject to mandatory managed care enrollment. Choice counseling requirements will be satisfied through mail outs and brochures. Also defines "managed care plans" to include exclusive provider organizations, provider service networks, minority physician networks, and pediatric emergency department division programs authorized by the General Appropriations Act.

Section 10: Amends s. 409.913 (15) and (21), (22)(a), and (24)(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 upon entry of an order; other remedies as permitted by law to effect the recovery of a fine or overpayment; eliminating the $15,000 limit on costs that may be recovered against a provider; requiring disclosure of certain information relating to rendering of services by a provider; and eliminating the exclusion for withholding certain payments to physicians whose overpayments are being determined by administrative proceedings. A new subsection (26) is added that transfers s. 414.41(4), F.S., related to the Agency recovery of overpayments. A new subsection (27) is added that requires venue for all Medicaid program integrity overpayment cases to lie in Leon County, at the discretion of the Agency. This section is effective upon becoming law.

Section 11: Repeals s. 414.41(4), F.S. related to the Agency recovery of overpayments.

Section 12: Amends s. 409.908 (14), F.S., to require an increase of 50 cents in the Medicaid dispensing fee for dispensing of a 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 13: 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 14: Amends s. 400.179, F.S., to require the continuation of liability for overpayment when a nursing facility is sold.

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

Section 18: Amends s. 409.815 (2), F.S., to conform a cross reference related to children's dental services.

Section 19: 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:

None.

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
A. Non-Recurring			
Section 1			
Restore Ticket to Work			
State		$789,121	
Federal		$1,143,326	
Total		$1,932,447	
Section 3			
Eliminate Adult Coverage in the Medically Needy Program			
State		$55,702,182	
Federal		$86,588,642	
Total		$142,290,824	
Section 5			
Eliminate Adult Dental, Visual, and Hearing Services			
State		$6,590,242	
Federal		$8,826,806	
Total		$15,417,048	
Section 7 and 10			
Expand Fraud and Abuse Recoupment			
State		($56,670)	
Federal		($56,674)	
Total		($113,344)	
Section 9			
Medicaid Choice Counseling			
State		$674,021	
Federal		$674,021	
Total		$1,348,042	
TOTAL NON-RECURRING			
State		$63,698,896	
Federal		$97,850,142	
Total		$161,549,038	
B. Recurring			
Section 1			
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)

	FTE	FY 2001-02	FY 2002-03
Section 2			
Reduce the Income Standard for MEDS/AD from 90% to 89% of			
State		($3,203,794)	($7,809,716)
Federal		($8,099,711)	($19,134,538)
Total		($11,303,505)	($26,944,254)
Section 3			
Eliminate Adult Coverage in the Medically Needy Program			
State		($55,702,182)	($111,404,364)
Federal		($86,588,642)	($173,177,284)
Total		($142,290,824)	($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			
Reduce the AIDS CARE Waiver			
State		($2,177,500)	($4,355,000)
Federal		($2,822,500)	($5,645,000)
Total		($5,000,000)	($10,000,000)
Section 5			
Implement Mail Order Pharmacy Services for Maintenance			
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)
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 (fraud & abuse)		$1,334,025	$2,574,152
Federal		$1,391,476	$2,689,046
Total	28.0	$2,725,501	$5,263,198

Section 8

	FTE	FY 2001-02	FY 2002-03
Reduce Ingredient Cost of Drugs to AWP - 13.75%			
State		($2,886,889)	($5,773,778)
Federal		($3,742,018)	($7,484,036)
Total		($6,628,907)	($13,257,814)
Section 8			
Mail Order Diabetic Supplies			
State		($957,227)	($1,914,454)
Federal		($1,240,769)	($2,481,538)
Total		($2,197,996)	($4,395,992)
Section 9			
Medicaid Choice Counseling			
State		($674,021)	($1,348,042)
Federal		($674,021)	($1,348,042)
Total		($1,348,042)	($2,696,084)
Section 12			
Implement a Variable Dispensing Fee (Incentives) for Prescribed			
State		($1,722,003)	($3,444,006)
Federal		($2,230,265)	($4,460,530)
Total		($3,952,268)	($7,904,536)
Section 13, 14, 15, 16 and 17			
Eliminate Nursing Home Consumer Satisfaction Survey			
State		($500,000)	($500,000)
Federal			
Total		($500,000)	($500,000)
TOTAL RECURRING			
State		($103,055,876)	($187,059,865)
Federal		($122,578,975)	($251,605,389)
Total		($225,634,851)	($438,665,254)
TOTAL ALL			
State		($39,356,980)	($187,059,865)
Federal		($24,728,833)	($251,605,389)
Total		($64,085,813)	($438,665,254)

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Amendments:

None.

This Senate staff analysis does not reflect the intent or official position of the bill's sponsor or the Florida Senate.