HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 5085 PCB PBC 08-06 Health Care & Medicaid
SPONSOR(S): Policy & Budget Council; Bean
TIED BILLS: **IDEN./SIM. BILLS:** SB 1854

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
Orig. Comm.: Policy & Budget Council	20 Y, 9 N	Leznoff	Hansen
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SUMMARY ANALYSIS

The bill makes statutory changes to implement the funding decisions included in the proposed General Appropriations Acts for Fiscal Year 2008-2009.

- The bill transfers the statutory duties and functions related to drugs, devices, cosmetics and household products from the Department of Health to the Department of Business and Professional Regulation, effective April 1, 2009.
- The bill authorizes the transfer of revenues for nursing home Medicaid overpayments, requires legislative notification before seeking amendments to the Medicaid state plan for programs authorized through the Deficit Reduction Act of 2005, and eliminates mailing of the explanation of benefits for Medicaid school-based and laboratory services.
- The bill prohibits payment for optional Medicaid chiropractic, hospice care, and podiatric services for two fiscal years and adds anesthesiologist assistant services as a reimbursable cost.
- The bill eliminates authority for certain Medicaid hospital inpatient per diem rate adjustments and permits Medicaid payment for Medicare deductibles and coinsurance for hospital inpatient service amounts not covered by Medicaid and other services not covered by Medicaid.
- The bill reduces pharmacy reimbursement rates and requires AHCA to set rates for hospitals, nursing homes, community intermediate care facilities for the developmentally disabled and county health departments in a manner that results in no automatic cost-based statewide expenditure increase for two fiscal years and requires the establishment of a work group to evaluate alternate payment methods.
- The bill reduces nursing home licensure minimum staffing requirements for two fiscal years and changes the distribution criteria for Medicaid Disproportionate Share (DSH) Program payments, which are necessary to implement the DSH funding decisions included in the proposed General Appropriations Act.
- The bill expands the Medicaid managed care pilot program to Hardee, Highlands, Hillsborough, Manatee, Miami-Dade, Monroe Pasco, Pinellas and Polk counties in 2010.
- The bill allows Medicaid-eligible children in Hillsborough County receiving child welfare services in the HomeSafeNet system to receive behavioral health care services through the specialty prepaid plan operated by community-based lead agencies.
- Creates s. 409.91205, F.S., allowing the Governor, the President of the Senate, and the Speaker of the House of Representatives to convene workgroups to propose alternatives for cost-effective health and long-term care reforms, including, but not limited to, reforms for Medicaid.
- The bill repeals the Florida Patient Safety Corporation, the Florida Statewide Advocacy Council and local advocacy councils, the teaching nursing home pilot project, the Sunshine for Seniors Program, and the Florida Center for Nursing.

The bill provisions allow for a reduction of $343.7 million in General Revenue in Fiscal Year 2008-09 in the proposed General Appropriations Act and a $351.9 million General Revenue reduction in Fiscal Year 2009-10. This bill is effective July 1, 2008.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide Limited Government—The bill conforms statutes to appropriations in the proposed General Appropriations Act (GAA) to reduce government activity consistent with reduced revenues.

B. EFFECT OF PROPOSED CHANGES:

Drugs, Devices, Cosmetics

Part I of chapter 499 requires the Department of Health (DOH) to regulate drugs, devices, and cosmetics. The bill transfers, by a type two transfer,[1] all statutory powers, duties and functions, records, personnel, property, and unexpended balances of appropriations, allocations, or other funds for the administration of part I of chapter 499, F.S., related to Drugs, Devices, Cosmetics, and Household Products, from DOH to the Department of Business and Professional Regulation. The bill also provides for the continued validity of pending judicial or administrative actions in which DOH is a party; provides for the continued validity of lawful orders issued by DOH; transfers rules created by DOH to the Department of Business and Professional Regulation; and provides for the continued validity of permits and certifications issued by DOH.

Liability for Medicaid Underpayments and Overpayments

Current law allows the Agency for Health Care Administration (AHCA) to collect overpayments by Medicaid to a nursing facility when the nursing facility is being or has been transferred to a new owner.[2] For leased facilities, AHCA requires transferees, as a condition of obtaining a license, to acquire, maintain, and provide proof to AHCA of a bond with a term of 30 months renewable annually in an amount not less than the total of 3 months' Medicaid payments of the facility computed based upon the preceding 12-month average Medicaid payments to the facility; or the transferee may, at the time of licensure, at the time of change of ownership, and annually thereafter, pay a non-refundable fee in the amount of 1 percent of the total of three months' Medicaid payments to the facility computed on the bases of the preceding 12-month average Medicaid payments to the facility. If such an average is not available, then a projected Medicaid payment may be used.

Fees are deposited into the Health Care Trust Fund and the agency has the discretion to use such funds to repay nursing home Medicaid overpayments. The bill provides AHCA authority to transfer such payments to the Grants and Donations Trust Fund as necessary to repay such overpayments.

Nursing Facility Staffing

In 2000, the Legislature created the Task Force on Availability and Affordability of Long-Term Care to evaluate issues related to quality, liability insurance, and reimbursement in long-term care. A staff report of information discussed by and presented to the task force was developed. Much of the staff report served as a basis for chapter 2001-45, Laws of Florida. The legislation had a multi-prong approach incorporating reforms in tort liability, quality of care and enforcement, and corresponding reimbursement. Adequacy of staffing was central to the quality reforms.

[1] *See* s. 20.06(2), F.S. ("A **type two transfer** is the merging into another agency or department of an existing agency or department or a program, activity, or function thereof or, if certain identifiable units or subunits, programs, activities, or functions are removed from the existing agency or department, or are abolished, it is the merging into an agency or department of the existing agency or department with the certain identifiable units or subunits, programs, activities, or functions removed there from or abolished.")

[2] s. 400.179, F.S.

In recognition of the fact that the majority of nursing home care is paid by Medicaid, the Legislature acknowledged that staffing increases should be supported by an additional Medicaid appropriation to pay for the additional staff required. It was also understood that to obtain a desired level of 2.9 certified nursing assistant hours per resident per day would require additional staff recruitment efforts. Therefore, a gradual increase to 2.9 was enacted in s. 400.23, F. S., specifying the nursing assistant ratio increases to 2.3 effective January 1, 2002; 2.6 effective January 1, 2003; and 2.9 effective January 1, 2004. AHCA was granted rulemaking authority to address minimum staffing requirements.

The Legislature delayed the effective date of the increase to 2.9 hours certified nursing assistant hours per resident per day during the 2004, 2005, and 2006 regular sessions, and modified the staffing provisions to require an *average* of 2.9 hours of certified nursing assistant hours per resident per day. Current law sets July 1, 2007, as the effective date of the increase.

The bill would reduce minimum staffing requirements for two fiscal years from July 1, 2008, through June 30, 2010, to a minimum daily combined average certified assistant and licensed nursing staffing of 3.7 hours of direct care per resident per day, and a minimum certified nursing assistant staffing of 2.6 hours of direct care per resident per day and a minimum licensed nursing staffing of 1.0 hours of direct care per resident per day. The bill prohibits any facility from staffing below one certified nursing assistant per 20 residents and below one licensed nurse per 40 residents.

Medicaid Reimbursement for Hospital Inpatient Services

Current law allows AHCA to adjust a hospital's current hospital inpatient per diem rate if (1) the hospital receives an increase in Medicaid caseload by more than 25 percent in any year that is primarily the result of another hospital in the same service area closing after July 1, 1995; (2) the hospital's Medicaid per diem rate is at least 25 percent below the Medicaid per patient cost for that year; or (3) the hospital is in a county that has five or fewer hospitals, began offering obstetrical services on or after September 1999, and submitted a request in writing to AHCA for a rate adjustment after July 1, 2000 but before September 30, 2000, in which case the rate shall is adjusted to cost. AHCA is required to report any qualifying hospitals to the Legislature, which may appropriate funds for the adjustment. Currently, five hospitals qualify for and receive the adjusted rate: Health Central Hospital (Ocoee), Lake Wales Hospital, Winter Haven Hospital, New Port Richey Hospital and Larkin Community Hospital (Miami). One hospital, Heart of Florida Hospital (Haines City) qualifies for the adjusted rates but the adjustment has not been appropriated.

The bill eliminates the provisions authorizing these adjustments of hospital inpatient per diem rates.

Medicaid Optional Services

Medicaid currently reimburses providers for at least 25 optional services, including the following:

- Chiropractic Services – Medicaid currently covers chiropractic services rendered by a licensed, Medicaid participating chiropractic physician. Chiropractic services include manual manipulation of the spine and initial services, screening and x-rays provided by a licensed chiropractic physician.
- Hospice Care Services – Medicaid covers hospice care services by hospices licensed under part IV of chapter 400 and meets Medicare certification requirements. Hospice services include reasonable and necessary services for the palliation or management of a recipient's terminal illness.
- Podiatric Services – Medicaid covers podiatric services provided by licensed, Medicaid participating podiatric physicians. Podiatric services include diagnosis and medical, surgical, palliative, and mechanical treatment of the human foot and lower leg.

The bill prohibits Medicaid reimbursement of the above-referenced optional services for the next two fiscal years.

Currently, Florida Medicaid reimburses Certified Registered Nurse Anesthetists at not less that 80 percent of the reimbursement that would be paid to a physician who provided the same service. The bill adds anesthesiologist assistant services as an optional service covered by Medicaid, which shall be reimbursed at no less than 80 percent of the reimbursement that would be paid to a physician who provided the same services. This would enable an anesthesiologist assistant licensed under section 458.3475 or section 459.023, Florida Statutes, to be reimbursed at the same level as the Certified Registered Nurse Anesthetist.

Medicaid Reimbursement for Prescribed Drug Services

Prescribed drug services are optional services in the Medicaid program. Currently, prescribed drugs are reimbursed to pharmacies at the lesser of the average wholesale price minus 15.4 percent, the wholesaler acquisition cost plus 5.75 percent, the federal upper limit, the state maximum allowable cost, or the usual and customary charge billed by the provider.[3] "Average wholesale price" refers to the drug manufacturer's sticker price, or list price, for a drug. It is a figure reported by commercial publisher of drug pricing data based on wholesale pricing information provided to them by drug manufacturers.[4] "Wholesaler acquisition cost" refers to the manufacturer's charge to the wholesaler to purchase the drug.[5] "Federal upper limit" refers to a federal payment ceiling that applies to drugs with three or more generic versions.[6] "Maximum allowable cost" refers to the upper limit price that a purchaser, such as a state Medicaid program or health plan, will reimburse for multiple source medications or medications for which generics are available.[7]

The bill reduces reimbursement for prescribed drugs to the lesser of the average wholesaler price minus 16.4 percent or the wholesaler acquisition price plus 4.75 percent, the federal upper limit, the state maximum allowable cost, or the usual and customary charge billed by the provider.

Medicaid Payments for Deductibles and Coinsurance for Qualified Medicaid Beneficiaries

Qualified Medicaid beneficiaries (QMBs) are Medicaid recipients who are also covered by Medicare. Current Florida law prohibits Medicaid from paying the Medicare deductibles and coinsurance for QMBs for services not covered by Medicaid or for services not covered by Medicaid for the same duration as covered by Medicare.[8] Currently, Medicaid covers up to 45 hospital inpatient days per fiscal year, and therefore pays the Medicare deductible and coinsurance for QMBs for up to 45 days. However, Medicare Part A covers up to 150 hospital inpatient days. Medicaid does not pay the Medicare deductible and coinsurance for the additional days covered by Medicare. Similarly, Medicare covers physician services under Part B. However, Medicaid does not cover certain physician services covered by Medicare, and therefore does not pay the Medicare deductible and coinsurance for those services.

According to the Centers for Medicare and Medicaid Services, this restriction in Florida law puts the Medicaid program out of compliance with federal law, which requires that Medicaid reimburse for such coinsurance and deductibles for QMBs in an amount that would have been paid by Medicaid for such services provided to a Medicaid recipient other than a Medicare beneficiary.[9] If CMS determines that Florida Medicaid is out of compliance, they may take a number of actions against the Medicaid program, including withholding federal financial participation.

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[3] ss. 409.908(14); 409.912(39), F.S.
[4] National Health Policy Forum, Issue Brief No. 775, George Washington University, June 2002, available at http://nhpf.ags.com/pubs/pubs.htm#2002.
[5] Id.
[6] Id.
[7] Id.
[8] ss. 409.908(13)(a), (c)3., F.S.
[9] 42 U.S.C. s. 1396a(n)(2). *See also*, February 23, 2007 Letter to Assistant Secretary of Medicaid from CMS Associate Regional Administrator for Division of Medicaid and Children's Health.

The bill removes the prohibition against Medicaid payments for these deductibles and coinsurance for QMBs, and provides that the methodology for calculating the Medicaid payment for Medicare coinsurance shall be based on the Medicaid per diem rate.

Reimbursement Rates for Medicaid Providers

Currently, Medicaid reimburses Medicaid providers in one of three ways: fee-for-service, capitation, or cost-based reimbursement.

Capitated reimbursement is provided for in s. 409.9124, F.S, and is a methodology used for managed care providers. Capitated rates are set annually based upon two years of fee-for-service claims for all recipients eligible for enrollment in a health maintenance organization (HMO) plan, and must be actuarially sound for comparable recipients. Thus, current rates are based upon data from Fiscal Years 2004-2005 and 2006-2007, and are based upon 25 different service categories, such as hospital inpatient, laboratory, x-ray, prescription medicine, etc. To determine actuarially sound rates for comparable recipients, Medicaid separates fee-for-service rates into categories, such as TANF, SSI without Medicare, SSI with Medicare Parts A and B, and SSI with Medicare Part B only; geographic areas (all 11 AHCA areas); and age/gender bands (birth to 2 months; 3-11 months, 1-5 years, 6-13 years, 14-20 years female; 14-20 years male; 21-54 years female; 21-54 years male; and 55+).

Fee-for-service reimbursement is accomplished through the assignment of an established fee for each service provided by specific Medicaid provider types, which is established by Medicaid based upon funding provided in the GAA. The types of services typically reimbursed through a fee for service payment are physician and nursing care, dental services, pharmaceuticals, laboratory services, durable medical equipment and supplies, home health agency services, dialysis center services, and emergency transportation services. Reimbursement rates for physicians are set for periodic adjustment pursuant to federal directive, which is based upon updates to the Resource Based Relative Value Scale that requires budget neutrality as part of adjustments.

Cost-based reimbursement is accomplished through periodically establishing fees for each provider type based upon the provider type's historic cost of providing services, which, for institutional providers, is generally indexed to pre-determined health care inflation indices (price level increases). AHCA collects the cost data from individual providers to use in calculating and setting cost-based reimbursement rates. Nursing homes, hospitals, intermediate care facilities for the developmentally disabled, rural health clinics, county health departments, hospices, and federally qualified health centers are the types of providers that are reimbursed using cost-based methodologies, and provider types may be subject to specified reimbursement ceilings.

The bill requires AHCA to establish provider rates for hospitals, nursing homes, community intermediate care facilities for the developmentally disabled and county health departments in a manner that results in no increase in statewide expenditures resulting from a change in unit costs for two fiscal years. This effectively eliminates the automatic cost-based rate increases for that period of time. The bill also requires AHCA to establish work groups to look at alternative ways to pay nursing homes, hospitals and managed care plans in future. The work groups are to consider prospective payment methodologies for hospitals and nursing facilities, and consider price-based methodologies for indirect care and acuity adjustments for direct care for nursing facilities. AHCA is required to submit a report of its work to the relevant committees of the Senate and the House of Representatives by November 1, 2009.

Disproportionate Share Program (DSH)

Each year the Low-Income Pool Council (formerly Disproportionate Share Council) makes recommendations to the Legislature on the Medicaid Disproportionate Share Program funding distributions to hospitals that provide a disproportionate share of the Medicaid or charity care services to uninsured individuals.

The bill amends chapter 409, F.S, to implement the current recommendations of the Low-Income Pool Council. The bill amend s. 409.911, F.S., revising the method for calculating disproportionate share payments to hospitals for Fiscal Year 2008-2009 by changing the years of averaged audited data from 2000, 2001 and 2002 to 2002, 2003 and 2004. The bill amends section 409.9112, Florida Statutes, revising the time period from Fiscal Year 2007-2008 to Fiscal Year 2008-2009 during which the agency is prohibited from distributing funds under the Disproportionate Share Program for Regional Perinatal Intensive Care Centers. The bill also amends section 409.9113, Florida Statutes, requiring that funds for statutorily defined teaching hospitals in Fiscal Year 2008-2009 be distributed in the same proportion as funds were distributed under the Disproportionate Share Program for Teaching Hospitals in Fiscal Year 2003-04, or as otherwise provided in the GAA. The bill amends section 409.9117, Florida Statutes, revising the time period from Fiscal Year 2007-2008 to Fiscal Year 2008-2009 during which the agency is prohibited from distributing funds under the Primary Care Disproportionate Share Program.

Deficit Reduction Act of 2005

The State Medicaid Plan is the document that defines how each state will operate its Medicaid program and is approved by the Centers for Medicare and Medicaid Services within the U.S. Department of Health and Human Services. The state plan addresses the areas of state program administration, Medicaid eligibility criteria, service coverage, and provider reimbursement.

In 2005, Congress enacted the Deficit Reduction Act (DRA), which was signed into law in 2006. The Act affects various entitlement programs, including Medicaid. Among other things, the DRA provides states with greater flexibility to make reforms to their Medicaid programs. To provide flexibility in benefit packages, states were previously required to seek federal waivers of various federal requirements. The DRA gives states the option to amend their State Medicaid Plans, rather than seeking waivers, to provide flexibility in benefit packages without regard to traditional requirements such as statewideness, comparability, freedom of choice, or certain other traditional Medicaid requirements.

The bill requires AHCA to notify the Legislature before seeking an amendment to the Medicaid state plan for the purpose of implementing programs authorized by the Deficit Reduction Act of 2005.

Managed Care Reimbursement

Each year, AHCA reviews all prior year adjustments to managed care rates to determine the presence of changes in trend, and reduces or eliminates adjustments that are not reasonable or outdated to establish new managed care rates. Under federal law, the rates must be reviewed for actuarial soundness. Currently, AHCA is required to pay rates at per-member, per-month averages that do not exceed the amounts allowed for in the GAA applicable to the fiscal year for which the rate shall be in effect. The bill eliminates this requirement since AHCA managed care rate setting methodology determines the amounts of payment.

Prepaid Behavioral Health Plans

Currently, Medicaid eligible children who are receiving child welfare services in the HomeSafeNet system receive behavioral health care services through the specialty prepaid plan operated by community-based lead agencies. Children in Medicaid areas 1 and 6 are not eligible to participate in the specialty prepaid plan operated by community-based lead agencies. These children receive their behavioral health services through a behavioral health care prepaid plan for children in Medicaid areas 1 and 6. Medicaid-eligible children whose cases are open for child welfare services in the HomeSafeNet system and who reside in area 10 are exempt from the specialty prepaid plan operated by community-based lead agencies upon the development of a service delivery mechanism for children who reside in area 10 as specified in s. 409.91211(3)(dd). The bill allows Medicaid-eligible children in Hillsborough County who are receiving child welfare services in the HomeSafeNet system to receive

behavioral health care services through the specialty prepaid plan operated by community-based lead agencies.

Oversight and Integrity of the Medicaid Program

Current law requires AHCA to mail each Medicaid recipient or his or her representative with an explanation of benefits in the form of a letter that includes the patient's name, the name of the health care provider and the address of the location where the services were provided, a description of all services billed to Medicaid, and information on how to report inappropriate or incorrect billing to AHCA or law enforcement entities for review or investigation.

This has caused confusion when the school-based services billed to Medicaid are listed on the explanation of benefits, because the parent or guardian who receives the explanation of benefits is not present when the services are provided. Similarly, this has caused confusion when laboratory services are listed on the explanation of benefits because the Medicaid recipient is not present when testing is performed.

The bill provides that such explanation of benefits shall not be mailed for Medicaid independent laboratory services as described in s. 409.905(7) or for Medicaid certified match services as described in ss. 409.9071 and 1011.70, Florida Statutes.

Medicaid Reform

In 2005, the Legislature enacted laws to revise the delivery of and payment for health care services in Medicaid, and authorized AHCA to seek and implement a federal waiver for a managed care pilot program.[10] AHCA received approval for the five-year pilot and began implementing reformed Medicaid in 2006 in Broward and Duval Counties, adding Baker, Clay and Nassau Counties in 2007, pursuant to statutory direction. Current law requires legislative approval for further expansion and sets a goal of statewide expansion by 2011. The bill requires AHCA to establish a third Medicaid Reform demonstration site in Hardee, Highlands, Hillsborough, Manatee, Miami-Dade, Monroe Pasco, Pinellas and Polk Miami-Dade and Monroe counties, and requires AHCA to begin enrolling recipients by September 2010.

Medicaid reform is designed to encourage the development of diverse types of managed care organizations, including hospital and physician provider service networks (PSNs). In non-reform Medicaid, PSNs provide care management and are reimbursed on a fee-for-service basis. PSNs are non-risk-bearing, but are obligated to generate savings compared to fee-for-service Medicaid without such case management. They are subject to a reconciliation process by which they must demonstrate the required savings or make payments back to AHCA.[11] In Medicaid reform, current law requires all managed care organizations to bear risk; however, PSNs may choose to be reimbursed on a fee-for-service basis, with a savings settlement mechanism consistent with non-reform requirements, for up to 3 years. The bill allows PSNs that opt for fee-for-service payment to carve out prescribed drug and transportation services from that payment method, and to receive risk-adjusted capitated payments for those services.

Current law requires AHCA to implement program standards and credentialing requirements for capitated managed care networks to participate in the pilot program, including those related to fiscal solvency, quality of care, and adequacy of access to health care providers. Additionally, current law requires AHCA to implement standards for plan compliance, including standards for quality assurance and performance improvement, standards for peer or professional reviews, grievance policies, and policies for program integrity. The bill specifies that AHCA must monitor quarterly and evaluate annually each plan offered in reform areas based upon program standards and credentialing requirements for adequacy of access to health care providers to ensure consistent compliance. The

[10] Sections 409.91211 - 409.91213, F.S.
[11] Section 409.912(44), F.S.

bill also requires AHCA to also set reasonable standards for prompt payment of provider claims. The bill requires AHCA to encourage PSNs to encourage the development of innovative methods by provider service networks to perform administrative functions in a cost-effective manner, including coordination and consolidation of such functions between provider service networks and across demonstration sites. This will allow PSNs to collaborate with other PSNs to achieve administrative efficiencies and other organizational benefits.

Under current law, AHCA is required to provide recipients in reform areas the following information about each plan available in their reform area: (1) a list and description of the benefits provided; (2) information about cost sharing; (3) plan performance data, if available; (4) an explanation of benefit limitations; (5) contact information, including identification of providers participating in the network, geographic locations, and transportation limitations; and (6) any other information the agency determines would facilitate a recipient's understanding of the plan or insurance that would best meet his or her needs. The bill requires AHCA to also provide "specific information about prescription drugs that are covered for each plan available" to recipients.

In reform areas, Medicaid recipients have 30 days to choose which reform plan in which to enroll. For those recipients who fail to make a choice, AHCA assigns the recipients to reform managed care plans in one of two ways. (1) A recipient who was not enrolled in a managed care plan prior to reform is assigned to a reform plan based upon the assessed needs of the recipient. AHCA is required to take certain criteria into consideration when making an assignment in such circumstances, such as plan network capacity, the recipient's previously expressed preference, geographic accessibility of providers in the plan to the recipient, and whether the recipient has previously received primary care from a provider in the plan's network. (2) A recipient who was enrolled in a managed care plan prior to reform is assigned to the reform plan operated by the recipient's old managed care plan. If the recipient's old managed care plan does not operate a reform plan, the recipient is assigned to a reform plan using the same criteria listed above. These assignment methods are relevant only to the first enrollment period of a pilot area; after that time, all enrollees will either be new Medicaid recipients or those already in Medicaid making a choice in their annual enrollment period.

The bill modifies these mandatory assignment processes in reform areas. (1) For recipients who do not make a choice and *are not* enrolled in managed care plans prior to reform, AHCA is required to assign the recipients to a PSN for the first five years of implementation of each demonstration site, or until the number of recipients enrolled in PSNs in that demonstration site reaches 10 percent of the total number of participating Medicaid recipients in the demonstration site, whichever is first. After that time, the AHCA will assign recipients who do not make a choice to managed care plans based on the assessed needs of the recipients taking into account the criteria listed above. (2) For recipients who do not make a choice and *are* enrolled in managed care plans prior to reform, AHCA is required to assign the recipients to a PSN for the first five years of implementation of each demonstration site, or until the number of recipients enrolled in PSNs in that demonstration site reaches 10 percent of the total number of participating Medicaid recipients in the demonstration site, whichever is first. After that time, AHCA will assign recipients who do not make a choice to a reform plans using the same criteria listed above.

The bill creates s. 409.91205, F.S., allowing the Governor, the President of the Senate, and the Speaker of the House of Representatives to convene workgroups to propose alternatives for cost-effective health and long-term care reforms, including, but not limited to, reforms for Medicaid.

Florida Patient Safety Corporation

In 2004, the Legislature created the Florida Patient Safety Corporation.[12] The Florida Patient Safety Corporation is a not-for-profit corporation created to provide coordination and direction to efforts in the state to improve the quality and safety of health care, and reduce harm to patients. In addition to creating the Patient Safety Corporation, the Legislature created a public records exemption for patient

[12] See CS/SB 702; 2004-70, L.O.F. creating s. 381.0271, F.S.

safety data, which provides that information in records held by the Corporation that identifies a patient, identifies a person or entity that reports patient safety data, or identifies a health care practitioner or health care facility is confidential and exempt from disclosure by the Corporation, its advisory committees, subsidiaries, or its contractors.

The bill repeals ss. 381.0271 and 381.0273, F.S. relating to the Patient Safety Corporation and its public records and open meeting exemptions.

Statewide and Local Advocacy Councils

The Statewide Advocacy Council (SAC) and Local Advocacy Councils (LAC) (collectively, the SAC) was created by state law to serve as a volunteer network of councils that undertake to discover, monitor, and investigate the presence of conditions that constitute a threat to the rights, health, safety or welfare of persons who receive services from state agencies. The provisions governing the SAC are located in ss. 402.164-402.167, F.S. The SAC is funded predominantly by state funds, though it is authorized to seek funding from other sources. The SAC is authorized to serve as an independent, third-party mechanism for protecting the constitutional and human rights of clients by entering into Interagency Agreements with agencies providing client, which are limited to the Agency for Persons with Disabilities (APD), the Department of Children and Families (DCF), the Agency for Health Care Administration (AHCA) and the Department of Elder Affairs (DOEA).

With regard to the Department of Elderly Affairs, the SAC's functions are very similar to the functions of the State Long Term Care Ombudsman Office, an office that is required pursuant to the federal Older Americans Act.[13] Accordingly, the Ombudsman Office and the SAC are required to enter into a cooperative agreement to avoid duplication of advocacy services provided to long-term care residents.[14] Similarly, the Advocacy Center for Persons with Disabilities is designated by the State of Florida as the protection and advocacy agency for individuals with certain disabilities required by federal law as a condition of receiving federal allotments to supplement state funds provided for protection of individuals with developmental disabilities from abuse, neglect and violations of rights.[15] The SAC's functions with regard to individuals with developmental disabilities appear to be duplicative of functions provided by the Advocacy Center for Persons with Disabilities.

The bill repeals ss. 402.164, 402.165, 402.166, 402.167, F.S., which provide statutory authorization for the Statewide Advocacy Council and Local Advocacy Councils. The bill also makes conforming amendments consistent with the repeal of ss. ss. 402.164, 402.165, 402.166, 402.167, F.S., relating to the Statewide Advocacy Council and Local Advocacy Councils.

Statewide Laboratory Services

In 2004, the Legislature authorized AHCA to contract on a capitated, fixed-sum, or prepaid basis with a laboratory service provider to provide statewide laboratory services for Medicaid recipients.[16] Pursuant to s. 409.9061, Florida Statutes, AHCA is required to ensure that it secures laboratory values from Medicaid-enrolled laboratories for all tests provided to Medicaid recipients, which shall be included in the Medicaid real-time web-based reporting system that interfaces with a real-time web-based prescription ordering and tracking system. Proviso included in the Fiscal Year 2004-05 General Appropriations Act directed the agency to reduce all Medicaid fees for independent laboratory procedures by 10 percent if the agency was unable to enter into a risk-based contract with single or multiple independent laboratories.[17] After multiple procurement attempts, the agency has been unable to execute a contract; however, rates have been adjusted in accordance with the proviso.

[13] The State Long Term Care Ombudsman Office is tasked with, among other things, identifying, investigating, and resolving complaints made by or on behalf of residents relating to acts or omissions of providers, public or private agencies, guardians, or representative payees that may adversely affect the health, safety, welfare, or rights of residents.
[14] s. 400.0065, F.S.
[15] *See generally* 42 U.S.C.A. § 15043; 45 CFR s. 1386.21.
[16] 2004-70, L.O.F., creating s. 409.9061, F.S.
[17] 2004-68, L.O.F. line 210

The bill repeals s. 409.9061, F.S., which provides statutory authorization for a statewide Medicaid laboratory services contract.

Teaching Nursing Home Pilot Program

In 1999, the Legislature enacted a "Teaching Nursing Home Pilot Project" to implement a comprehensive multidisciplinary program of geriatric education and research in a nursing home facility designated by AHCA as a teaching nursing home.[18] The Miami Jewish Home and Hospital for the Aged at Douglas Gardens was licensed in July 2000 as a teaching nursing home,[19] and it remains the only nursing home so designated. Since that time, the teaching nursing home has received $5.2 million to implement the program. According to AHCA, the program was intended to function like a teaching hospital; however, much of the education provided by the teaching nursing home is conducted through a web-based program known as Geri-U, located at http://ltc.geriu.org/. A survey conducted in Fiscal Year 2005-2006 found that less than 5 percent of Florida nursing homes use the website.
The bill repeals s. 430.80, F.S., which authorizes the Teaching Nursing Home Pilot Program. The bill also makes conforming amendments consistent with the repeal of s. 430.80, F.S., relating to the Teaching Nursing Home Pilot Program.

Sunshine for Seniors

The Department of Elderly Affairs receives $1.9 million in federal funding for the Serving Health Insurance Needs of Elders (SHINE), which is a statewide volunteer-based program offering free Medicare, long-term planning prescription assistance and health insurance education counseling to people with Medicare, their families and caregivers. In 2003, the Legislature created the Sunshine for Seniors program in the Department of Elderly Affairs.[20] The Sunshine for Seniors program was created prior to the development of the Medicare Modernization Act (Medicare Part D) to assist low-income elders with obtaining prescription drugs from manufacturers' pharmaceutical assistance programs. Since the implementation of Medicare Part D in 2006, the Sunshine for Seniors Program has focused its attention on providing assistance to seniors during gaps in insurance coverage. The bill repeals s. 430.83, F.S., the Sunshine for Seniors Program.

Florida Center for Nursing

The Florida Center for Nursing was created by the Legislature in 2001 to address issues of supply and demand for nursing, including issues of recruitment, retention, and utilization of nurse workforce resources.[21] The center collects and analyzes nursing workforce data, develops and disseminates a strategic plan for nursing, develops and implements reward and recognition activities for nurses, promotes nursing excellence programs, image building, and recruitment into the profession.

The center is governed by board of directors appointed by the Governor based upon recommendations from the Florida Senate, House of Representatives, and Board of Education.[22] Further, current law provides that the center have state budget support for its operations so that it will have adequate resources to accomplish its statutory mission.[23]

[18] 99-394, L.O.F., creating s. 430.80, F.S.
[19] Pursuant to s. 430.80(1) and (2), a teaching nursing home is a nursing home facility licensed under chapter 400 which contains a minimum of 400 licensed nursing home beds; has access to a resident senior population of sufficient size to support education, training, and research relating to geriatric care; and has a contractual relationship with a federally funded accredited geriatric research center in this state. The facility must also meet certain accreditation and educational requirements.
[20] Chapter 2003-405, L.O.F., creating s. 430.83, F.S.
[21] Chapter 2001-277, L.O.F., creating ss. 464.0195-464.0197, F.S.
[22] s. 464.0196, F.S.
[23] s. 464.0197, F.S.

The bill repeals ss. 464.0195, 464.0196, and 464.0197, F.S, which creates the Florida Center for Nursing, provides for the Board of Directors of the Center, and provides for budget support for the Center. The bill also makes conforming amendments consistent with the repeal of ss. 464.0195, 464.0196, and 464.0197, F.S, relating to the Florida Center for Nursing.

C. SECTION DIRECTORY:

Section 1. Creating an unnumbered section of law; requiring transfer of statutory powers, duties functions and funds for the administration of part I of chapter 499, F.S., relating to drugs, devices, cosmetics and household products from the Department of Health to the Department of Business and Professional Regulation; creating a Type II transfer from the Department of Health to the Department of Business and Professional Regulation.

Section 2. Amending s. 400.179, F.S.; relating to liability for Medicaid underpayments and overpayments.

Section 3. Amending s. 400.23, F.S.; relating to rules, evaluation and deficiencies, licensure for nursing facilities.

Section 4. Amending s. 409.905, F.S.; relating to mandatory Medicaid services.

Section 5. Amending s. 409.906, F.S.; relating to optional Medicaid services.

Section 6. Amending s. 409.908, F.S.; relating to reimbursement of Medicaid providers.

Section 7. Amending s. 409.911, F.S.; relating to the disproportionate share program.

Section 8. Amending s. 409.9112, F.S.; relating to the disproportionate share program for regional perinatal intensive care units.

Section 9. Amending s. 409.9113, F.S., relating to the disproportionate share program for teaching hospitals.

Section 10. Amending s. 409.9117, F.S.; relating to primary care disproportionate share program.

Section 11. Amending s. 409.912, F.S.; relating to cost effective purchasing of health care.

Section 12 Creating s 409.91206, F.S. relating alternatives for health and long-term care reforms.

Section 13. Amending s. 409.91211, F.S.; relating to the Medicaid managed care pilot program.

Section 14. Amending s. 409.9124, F.S.; relating to managed care reimbursement.

Section 15. Amending s. 409.913, F.S.; relating to oversight of the integrity of the Medicaid program.

Section 16. Amending s. 39.001, F.S.; conforming provisions and correcting cross-references related to the Florida local advocacy councils.

Section 17. Amending s. 39.0011, F.S.; relating to conforming provisions and correcting cross-references related to the Florida local advocacy councils.

Section 18. Amending s. 39.202, F.S.; relating to conforming provisions and correcting cross-references related to the Florida Statewide Advocacy Council and the Florida local advocacy councils.

Section 19. Amending s. 39.302, F.S.; relating to conforming provisions and correcting cross-references related to the Florida local advocacy councils.

Section 20. Amending s. 215.22, F.S., relating to conforming provisions and correcting cross-references related to the Florida Center for Nursing.

Section 21. Amending s. 394.459, F.S.; relating to conforming provisions and correcting cross-references related to the Florida Statewide Advocacy Council and the Florida local advocacy councils.

Section 22. Amending s. 394.4597, F.S.; relating to conforming provisions and correcting cross-references related the Florida local advocacy councils.

Section 23. Amending s. 394.4598, F.S.; relating to conforming provisions and correcting cross-references related to the Florida local advocacy councils.

Section 24. Amending s. 394.4599, F.S.; relating to conforming provisions and correcting cross-references related to the Florida local advocacy councils.

Section 25. Amending s. 394.4615, F.S.; relating to conforming provisions and correcting cross-references related to the Florida Statewide Advocacy Council and the Florida local advocacy councils.

Section 26. Amending s. 400.0065, F.S.; relating to conforming provisions and correcting cross-references related to the Florida Statewide Advocacy Council.

Section 27. Amending s. 400.118, F.S.; relating to conforming provisions and correcting cross-references related to the Florida Statewide Advocacy Council and the Florida local advocacy councils.

Section 28. Amending s. 400.141, F.S.; relating to conforming provisions and correcting cross-references related to the Florida Statewide Advocacy Council and the teaching nursing home pilot project.

Section 29. Amending s. 415.1034, F.S.; relating to conforming provisions and correcting cross-references related to the Florida Statewide Advocacy Council and the Florida local advocacy councils.

Section 30. Amending s. 415.104, F.S.; relating to conforming provisions and correcting cross-references related to the Florida local advocacy councils.

Section 31. Amending s. 415.1055, F.S.; relating to conforming provisions and correcting cross-references related to the Florida local advocacy councils.

Section 32. Amending s. 415.106, F.S.; relating to conforming provisions and correcting cross-references related to the Florida Statewide Advocacy Council.

Section 33. Amending s. 429.19, F.S.; relating to conforming provisions and correcting cross-references related to the Florida Statewide Advocacy Council and the Florida local advocacy councils.

Section 34. Amending s. 415.107, F.S.; relating to conforming provisions and correcting cross-references related to the Florida Statewide Advocacy Council.

Section 35. Amending s. 429.28, F.S.; relating to conforming provisions and correcting cross-references related to the Florida local advocacy councils.

Section 36. Amending s. 429.34, F.S.; relating to conforming provisions and correcting cross-references related to the Florida Statewide Advocacy Council and the Florida local advocacy councils.

Section 37. Amending s. 430.04, F.S.; relating to conforming provisions and correcting cross-references related to the Florida Statewide Advocacy Council and the Florida local advocacy councils.

Section 38. Repealing ss. 381.0271, 381.0273, 402.164, 402.165, 402.166, 402.167, 409.9061, 430.80, 430.83, 464.0195, 464.0196, and 464.0197, F.S.; relating to the Florida Patient Safety Corporation, the Statewide and local advocacy councils, statewide laboratory services, teaching nursing home pilot project, Sunshine for Seniors Program, Florida Center for Nursing.

Section 39. Providing an effective date of July 1, 2008.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

Federal Medicaid and Refugee Assistance Grant funding will be reduced by $434.7 million in Fiscal Year 2008-09 and $445.0 in Fiscal Year 2009-10 because of program reductions, $121.1 million in federal Medicaid funds will be generated through implementation of DSH programs.

2. Expenditures:

	FY 2008-09	FY 2009-10
Nursing Home Overpayments		
Grants and Donations Trust Fund	$1,781,600	$1,781,600
Hospital Inpatient Per Diem Adjustment		
General Revenue Fund	($5,348,859)	($5,348,859)
Medical Care Trust Funds	($6,660,254)	($6,660,254)
Eliminate Chiropractic and Podiatric Coverage		
General Revenue Fund	($1,288,113)	($1,717,484)
Medical Care Trust Funds	($1,618,838)	($2,158,451)
Refugee Assistance Trust Funds	($11,978)	($15,971)
Eliminate Hospice Coverage		
General Revenue Fund	($23,372,406)	($31,163,208)
Medical Care Trust Funds	($29,102,687)	($38,803,582)
Refugee Assistance Trust Funds	($5,814)	($7,752)
Cost Sharing for Qualified Medicare Beneficiary		
General Revenue Fund	$7,714,941	$7,714,941
Medical Care Trust Funds	$9,606,468	$9,606,468
Pharmacy Ingredient Cost Adjustment		
General Revenue Fund	($4,343,431)	($4,343,431)
Medical Care Trust Funds	($5,395,197)	($5,395,197)
Nursing Home Rate Reduction		
General Revenue Fund	($123,822,408)	($123,822,408)
Medical Care Trust Funds	($154,180,304)	($154,180,304)
Hospital Inpatient Rate Reduction		
General Revenue Fund	($113,815,778)	($113,815,778)
Medical Care Trust Funds	($141,728,112)	($141,728,112)
Refugee Assistance Trust Funds	($466,398)	($466,398)
Hospital Outpatient Rate Reduction		
General Revenue Fund	($32,116,188)	($32,116,188)
Medical Care Trust Funds	($40,056,758)	($40,056,758)

Refugee Assistance Trust Funds	($258,118)	($258,118)
ICF DD Rate Reduction		
General Revenue Fund	($8,775,921)	($8,775,921)
Medical Care Trust Funds	($10,927,539)	($10,927,539)
HMO Rate Reduction		
General Revenue Fund	($42,321,340)	($42,321,340)
Medical Care Trust Funds	($52,974,466)	($52,974,466)
Refugee Assistance Trust Funds	($927,292)	($927,292)
Eliminate SAC Funding		
General Revenue Fund (13.0 FTE)	($955,051)	($955,051)
Eliminate Teaching Nursing Home Funding		
General Revenue Fund	($625,000)	($625,000)
Eliminate Patient Safety Corporation Funding		
General Revenue Fund	($725,000)	($725,000)
Eliminate Sunshine for Senior Program		
General Revenue Fund	($158,000)	($158,000)
Disproportional Share Hospital Programs		
General Revenue	$6,236,673	$6,236,673
Medical Care Trust Fund	$121,111,741	$121,111,741
Grants and Donations Trust Fund	$91,264,837	$91,264,837
Total		
General Revenue Fund	**($343,715,881)**	**($351,936,054)**
Medical Care Trust Fund	**($311,925,946)**	**($322,166,454)**
Refugee Assistance Trust Fund	**($1,669,600)**	**($1,675,531)**
Grants and Donations Trust Fund	**$93,046,437**	**$93,046,437**

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None

2. Expenditures:

   Local governments and other local political subdivision may provide $91.7 million in contributions for DSH programs.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The elimination of optional services and provider rate reductions may cause a reduction in private sector employees. In additional, hospitals may experience an increase in uncompensated care. Hospitals providing a disproportionate share of Medicaid or charity care services will receive additional reimbursements towards the cost of providing care to uninsured individuals.

D. FISCAL COMMENTS:

The bill changes the distribution criteria for Medicaid Disproportionate Share (DSH) Program payments which are necessary to implement the DSH Program funding decisions included in the proposed General Appropriations for Fiscal Year 2008-09. The changes generate DSH Program funding for Fiscal Year 2008-2009 in the amount of $218.6 million ($6.2 in state funds, $91.3 in local government

or other local political division contributions and $121.1 million in federal funds) in special payments to hospitals that provide a disproportionate share of the Medicaid or charity care services to uninsured individuals.

The bill authorizes the transfer of functions related to drugs, devices, cosmetics and household products from the Department of Health to the Department of Business and Professional Regulation, effective April 1, 2009. All unexpended balances of appropriations will be transferred at that time.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This legislation does not appear to require counties or municipalities to spend funds or take any action requiring the expenditure of funds; reduce the authority that municipalities or counties have to raise revenue in the aggregate; or reduce the percentage of a state tax shared with counties or municipalities.

2. Other:

   None

B. RULE-MAKING AUTHORITY:

The agency has sufficient rulemaking authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

D. STATEMENT OF THE SPONSOR

IV. AMENDMENTS/COUNCIL SUBSTITUTE CHANGES

On April 3, 2008, the Policy and Budget Council reported the proposed council bill favorably with four amendments as follows:

- Allows Medicaid-eligible children in Hillsborough County who are receiving child welfare services in the HomeSafeNet system to receive behavioral health care services through the specialty prepaid plan operated by community-based lead agencies. Currently, these children are not eligible to receive services through this plan, but are served through a behavioral health care prepaid plan for children in Medicaid areas 1 and 6..

- Creates s. 409.91205, F.S., allowing the Governor, the President of the Senate, and the Speaker of the House of Representatives to convene workgroups to propose alternatives for cost-effective health and long-term care reforms, including, but not limited to, reforms for Medicaid.

- Modifies the counties included in the third demonstration site for Medicaid reform to include Pasco, Pinellas, Hardee, Highlands, Hillsborough, Manatee and Polk along with Miami-Dade and Monroe Counties. The amendment also moves the date the agency can begin enrolling recipients in the demonstration site to September 2010.

- Clarifying Title amendment.

The staff analysis reflects HB 5085.