

The Florida Senate
BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Budget Committee

BILL: SB 2144 (SPB 7174)

INTRODUCER: Budget Committee

SUBJECT: Medicaid

DATE: April 1, 2011

REVISED: _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Kynoch	Meyer, C.	BC	SPB 7174 Favorable
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____

I. Summary:

The bill makes the following changes to the Medicaid program:

- Renames the Medically Needy program as the Medicaid nonpoverty medical subsidy. Effective April 1, 2012, benefits for the program are limited to physician services only, except for pregnant women and children, who will continue to receive the full range of Medicaid benefits with the exception of services in skilled nursing facilities and intermediate care facilities for the developmentally disabled;
- Eliminates a requirement for a hospitalist program in nonteaching hospitals and makes optional instead of mandatory the electronic access of Medicaid prescription refill data and information relating to the preferred drug list by health care providers;
- Revises the Medicaid program formula for determining the amount prescribed drug providers will be paid for pharmaceuticals;
- Repeals the sunset date related to the freeze on Medicaid institutional unit cost, specifies reimbursement rates shall be as provided in the General Appropriations Act (GAA) for the 2011-2012 fiscal year, and deletes obsolete language;
- Authorizes the amount of quality assessments on nursing home facilities to increase to the maximum percentage of the total aggregate net patient services revenue as permitted under federal regulations; and
- Revises the years of audited data used in determining Medicaid and charity care days for each hospital in the Disproportionate Share Hospital (DSH) program; continues for the 2011-2012 fiscal year, the prohibition on funding for the regional perinatal intensive care centers DSH program and the primary care DSH program; and authorizes payment for the DSH program for teaching hospitals for the 2011-2012 fiscal year.

The Senate's proposed General Appropriations Act (GAA) for the 2011-2012 fiscal year reflects the following reductions to comport with the provisions of the bill:

- Non-poverty Medical Subsidy program - \$230.2 million to reflect the revision of the program to provide physician only services for adults effective April 1, 2012;
- Medicaid Aged and Disabled (MEDS-AD) program – \$224.4 million to reflect the elimination of the program effective April 1, 2012;
- Institutional Reimbursement Rates – \$346.7 million to reflect the policy of establishing rates at a level that ensures no increase in statewide expenditures resulting from a change in unit cost;
- Various contracts eliminations relating to a hospitalist program and electronic access of Medicaid prescription refill and preferred drug list information – \$9.6 million; and
- Pharmaceutical Formula – \$29.7 million.

This bill substantially amends, creates, or repeals the following sections of the Florida Statutes: ss. 409.904; 409.905; 409.908; 409.9082; 409.911; 409.9112; 409.9113; 409.9117; 409.912; 409.9122; 409.915; and 409.9301, F.S.

II. Present Situation:

Medically Needy Program

The Medically Needy eligibility category is an optional eligibility group authorized under Section 409.904, F.S. Title XIX of the Social Security Act specifies categories of individuals that the federal government gives state Medicaid programs the choice of covering (optional coverage groups) under their state plan. If states choose to implement a program they are required to cover, at minimum, some level of ambulatory service and must provide prenatal and delivery services to pregnant women. States can choose to provide one or more ambulatory service, although states must provide all medically necessary services to children. Currently, Florida's program includes all Medicaid covered services with the exception of services in skilled nursing facilities and intermediate care facilities for the developmentally disabled.

The Medically Needy program covers persons who have experienced a catastrophic illness and either have no health insurance, or have exhausted their benefits. The program provides Medicaid coverage for those persons who qualify categorically for Medicaid except that their income or assets are greater than the level allowed under other Medicaid programs. There is no limit to the monthly income an individual can have; however, there is an asset limit, which varies based upon the family's size. To be eligible, the individual must incur enough medical bills to offset his or her income to the income level that would qualify the individual for the Medically Needy program, 24% of the federal poverty level (FPL). Qualifying individuals have a monthly share of cost similar to an insurance deductible; the amount varies depending on the family's size and income.

Once a person is determined eligible for the program and their share of cost has been set by the Department of Children and Families (DCF), accumulated and on-going medical bills that meet allowable medical expense criteria must be submitted to the DCF. After the share of cost is met, the individual can receive full Medicaid benefits for the remainder of the month in which their

share of cost has been met with the exception of services in a skilled nursing facility, an intermediate care facility for the developmentally disabled, or home and community-based services.

For the 2011-2012 fiscal year, the estimated average monthly caseload for the Medically Needy program is 46,096¹.

Medicaid Aged and Disabled Program

The Medicaid Aged and Disabled Program (Meds AD) was implemented January 1, 2006, upon approval by the Federal Centers for Medicare and Medicaid Services of the Agency for Health Care Administration's request for an 1115 demonstration waiver. Subsequently, the waiver was renewed on January 1, 2011. The Meds AD program is an optional Medicaid eligibility group under s. 409.904(1), F.S., that provides Medicaid coverage to individuals who are elderly or disabled, whose incomes are under 88 percent of the federal poverty level and meet asset limits. The waiver seeks to show that by allowing this population access to Medicaid services and by providing pharmacy case review services to a sample of the population, hospitalization rates and institutionalization can be reduced or delayed.

The waiver functions more as an eligibility expansion than a service-delivery waiver. Qualifying individuals receive all state plan Medicaid services or home and community based services if enrolled. Medicaid is required to provide Medicare "buy-in" coverage for aged and disabled individuals who are Medicare beneficiaries; hence Medicaid remits payment on behalf of these individuals for Medicare premiums, deductibles, and coinsurance.

Payments for services to individuals in optional eligibility categories are subject to the availability of monies and any limitations established by the General Appropriations Act or chapter 216, F.S. For the 2011-2012 fiscal year, the estimated average monthly caseload for the Meds AD program is 42,115.²

Nursing Home Quality Assessment

Chapter 2009-4, L.O.F, created s. 409.9082, F.S., to provide for a quality assessment on nursing home facility providers and required the assessment to be imposed beginning April 1, 2009. The assessment may not exceed the federal ceiling of 5.5 percent of the total aggregate net patient service revenue. The bill required the agency to calculate the assessment annually on a per-resident-day basis, exclusive of those days funded by the Medicare program. The purpose of the nursing home quality assessment is to assure continued quality of care and that the collected assessments are to be used to obtain federal financial participation through the Medicaid program in order to make Medicaid payments for nursing home facility services up to the amount of nursing home facility Medicaid rates as calculated in accordance with the approved state Medicaid plan in effect on December 31, 2007. Effective October 1, 2011, federal regulations will allow the total aggregate amount of assessment for all nursing home facilities to increase to 6.0%.

¹ January 2011 Social Services Estimating Conference (SSEC) - Medicaid Caseloads.

² January 2011 SSEC – Medicaid Caseloads

Disproportionate Share Hospital (DSH) Program

There are currently five separate Medicaid disproportionate share programs that are operational in Florida. The programs are as follows: the original program established in s. 409.911, F.S.; the Teaching Hospitals program established in s. 409.9113, F.S.; the Mental Health Hospital program established in s. 409.9115, F.S.; the Rural Hospital/Financial Assistance program established in s. 409.9116, F.S.; and the Specialty Hospital program established in s. 409.9118, F.S.

Additionally, there are three separate Medicaid DSH programs that are listed in law but are not operational at this time. The programs are as follows: the Regional Perinatal Intensive Care Center (RPICC) program established in s. 409.9112, F.S.; the Primary Care program established in s. 409.9117, F.S.; and the Specialty Hospitals for Children program established in s. 409.9119, F.S.

Chapter 2005-358, L.O.F., directed the agency to create the Medicaid Low Income Pool (LIP) Council, codified in s. 409.911(9), F.S. Annually, the council makes recommendations on the financing and distribution of the LIP and the DSH funds, advises the agency on the development of the LIP plan required by the Centers for Medicare and Medicaid Services waiver, and advises the agency on the distribution of hospital funds used to adjust inpatient hospital rates, rebase rates, or otherwise exempt hospitals from reimbursement limits as financed by intergovernmental transfers (IGT's). Though the council is required to submit its findings and recommendations to the Governor and Legislature each year, by February 1, the legislature delineates how the funds will be distributed.

Medicaid Reimbursement for Prescribed Drugs Services

Reimbursement for prescribed drug claims is made in accordance with the provisions of 42 CFR 447.512-516; and ss. 409.906(20), 409.908, 409.912(39) (a), F.S. The current reimbursement for covered drugs dispensed by a licensed pharmacy, approved as a Medicaid provider, or an enrolled dispensing physician filling his own prescriptions, is the lesser of:

- Average Wholesale Price (AWP) minus 16.4%, plus a dispensing fee of \$3.73, or;
- Wholesaler Acquisition Cost (WAC) plus 4.75%, plus a dispensing fee of \$3.73, or;
- The Federal Upper Limit (FUL) established by the CMS, plus a dispensing fee of \$3.73, or;
- The State Maximum Allowable Cost (SMAC), plus a dispensing fee of \$3.73, or;
- The provider's Usual and Customary (UAC) charge, inclusive of dispensing fee.

AWP and WAC are published by First Data Bank (FDB) as reference prices for pharmaceuticals. AWP is a "list price" and is higher than the cost wholesalers actually pay. WAC is slightly more representative of costs actually paid by wholesalers, and is more accurate with respect to branded pharmaceuticals than generics. Third party payors and State Medicaid Programs use these published prices (AWP and WAC) in their retail pharmacy reimbursement calculations.

On March 30, 2009, the U.S. District Court for the District of Massachusetts entered a Final Order and Judgment approving a class action settlement that involved two major publishers of drug pricing information, FDB and Medi-Span. The Plaintiffs in this case alleged that FDB's

and Medi-Span's policies and practices caused them to pay inflated prices for certain pharmaceutical products.

The settlement requires FDB and Medi-Span to reduce the AWP mark-up factor to a standard ceiling of 120 percent of WAC on all National Drug Codes (NDCs). This change took effect on September 26, 2009, and will affect all prescriptions where the reimbursement calculation was based on AWP. With respect to Florida Medicaid, 25.39 percent of prescriptions are reimbursed based on AWP. These are primarily branded pharmaceuticals still under patent. Both FDB and Medi-Span have independently announced plans to discontinue publishing AWP by March, 2011. Under current pricing logic, if AWP is no longer reported, then the pricing default for branded pharmaceuticals becomes WAC + 4.75%

Reimbursement Rates for Medicaid Providers

Currently, Medicaid reimburses Medicaid providers in one of the following 3 ways:

Capitated Rate Setting - Capitated reimbursement is provided for in ss. 409.9124, and 409.91211. F.S, and is a methodology used for managed care providers.

- **Fee-For-Service Method** -
Capitated rates are set annually based upon two years of fee-for-service claims and financial data 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 State Fiscal Years 2007-2008 and 2008-2009, and are based upon 25 different service categories, such as hospital inpatient, laboratory, x-ray, etc. Actuarially sound rates are established for recipient categories, such as TANF, SSI without Medicare, SSI with Medicare Parts A and B, and SSI with Medicare Part B only; in all 11 AHCA areas for 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+). Age and gender bands are only utilized in non-reform rate setting. Reform has composite rates.
- **Financial/Encounter Data Method** -
In addition to the Fee-for-Service data, plan financial data for Calendar Years 2008 and 2009 for non-pharmacy services was used. The non-pharmacy encounter data was used as a source for validation of the plan specific financial reporting. The Financial Data Method receives 24 percent weight for Non-Reform rates and 50 percent for Reform rates for non-pharmacy services in rate calculation for the TANF and SSI without Medicare categories for Fiscal Year 2010-2011.
- **Pharmacy Encounter Data Method** -
Pharmacy encounter data was used from State Fiscal Year 2008-2009. The pharmacy encounter data was submitted by the HMOs to develop the pharmacy component of the capitation rates. The Pharmacy Encounter Data Method received 100% weight for pharmacy services in the rate calculation for the TANF and SSI without Medicare categories.

- Risk Adjustment –
The Reform Area final rates are risk adjusted for age, gender, medical conditions and diagnosis.

Fee-For-Service - 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, 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 - 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 and targets.

Section 5, chapter 2008-143, L.O.F., directed the agency to establish provider rates for hospitals, nursing homes, community intermediate care facilities for the developmentally disabled and county health departments in a manner that would result in the elimination of automatic cost-based rate increases for a period of two fiscal years. The unit cost rate freeze is set to expire July 1, 2011.

Modifications in Contractual Arrangements

Wireless Handheld Devices – Pursuant to s. 409.912 (16)(b), F.S., the agency was directed to contract with an entity in the state to implement a wireless handheld clinical pharmacology drug information database for practitioners. The device was envisioned to provide continuous updates of clinical pharmacology information, reference to the Medicaid Preferred Drug List (PDL), specific patient medication history, and ongoing education and support. Initially, the vendor provided a pilot group of 1,000 high volume practitioners with the wireless handheld device. The objective with this pilot group was to prevent duplicate prescribing and improve clinical outcomes. The device gave the practitioners a specific patient drug profile and access to clinical drug information at the point of care. The 2004 Legislature expanded the program to 3,000 devices. In 2005, e-prescribing capability was added giving practitioners access to continuous updates of clinical pharmacology information, reference to the Medicaid PDL and specific patient medication history at the point of care. Prescriptions could also be submitted electronically to the patient's pharmacy of choice. However, utilization remained at less than capacity. In 2009, the number of handheld devices was reduced to 1,000 due to low utilization by

practitioners. Currently, the vendor provides 555 handheld devices to high volume practitioners to support e-prescribing.

Therapy Management Contract (Prescribed Drugs) - The 2005 Legislature directed the AHCA to implement a prescription drug management system with various components to reduce costs, waste, and fraud, while improving recipient safety. The drug management system implemented must rely on cooperation between physician and pharmacist to determine appropriate practice patterns and clinical guidelines to improve prescribing, dispensing, and medication usage for recipients in the Medicaid program. The AHCA entered into a contractual arrangement to reduce clinical risk, lower prescribed drug costs and the rate of inappropriate spending for certain Medicaid prescription drugs.

There are over 4,000 pharmacy providers in Florida. There are 841 pharmacies enrolled in the program and 200 of those pharmacies are actively participating in the program.

Hospitalist Program Replacement of Existing Utilization Review - The 2004 Legislature created paragraph (d) of subsection (5) of s. 409.905, F. S., to implement a Medicaid hospitalist program. The program became operational on May 1, 2007, and was implemented to manage the inpatient hospital length and readmission rates of stay for fee-for-service and MediPass Medicaid recipients while also replacing the existing utilization management program. Hospitals were chosen to participate in the program by calculating a case mix adjusted average length of stay (ALOS) for each county. Any hospital with an ALOS higher than the county average was selected as a participant.

The agency is not able to eliminate the current utilization management program for inpatient services, per federal guidelines and at the direction of the Centers for Medicare and Medicaid Services (*See 42 U.S.C. 1396(a)(30)*). Currently the agency has two contracts that manage the length of stay for inpatient services.

III. Effect of Proposed Changes:

Section 1 amends 409.904, F.S., to rename the Medically Needy program as the Medicaid nonpoverty medical subsidy. Effective April 1, 2012, benefits for the program are limited to physician services only, except for pregnant women and children, who will continue to receive the full range of Medicaid benefits with the exception of services in skilled nursing facilities and intermediate care facilities for the developmentally disabled.

Section 2 amends s. 409.905, F.S., to eliminate a requirement for a hospitalist program in nonteaching hospitals.

Section 3 amends s. 409.908, F.S., to modify reimbursement for prescribed drugs to the lowest of the wholesaler acquisition cost plus 1.5 percent, the federal upper limit, the state maximum allowable cost, or the usual and customary charge billed by the provider.

Section 4 amends ss. 409.9082(2); F.S., to authorize an increase in the nursing home quality assessment not to exceed the maximum percentage of the total aggregate net patient services revenue of assessed facilities allowed under federal law.

Sections 5 through 8 amends s. 409.911(2)(a), and 409.912, 409.9113, and 409.9117, F.S., relating to hospital disproportionate share, to update the dates in the DSH program; to continue for the 2011-2012 fiscal year, the prohibition on funding for the regional perinatal intensive care centers DSH program and the primary care DSH program; and to authorize payment for the DSH program for teaching hospitals for the 2011-2012 fiscal year.

Section 9 amends s. 409.912 (16)(b) and (39)(a), F.S., to make optional instead of mandatory the provision of electronic access of Medicaid prescription refill data and information relating to the preferred drug list by health care providers and makes technical and conforming changes. Specifically it eliminates certain components of the prescription drug management system, but continues general authority that allows the agency to implement a drug management system. Further, the bill removes the requirement for the agency to implement a wireless handheld program and grants the agency authority to provide electronic access to pharmacology drug information to Medicaid providers to ensure adequate access to e-prescribing in the most cost effective manner.

Section 10 through 12 amends ss. 409.9122(2)(a), 409.915(1)(a), and 409.9301(1) and (2), F.S., to make technical and conforming changes relating to the Medicaid nonpoverty medical subsidy program.

Section 13 provides an effective date of June 30, 2011.

Other Potential Implications:

All of these amendments to statute are necessary in order to achieve the budget policy for the Medicaid program proposed in Senate Proposed Bill 7084.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

D. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:**A. Tax/Fee Issues:**

None.

B. Private Sector Impact:

Hospitals providing a disproportionate share of Medicaid or charity care services will receive additional reimbursements towards the cost of providing care to uninsured individuals. The nursing home facility providers will be able to restore a portion of reductions to the reimbursement rates through the quality assessments.

C. Government Sector Impact:

The Senate's proposed General Appropriations Act (GAA) for the 2011-2012 fiscal year reflects the following reductions to comport with the provisions of the bill:

- Non-poverty Medical Subsidy program - Total reduction: \$230.2 million (\$96.2 million general revenue and \$134.0 million trust funds) to reflect the revision of the program to provide physician only services for adults effective April 1, 2012;
- Medicaid Aged and Disabled (MEDS-AD) program – Total reduction: \$224.4 million (\$97.7 million general revenue and \$126.7 million trust funds) to reflect the elimination of the program effective April 1, 2012;
- Institutional Reimbursement Rates – Total reduction: \$346.7 million (\$115.4 million general revenue and \$231.3 million trust funds) to reflect the policy of establishing rates at a level that ensures no increase in statewide expenditures resulting from a change in unit cost;
- Various contracts eliminations relating to a hospitalist program and electronic access of Medicaid prescription refill and preferred drug list information – Total reduction: \$9.6 million (\$3.9 million general revenue and \$5.7 million trust funds); and
- Pharmaceutical Formula – Total reduction: \$29.7 million (\$13.1 million general revenue and \$16.6 million trust funds).

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

- A. **Committee Substitute – Statement of Substantial Changes:**
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

- B. **Amendments:**

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.
