HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1901 (PCB HC 03-02A) Health Care (Medicaid and Prescription Drugs)
SPONSOR(S): Committee on Health Care and Farkas
TIED BILLS: None. **IDEN./SIM. BILLS:** CS/SB 390 (c)

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care	12 Y, 6 N	Rawlins	Collins
2)			
3)			
4)			
5)			

SUMMARY ANALYSIS

HB 1901 implements measures that decrease the annual Medicaid budget while providing consistent level of services to Medicaid recipients, by:

- Doubling the fines and penalties for Medicaid fraud and abuse;
- Providing a prepaid plan for Medicaid recipients with HIV and AIDS, saving an estimated $400,000;
- Establishing premiums for participants in Florida Kidcare program, $15 for a family with one child, $30 for a family with two children, and $45 for a family of three or more children;
- Providing a disincentive for use of the emergency department for non-emergent care by establishing a $15 co-pay for Medicaid recipients; estimated cost savings: $21,513,868; and
- Establishing co-pays for prescription drugs at $2 for each generic drug, $5 for each Medicaid preferred drug list product, and $15 for each non-Medicaid preferred drug list brand name drug; estimated cost saving: $62,777,250.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. DOES THE BILL:

1. Reduce government?	Yes[X]	No[]	N/A[]
2. Lower taxes?	Yes[]	No[]	N/A[X]
3. Expand individual freedom?	Yes[X]	No[]	N/A[]
4. Increase personal responsibility?	Yes[X]	No[]	N/A[]
5. Empower families?	Yes[]	No[]	N/A[x]

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

B. EFFECT OF PROPOSED CHANGES:

FLORIDA MEDICAID PROGRAM

Florida implemented the Medicaid program on January 1, 1970, to provide medical services to low-income people. Over the years, the Florida Legislature has authorized Medicaid reimbursement for additional services. A major expansion occurred in 1989, when the United States Congress mandated that states provide all Medicaid services allowable under the Social Security Act to children under the age of 21.

The Medicaid program is funded through federal and state participation with counties contributing to the cost of inpatient hospital and nursing facility services. Matching federal funds are contingent upon the state's continued compliance with the federal laws in Title XIX of the Social Security Act and regulations in Title 42 of the Code of Federal Regulations. It is estimated that Florida will spend $11.9 billion on Medicaid services in FY 2003-04. Florida's Medicaid spending has increased with the corresponding increase in enrollment , in FY 97, there were 1,454,932 individuals enrolled in the Florida Medicaid plan and in FY 2002 there were over 2,012,877 enrolled participants.

The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. It is administered by the Agency for Health Care Administration (AHCA). The Medicaid fiscal agent enrolls non-institutional providers and processes claims. The Department of Children and Families and the Social Security Administration determine Medicaid recipient eligibility.

AHCA has eleven area offices that serve as the local liaisons to providers and recipients. The area offices are responsible for exceptional claim processing; provider relations and training; consumer relations; managing the Child Health Check-Up, Transportation and School Match programs on a local level; and conducting credentialing site visits to MediPass providers.

COST EFFECTIVE PURCHASE OF SERVICE

Florida law [1]directs the agency to purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care and to maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding [2] designed to facilitate the cost-effective purchase of a case-managed continuum of care.

Florida began its Medicaid managed care plan in 1984, when Florida was selected as one of five states to receive a grant from the organization formerly known as the Health Care Financing Administration

[1] s. 409.912, F.S.
[2] s. 287.057, F.S.

(HCFA) [now known as the Centers for Medicare and Medicaid Services (CMS)] to implement a demonstration program. Federal waiver authority from the Centers for Medicare and Medicaid Services continues to be used to implement new managed care initiatives in an effort to increase access for recipients while enhancing utilization and provider network controls. However, not unlike other states throughout the nation, managed care options in Florida were sporadic, leaving many areas of the State uncovered. Most of the uncovered areas are Florida's rural counties.

Recently, the Florida Legislature authorized a new exclusive provider organization (EPO) as a managed care option for rural counties. The agency is currently negotiating with an organization to enroll Medicaid beneficiaries in an EPO in several counties.

The agency is authorized by law[3] to contract with health maintenance organizations certified pursuant to part I of chapter 641 for the provision of services to recipients. In addition, the law[4] authorizes the agency to contract on a prepaid or fixed-sum basis with an exclusive provider organization to provide health care services to Medicaid recipients provided that the exclusive provider organization meets applicable managed care plan requirements in this section, ss. 409.9122, 409.9123, 409.9128, and 627.6472, F.S., and other applicable provisions of law.

The health maintenance organizations (HMOs) may be proponents for clarifying the requirements for EPOs contracted to provide health care services to Medicaid beneficiaries. HMOs contracting with the Agency for Health Care Administration to provide health care services to Medicaid beneficiaries are subject to the statutory provisions for the Medicaid program appearing in ss. 409.901 through 409.9205 and 641.31, F.S. The HMOs compete for the largest market share of Medicaid beneficiaries. The presence of a Medicaid EPO will increase competition for Medicaid market share. The EPOs may be opposed to clarifying the requirements in Chapter 409, F.S., concerning exclusive provider organizations (EPOs) contracted to provide health care services to Medicaid beneficiaries.

PREENROLLMENT

Increasingly, health maintenance organizations have been investigated and sanctioned by the agency on numerous occasions for abusive activities involving the preenrollment process. The bill amends s. 409.912(27), F.S., and repeals the authority for managed care plans to perform preenrollments of Medicaid recipients.

Through this sanctioning process it has become evident that some of the requirements and definitions prescribed in s. 627.6472, F.S., conflict with the requirements and definitions prescribed in ss. 409.912, 409.9122, 409.9123, 409.9128 and 641.31, F.S. The bill specifies that when the provisions of s. 627.6472, F.S., are in conflict with the provisions of ss. 409.912, 409.9122, 409.9123, 409.9128 and 641.31, F.S., the provisions of ss. 409.912, 409.9122, 409.9123, 409.9128, and 641.31, F.S., shall prevail.

The health maintenance organizations may oppose the elimination of the preenrollment process. The HMOs compete for the largest market share of Medicaid beneficiaries. The HMOs may claim this will impede their ability to enroll beneficiaries.

The Code of Federal Regulation has been revised to clarify the definition of Prepaid Health Plans. Most of the federal regulations governing managed care organizations will be imposed by the Centers for Medicare and Medicaid Services on prepaid health plans with comprehensive coverage. The new federal regulations impose a June 13, 2003, deadline on the states for compliance. The bill provides a definition of managed care plan consistent with the requirement by the federal government.

MediKids is a component of the Florida KidCare program. The definition for 'managed care' in s. 409.901, F.S., is applicable to ss. 409.901-409.920, F.S. In counties in which there are no health

[3] Subsection (2) of s. 409.912, F.S.
[4] Subsection (6) of s. 409.912, F.S.

maintenance organizations contracting with the agency for the provision of health care, the only option for health care is the MediPass program. Section 409.8132, F.S., is amended to authorize the agency to enroll MediKids in managed care plans as defined in s. 409.811, F.S. The bill adds the definition to law to give MediKids beneficiaries additional managed care options.

PREPAID HIV/AIDS HEALTH PLANS

Medicaid is a primary source of health care for persons living with the human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS). Florida has historically promoted special programs for Medicaid beneficiaries with HIV/AIDS. The State has operated a home and community based services waiver program, Project AIDS Care, since the early 1990's. Through the provision of case management and enhanced services, the waiver program has proven effective in reducing costs for beneficiaries who would otherwise require the level of care in a hospital or nursing facility. Over the past two years, the State has developed a Medicaid disease management initiative for persons with HIV/AIDS. This initiative operates in conjunction with Florida Medicaid's primary care case management program, MediPass. Disease management of HIV/AIDS has demonstrated significant opportunities to improve care while containing health care costs.[5]

Building on these efforts, the 2000 Florida Legislature authorized the Agency for Health Care Administration (the Agency) to develop and implement specialty prepaid health plans to provide Medicaid services to beneficiaries living with HIV/AIDS. The Agency was directed to apply for any waivers of federal Medicaid regulations necessary to establish such plans. Currently, the agency is requesting authority from the Centers for Medicare and Medicaid Services (CMS) for applicable federal waivers that may be required to implement a capitated-prepaid health plan patients with HIV.

Project AIDS Care Waiver (PAC) waiver provides home and community based services to Medicaid recipients with a diagnosis of Acquired Immunodeficiency Syndrome (AIDS). Medicaid recipients who meet eligibility criteria for the Project AIDS Care (PAC) waiver are given a choice of enrolling in the program that is operated by approximately 65 PAC waiver case management agencies (CMAs) across the state or being institutionalized. Home and community based services are provided to enrollees for the purpose of preventing or delaying hospitalization or placement in a nursing facility. The Agency for Health Care Administration administers the waiver and has oversight of the program.

Enrollees are generally at a more advanced stage of the disease when there is a diagnosis of AIDS and other AIDS related opportunistic infections. The PAC waiver does not serve individuals with a diagnosis of Human Immunodeficiency Virus (HIV) alone. Medicaid eligible individuals with HIV can receive State Plan Medicaid services such as medications, physician services and are served by the Ryan White Title II program under the Department of Health.

As of December 2001, the waiver served 6,757 recipients with an average per capita expenditure of $3,719 per year. The total waiver expenditures was $25,126,169. Enrollment in the waiver is capped at 10,000 and does not have a waiting list at present. The impact will be a more streamlined coordination of the delivery of medical care and associated cost savings. A comprehensive benefit package from a prepaid health plan may be able to provide services that were otherwise covered under Medicaid, PAC Waiver, and Ryan White. It would limit administrative and case management expenses to one entity.

The proposed changes will provide home and community based Medicaid services in addition to State Plan Medicaid services, to Medicaid eligible individuals with HIV or AIDS. Ryan White Title II funds will be utilized only for those services that Medicaid does not cover.

Medicaid services can be used to prevent HIV from escalating to higher risk and expense associated with the treatment of AIDS.

[5] AHCA, *Comprehensive HIV/AIDS Managed Care Program Initial 1915(b) Medicaid Waiver Proposal,* August 7, 2002.

This bill amends the provisions of s. 409.91188, F.S., which initiated the Medicaid waiver for a HIV prepaid health plan as illustrated in the previous narrative, allowing the agency to amend the wavier, specifying that the program is not capitated, rather it is based on a risk-sharing contractual arrangement with the State. Participation in the prepaid plan is on a voluntary for HIV patients. Estimated saving to the Medicaid program is approximately $400,000.

DENTAL PLANS

Dental services are defined in the Medicaid Dental Coverage and Limitations Handbook. Medicaid children's dental services include diagnostic services, preventive treatment, restorative treatment, endodontic treatment, periodontal treatment, surgical procedures and/or extractions, orthodontic treatment and complete and partial dentures for recipients under age 21. Complete and partial denture relines and repairs are also included, as well as adjunctive and emergency services. Adult services include one cleaning per year and emergency services, limited to extractions and incision and drainage procedures, to relieve pain and/or infection. Services necessary to seat complete upper dentures, lower dentures, or both dentures, and repair and reline dentures for Medicaid recipients age 21 and older are also included. Relines are limited to one per denture, per 12 month period.

The 2002 General Appropriations Act provided that the Agency is authorized to continue a pilot program in Miami-Dade County to expand the use of dental management organizations in order to reduce cost, improve access, and reduce fraud. It was required that the results of the pilot program be provided to the Chairs of the Senate Appropriations Committee and the House Fiscal Responsibility Council for review prior to further expansion of the pilot program. According to AHCA, this pilot program did not come to fruition and therefore, no report is available.

The bill specifies in law[6] that the agency may contract on a pre-paid, fixed-sum basis with a licensed prepaid dental plan.

MEDICAID FAIR HEARINGS

Federal law requires that a State plan provide Medicaid recipients an opportunity for a fair hearing to any person whose claim for assistance is somehow denied or otherwise limited. The Agency's fair hearings are presently conducted by the Office of Appeals Hearings, Department of Children and Families. By agreement between the Agency and the Department, the Agency will assume fair hearing responsibilities for recipient requests that are unrelated to eligibility determinations. The Department, retains fair hearing responsibility for recipient requests that are related to eligibility determinations.

The bill grants specific authority to the Agency to establish and conduct such fair hearings, and amends existing statutory language to accurately reflect the proposed change.

In an effort accelerate the administrative hearing process to move cases through the system faster, legislation was adopted establishing minimal timeframes to process a case. Currently, s. 409.913, F.S., specifies that an administrative hearing is to be held within 90 days of case assignment to an administrative law judge. The Division of Administrative Hearings' policy is to not grant extensions or continuances of these cases. As a result of this accelerated process, state attorneys are frequently preparing for multiple hearings scheduled within the same week. According to AHCA, the 90-day requirement further impedes a proper and reasonable discovery schedule and increases litigation costs to the state as a result of the need for accelerated deposition transcripts and expert witness reviews.

The bill removes the 90-day requirement for administrative hearings, thereby by allowing more prudent case management. It is anticipated that with the 90-day window requirement removed from law, it will lead to a decreased in litigation expenses. Administrative law judges retain their ability to accelerate

[6] s. 409.912, F.S.

the scheduling of hearings, as they deem reasonable under the circumstances, and allows AHCA the ability to request that a hearing be expedited, when appropriate.

Currently, interagency agreements allow for cooperative efforts between agency and departments, but fail to provide specific legislative authority necessary for proper rulemaking in overlap areas. This problem was first brought to light by the Joint Administrative Procedures Committee (JAPC) in reviewing the Developmental Services Waiver Handbook that was promulgated by AHCA in the fall of 2002. The services covered by the handbook are almost exclusively delivered by the Department of Children and Families (DCF). The handbook was a cooperative effort between the two departments, however, the necessary statutory authority for AHCA to promulgate language governing another department (DCF) was deemed lacking by JAPC, despite the existing interagency agreements between AHCA and DCF, the cooperative effort between the two departments, and the need for such language to be published as a result of the *Prado-Steiman* case and settlement agreement. Current authority is arguably (per JAPC) lacking in specificity as required by law.

This bill amends s. 409.919, F.S., to provide specific rulemaking authority to the agency as it pertains to cooperative efforts between the Medicaid program and other departments. This change may insulate agency action from challenge in the future.

PRIOR AUTHORIZATION OF MEDICAID SERVICES

Some services require that providers obtain prior authorization (or post authorization in an emergency) before the services are performed in order to be reimbursed by Medicaid. Some services have limitations on the number of times Medicaid will reimburse for them.

42 CFR 456 requires the state to monitor health care services provided to Medicaid beneficiaries to safeguard against unnecessary or inappropriate use of Medicaid services. The state contracts with a Peer Review Organization (PRO) to provide this service, which is accomplished through a prior authorization program. In the 2002 Legislature, SB 792, amended s. 409.905, F.S., to require that the PRO make a determination on whether the services were medically necessary, within 4 hours of receipt of information. The PRO performs about 250,000 reviews per year, which includes the prior authorizations (PA) as well as reconsiderations on denials. According to the AHCA, the PRO currently completes 95% of PA requests within the 4 hour time frame. However, when a case is referred to a physician for potential denial, the PRO cannot adhere to the 4-hour turnaround time because of difficulty accessing referral physicians, especially during the night and early morning hours. In addition, requesting a 4-hour review increases agency contract costs because of higher PRO staffing requirements.

The bill increases the required 4 hour turnaround to 24 hours. According to AHCA, this will enhance quality of reviews, by focusing the reviews on quality rather than meeting an arbitrary time standard. Extending turnaround time to 24 hours will not negatively impact the providers' ability to receive timely reimbursement.

ACHA states that hospital providers may object to the extended timeframes for making a denial, especially during a concurrent review when the patient is an inpatient in the hospital.

HOSPITAL SERVICES–OUTPATIENT & EMERGENCY VISITS

Outpatient hospital services are preventive, diagnostic, therapeutic or palliative care and service items provided to an outpatient. The services must be provided under the direction of a licensed physician or dentist.

Medicaid reimbursement for outpatient hospital services is limited to $1,500 per recipient, per state fiscal year (July 1 through June 30) for recipients who are age 21 and older. There is no reimbursement limitation for children under the age of 21.

Exceptions to the outpatient fiscal year limitation are made for the surgical procedures that are performed in an outpatient setting. Services include, but are not limited to, cataract surgery, myringotomy with insertion of tube, single mastoidectomy, ligation and stripping of varicose lower limb veins, inguinal hernia repair, tubal ligation, ligation of vas deferens, dilation and curettage, vaginal child delivery, and dialysis services.

Medicaid will reimburse outpatient hospital services furnished by a non-Medicaid-participating hospital in an emergency, for the duration of the emergency. Medicaid reimburses for outpatient hospital services for all Medicaid recipients. Currently, there is a $3 recipient co-payment for each hospital outpatient department or clinic visit and emergency room visit to receive non-emergency services, unless the recipient is exempt.

The bill increases the emergency department co-pay from $3 to $15 for non-emergent visits, as a deterrent for the inappropriate utilization of services.

PRESCRIBED DRUG SERVICES

Medicaid reimburses licensed, Medicaid-participating pharmacies. Medicaid reimburses for most legend drugs used in outpatient settings, including injectable drugs, and specified nonlegend drugs. Brand name prescriptions are limited to four per month with some exceptions.[7] Generic drugs, insulin and diabetic supplies, contraceptives, mental health drugs, and antiviral drugs used to treat HIV are exempt from these limits. Based on the treatment needs of the Medicaid recipient, the agency may authorize exceptions to the four-brand-name drug restriction.

Medicaid does not reimburse pharmacies for any over-the-counter products dispensed to institutionalized recipients that could be floor stock and included in the institution's per diem.

Medicaid reimburses for prescribed drug services for all Medicaid recipients, except for those in limited programs, such as Qualified Medicare Beneficiary (QMB) and aliens.

Medicaid reimbursement for recipients age 21 and older is limited to four brand name prescriptions per month. Generic drugs, insulin and diabetic supplies, contraceptives, mental health drugs, and antiviral drugs used to treat HIV are exempt from these limits. There is no limitation on the number of prescriptions for recipients under the age of 21. Prior authorization is required for albumin, Botox®, Cytogam®, immune globulins, food supplements, Neupogen®, Neutrexin®, Panretin®, Proleukin®, Provigil®, Procrit®, Targretin® gel and capsules, Regranex® in long term care facilities and adult human growth hormone for HIV/AIDS.

This bill establishes co-pays for prescription drugs at $2 for each generic drug, $5 for each Medicaid preferred drug list product, and $15 for each non-Medicaid preferred drug list brand name drug.

FEDERAL MEDICAID DRUG REBATE PROGRAM

Created by the Omnibus Budget Reconciliation Act (OBRA) of 1990, the Medicaid Drug Rebate Program requires a drug manufacturer to enter into and have in effect a national rebate agreement with the Secretary of the U.S. Department of Health and Human Services for states to receive federal funding for outpatient drugs dispensed to Medicaid patients. The drug rebate program is administered by CMS's Center for Medicaid and State Operations (CMSO). This law was amended by the Veterans Health Care Act of 1992 which also requires a drug manufacturer to enter into discount pricing agreements with the Department of Veterans Affairs and with covered entities funded by the Public Health Service in order to have its drugs covered by Medicaid.

Approximately 520 pharmaceutical companies currently participate in this program. Forty-nine states, (Arizona is excluded), and the District of Columbia cover drugs under the Medicaid Drug Rebate Program.

[7] AHCA, *Florida Medicaid Program Summary of services 2002.*

As of January 1, 1996, the rebate for covered outpatient drugs is as follows:

- Innovator Drugs - the larger of 15.1% of the Average Manufacturer Price (AMP) per unit or the difference between the AMP and the best price per unit and adjusted by the CPI-U based on launch date and current quarter AMP.
- Non-innovator Drugs - 11% of the AMP per unit.

MEDICAID PRESCRIPTION DRUG REBATES & PREFERRED DRUG LIST

Over the past few years the Legislature has enacted several prescription drug cost control initiatives to curtail inappropriate prescribing, detect fraud, reduce prescription prices, and increase drug manufacturer rebates.

Florida Medicaid does not reimburse for drugs not included in a manufacturer's rebate agreement. Drugs must be prescribed for medically-accepted indications. Prior to the mandatory preferred drug list (PDL) with prior authorization, a voluntary drug list was prescribed by the Legislature for use by the Medicaid program in 1999.

Florida Medicaid implemented a mandatory PDL with prior authorization effective July 1, 2002. A committee, comprised of 5 physicians, 5 pharmacists and 1 consumer representative, meets quarterly to review the efficacy and cost of drugs within each therapeutic class to recommend which drugs to include or remove from the PDL. According to AHCA, of the nearly 600 therapeutic classes of drugs, 75% of Medicaid drug use is represented by 50 therapeutic classes.

The bill changes the requirement from a 100% class review by the Pharmaceutical &Therapeutic Committee to annual review of the top 75% of therapeutic classes based on the number of prescriptions and bi-annual review of all other classes. ACHA states that this change will allow better management of the higher utilized drug classes.

PRIOR AUTHORIZATION

Prior authorization is required for all prescribed drugs that are not on the Preferred Drug List (PDL). Mental health drugs and anti-retrovirals for HIV are exempt from PDL restrictions. Medicaid processes all prescription claims through Drug Utilization Review and will not reimburse for prescriptions that are refilled too often or too soon, that duplicate other prescriptions, or that result in excessively high dosages for the recipient.

Beginning August 2001, Florida Medicaid limited the number of brand name prescriptions to four per month for all adult beneficiaries. There was an exception created allowing for pharmacies to call for authorization for the brand name limit override as part of the phase-in for the long term care population, in September 2001. A prescriber may request a brand name drug over the four per month limit through the Therapeutic Consultation Program. Following a clinical discussion, which includes a discussion of PDL or generic options that may be as clinically effective and less costly, the prescriber decides which drug is most appropriate. At that time, a prior authorization is granted. Current law also allows an institutional or community pharmacy to call for a prior authorization on a brand name drug override for PDL drugs.

The bill eliminates the exemption created for the phase-in process and requires all prior authorizations to be sought by the prescriber and not by the pharmacy. AHCA states that this change will promote the clinical discussion between prescriber and pharmacist to help inform prescribers on drug alternatives that are as clinically effective and less costly.

MEDICAID PROGRAM INTEGRITY

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. Some of the more sophisticated types of fraud schemes involve providers that pay "kickbacks" to other providers for client referrals and providers that "hit and run," producing a large volume of claims and disappearing before the volume is discovered by detection methods.

The agency's Office of Medicaid Program Integrity is responsible for preventing, detecting, and deterring Medicaid provider fraud and abuse. To meet these responsibilities, staff develop and use statistical methodologies to identify providers that exhibit aberrant billing patterns; conduct investigations and audits of these providers; calculate provider overpayments; recommend sanctions; initiate recovery of overpayments in instances of provider abuse; and refer cases of suspected provider fraud to Medicaid Fraud and Control Unit (MFCU), located in the Department of Legal Affairs.

Currently state law provides that the agency may impose a fine of up to $5,000 for each Medicaid violation made by a provider. The bill increases all fines and penalties by 50%.

There have been numerous changes to Medicaid enforcement statues, in an effort to deter fraud and abuse within the Medicaid system. In former sessions, an "override" was established allowing the Secretary of the Agency for Health Care Administration to make a determination that imposition of a sanction or disincentive is not in the best interest of the Medicaid program, in which case a sanction or disincentive could not be imposed. The override was requested to allow leeway in the application of sanctions where the best interests of the Medicaid program might be adversely affected.

Currently, subsections (12), (14) and (15) of s. 409.913, F.S., provide differing methodologies for the application of sanctions against providers. This bill amends s.. 409.913(15), F.S., by changing the mandatory "shall" to an optional "may" consistent with the language of 409.913(12) and 409.913(14) and eliminates the language of 409.913(15) authorizing the secretary of the agency to override the imposition of sanctions or disincentives when in the best interest of the Medicaid program, which improves the clarity and creates consistency of language, thereby eliminating conflictions in law, and decreases the possibility of legal challenges. Changing the mandatory "shall" to an optional "may", eliminates the need for the language allowing for an override by the agency secretary. With the changes, the agency retains its sanctioning power.

FLORIDA HEALTHY KIDS CORPORATION

The Legislature created the non-profit Florida Healthy Kids Corporation to administer the Healthy Kids Program in s. 624.91, Florida Statutes, in 1990 to provide health insurance to uninsured school-age children who were not enrolled in Medicaid. Florida Healthy Kids began providing services in one county in 1992 and served 5,000 children by the end of that year. By 1997, the program was serving 47,000 children in 19 counties. Under the KidCare program, Healthy Kids was expanded to cover children ages 5-19 with family incomes up to 200% of the federal poverty level. 2 By August 2000, the program was providing services in all 67 counties. As of September 2001, Healthy Kids had enrolled 187,015 Title XXI-eligible children, which is an increase of approximately 55,000 children from the prior year.

The corporation operates under the supervision of a board of directors chaired by the Insurance Commissioner or his designee and is composed of 12 other members selected for three-year terms of office. The corporation's major responsibilities include establishing standards for preventive health services, providers, and insurance benefits; establishing eligibility and enrollment criteria for program participation and processing applications; and contracting with insurers and providers of health care services. The corporation aggregates local, state, federal, and family funds to pay premiums to commercial health plans that assume the insurance risk. During Fiscal Year 2001-02, the corporation

contracted with 13 health plans to serve all 67 counties. The corporation holds a contract with Dental Health and Administrative Consulting Services to manage client accounts and serve as the central point for eligibility review for the KidCare program, including Healthy Kids.

The Agency for Health Care Administration administers the contract with the Healthy Kids Corporation, which facilitates the release of state and federal funds to Healthy Kids. The Department of Health conducts outreach for the KidCare program including Healthy Kids. While the federal match rate is 69%, the federal portion of expenditures does not account for 69% of the total expenditures because some of the state expenditures do not qualify as federal matching dollars.

The Healthy Kids Corporation has administered the program by not following two basic principles of insurance:

- the more risk you share, the lower the premiums, and
- the more lives you can spread risk over, the lower the premiums.

Currently, Florida Healthy Kids Corporation purchases health insurance for their members. It costs the state roughly $40 more to cover a Florida Healthy Kid recipient than it costs to cover a Medicaid recipient in the same age group.

There are more than 250,000 individuals in the Florida Healthy Kids Program, yet rather than spreading the risk over this enormous group, the Florida Healthy Kids Corporation has primarily limited groups to individual counties. They are attempting to address this issue with a 56 county RFP due to be released in March of 2003. It will divide the state into 4 regions.

Florida Healthy Kids currently contracts with health maintenance organizations and Clarendon, an exclusive provider organization, to provide health benefits to Members of Florida Healthy Kids. Florida Healthy Kids Corporation states the company does not bear any risk under the contracts. Yet, the industry norm for large groups is to share risk on groups larger than 1000 lives.

There are many styles of risk sharing contracts. A common one involves an Administrative Services Only contract with Stop Loss Insurance. Under an Administrative Services Only contract large groups gain access to a corporation's provider networks and pay fee for service. The Stop Loss Insurance limits the self funding risk to a specific amount for each member or an aggregate amount for entire group. When large groups agree to some risk, their cost is lower.

The bill provides effective utilization of state dollars by transferring contractual obligations for health insurance plans from the Healthy Kids Corporation to the Agency for Health Care Administration

C. SECTION DIRECTORY:

Section 1. Amends s.120.80, F.S., providing the agency authority for Medicaid fair hearings.

Section 2. Amends s. 154.503, F.S., providing the agency with responsibility of coordinating with the activities of the primary care program.

Section 3. Amends s. 381.90, F.S., removing the Healthy Kids Corporation from the Health Information Systems Council.

Section 4. Amends s. 400.0255, F.S., designating the agency's office of fair hearings as entity initiating and conducting fair hearings; and providing rulemaking authority for hearing proceedings.

Section 5. Amends s. 400.179, F.S., revising a provision relating to accountability for certain outstanding liabilities to the state under certain circumstances.

Section 6. Amends s. 408.15, F.S., providing the agency with the authority to establish and conduct fair hearings unrelated to eligibility determination.

Section 7. Amends s. 409.811, F.S., providing for definitions of managed care plans, and renumbering subsequent subsections

Section 8. Amends s. 409.813, F.S., specifying that the Florida Kidcare program include health benefits coverage provided to children.

Section 9. Amends s. 409.8132, F.S., providing specifications for managed care plans as it relates to pre-enrollment in Medikids.

Section 10. Amends s. 409.814, F.S., providing authority for the agency to place limits on enrollment of children in the Healthy Kids Program.

Section 11. Amends s. 409.816, F.S., establishing premiums for participation in the Healthy Kids Program.

Section 12. Amends s. 409.818, F.S., eliminating the Florida Healthy Kids Corporation as an entity responsible for consultation with the department of health regarding eligibility determinations and specifying duties of the agency for eligibility; specifying that the agency shall approve premiums for the Healthy Kids program; and eliminating the Florida Healthy Kids Corporations as an entity responsible for making program modifications.

Section 13. Amends s. 409.820, F.S., eliminating the Florida Healthy Kids Corporation as an entity responsible for developing Quality assurance and access standards.

Section 14. Amends s. 409.904, F.S., clarifying provisions relating to optional payment for eligible persons.

Section 15. Amends s. 409.905, F.S., specifying authorization for inpatient admission is automatically granted when not denied within 24 hours.

Section 16. Amends s. 409.906, F.S., revising agency authorization to pay for adult dental services; limiting the agency's authority to provide hearing and visual services to children.

Section 17. Amends s. 409.9081, F.S., establishing co-pays for non-emergent ER visits and for prescription drugs.

Section 18. Amends s. 409.9117, F.S., eliminating the Florida Healthy Kids Corporation as an entity with responsibility for developing a feasibility study and plan to provide a low-cost comprehensive health insurance plan to residents along with hospitals that participate in the Medicaid primary care disproportionate share plan.

Section 19. Amends s. 409.91188, F.S., providing for a voluntary prepaid health plan for Medicaid recipients with HIV/AIDS, directing the agency to modify existing wavier applications, specifying reporting requirements to the agency, and requiring risk sharing.

Section 20. Amends s. 409.91195, F.S., providing that the class review by the pharmaceutical and therapeutics committee shall be the top 75% of therapeutic classes based on the number of prescriptions and requires a biennial review for all other classes; and specifies that Medicaid recipients may appeal agency preferred drug formulary decisions using the agency's office of Fair Hearings.

Section 21. Amends s. 409.912, F.S., specifying that the provisions in ss. 409.912, 409.9122, 409.9123, 409.9128, and 641.31, F.S., prevail if found conflicting with other sections of law, increasing fines, repealing authority for managed are plans to perform pre-enrollments for potential Medicaid recipients; specifying that the agency may contract on a pre-paid or fixed-sum basis for dental health plans; and renumbering subsequent subsections.

Section 22. Amends s. 409.9122, F.S., revising provisions relating to agency assignments of certain Medicaid recipients to managed care plans under certain circumstances.

Section 23. Amends s. 409.913, F.S., removing requirement of a 90-day window for an administrative hearing in cases of fraud and abuse within Medicaid; providing clarification and consistency of language between subsections; and renumbering subsequent subsections.

Section 24. Amends s. 409.919, F.S., providing rule making authority for the agency to create interagency agreements.

Section 25. Amends s. 411.01, F.S., requiring that Florida Partnership for School Readiness provide report to the Agency for Health Care Administration in lieu of the Florida Healthy Kids Corporations

Section 26. Amends s. 465.0255, F.S., specifying the expiration date for prescribed drugs.

Section 27. Provides an effective date of July 1, 2003.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   See Fiscal Comments section.

2. Expenditures:

   See Fiscal Comments section.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   See Fiscal Comments section.

2. Expenditures:

   See Fiscal Comments section.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

   See Fiscal Comments section.

D. FISCAL COMMENTS:

   The Agency for Health Care Administration provided the following information in a draft analysis of PCB HC 03-02a:

Fair Hearing:	COST:	$87,000
Co-payment for ER Visits:	SAVINGS:	$21,513,868
Co-payment for Rx's:	SAVINGS:	$62,777,250
Prepaid Dental Plans:	UNDETERMINED	
Prepaid HIV/AIDS Plan:	SAVINGS:	$400,000

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not appear to require cities or counties to spend funds or take an action requiring the expenditure of funds; reduce the authority that cities or counties have to raise revenues in the aggregate; or reduce the percentage of a state tax shared with cities or counties.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill provides the Agency for Health Care Administration with rulemaking authority.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES