FINAL BILL ANALYSIS

BILL #: CS/SB 2144

FINAL HOUSE FLOOR ACTION:
80 Y's 38 N's

SPONSOR: Budget (Rep. Hudson)

GOVERNOR'S ACTION: Approved

COMPANION BILLS: CS/HB 5311

SUMMARY ANALYSIS

CS/HB 2144 passed the House on May 6, 2011. The bill was approved by the Governor on May 26, 2011, chapter 2011-61, Laws of Florida, and becomes effective July 1, 2011. The bill:

- Modifies the minimum staffing requirements for nursing homes and modifies the formula for calculating the direct care subcomponent of the nursing home reimbursement.
- Authorizes a 30-day extension of all provider license types in the event of a denial or revocation to allow for the safe and orderly discharge of residents and authorizes the consideration of certain mitigating circumstance for applications subject to denial.
- Repeals the sunset of the Medically Needy for adults and the Medicaid Aged and Disabled (MEDS-AD) waiver, which will sunset June 30, 2011.
- Eliminates the requirement to implement the Hospitalist Program.
- Modifies the formula used for calculating reimbursements to providers of prescribed drugs.
- Repeals the sunset date for the freeze on Medicaid institutional unit cost; and deletes obsolete workgroups and reporting requirements.
- Authorizes the aggregated amount of assessments for all nursing home facilities to increase to the maximum percentage allowed under federal regulations and allows the exemption of or the application of a lower quality assessment if the qualified public nursing home facility's total annual indigent census days are greater than 20 percent of the facility's total annual census days.
- Repeals the sunset of the quality assessment on privately operated intermediate care facilities for the developmentally disabled.
- Revises the years of audited data used in determining Medicaid and charity care days for hospitals in the Disproportionate Share Hospital (DSH) Program; and changes the distribution criteria for Medicaid DSH payments to implement funding decisions for the DSH program; allows any public hospital eligible for payment on July 1, 2011 to remain eligible for the entire fiscal year; and removes a requirement that funding distribution to statutorily defined teaching hospitals be distributed in the same proportion as state fiscal year 2003-2004.
- Authorizes the development of clinically effective, evidence-based alternatives as downward substitution for the statewide inpatient psychiatric program and similar residential care and institutional services.
- Eliminates the requirement to implement a wireless handheld clinical pharmacology drug information database for practitioners; and allowing electronic access to certain pharmacology drug information.
- Authorizes the implementation of a no cost home delivery of pharmacy products program; establishes the requirements for the procurement and the program; and eliminates the requirement for the expansion of the mail-order-pharmacy diabetes-supply program.
- Eliminates certain specific components of the prescription drug management system program.

- Assigns Medicaid recipients diagnosed with HIV/AIDS residing in Broward, Miami-Dade, or Palm Beach counties to an HIV/AIDS specialty plan.
- Authorizes the use of a managing entity in the Medipass program in all counties with fewer than two prepaid plans.
- Exempts any entity providing services solely to Medicaid recipients through a contract with Medicaid from payment of the premium tax required by s. 624.509, F.S., and provides that the provisions will operate prospectively.
- Creates an undesignated section of law deleting a provision that sunsets the ability of tobacco companies to deposit a limited amount of security with the Florida Supreme Court.
- Authorizes an additional Program of All-inclusive Care for the Elderly (PACE) site in Palm Beach County and approves up to 150 initial enrollees, subject to a specific appropriation.

The House Proposed GAA appropriates:

- $1,161.95 million to restore the Medically Needy program with recurring funds;
- $889.3 million to restore the MEDS-AD waiver program with recurring funds; and
- $246.6 million to implement the changes in DSH program funding.

The House Proposed GAA includes the following reductions:

- $393.9 million due to the continuation of the institutional providers unit cost freeze;
- $22.3 million due to an adjustment in the reimbursement formula for prescribed drugs; and
- $9.6 million due to elimination of certain contractual arrangements.

I. SUBSTANTIVE INFORMATION

A. EFFECT OF CHANGES:

Nursing Facility Staffing

Section 400.23(3)(a), F.S., establishes general nursing home staffing standards and allows flexibility for nursing homes in determining how the minimum staffing requirements can be met. Current law allows a facility to meet the minimum staffing requirements with a combined average certified nursing assistant and licensed nursing staffing of 3.9 hours of direct care per resident per day; a minimum certified nursing assistant staffing of 2.7 hours of direct care per resident per day; and a minimum licensed nursing staffing of 1.0 hour of direct care per resident per day. A facility is prohibited from staffing below one certified nursing assistant per 20 residents and below one licensed nurse per 40 residents.

Section 409.908(2), F.S., authorizes the agency to establish and implement reimbursement plans for nursing home care in conformance with applicable state and federal laws. The patient care cost component of the per diem rate consists of direct care and indirect care subcomponents. The direct care subcomponent is limited by the cost-based class ceiling. The indirect care subcomponent may be limited by the lower of the cost-based class ceiling, the target rate class ceiling, or the individual provider target. Currently, the direct care cost subcomponent includes salaries and benefits of direct care staff providing nursing services and certified nursing assistants who deliver direct care to residents. Nursing administration, minimum data set, care plan coordinator, staff development, and staff coordinator are all excluded. The indirect care cost subcomponent includes all other patient care costs.

This bill amends the minimum staffing requirements for nursing home facilities by allowing a combined average certified nursing assistant and licensed nursing staffing of 3.6 hours of direct care per resident per day; a minimum certified nursing assistant staffing of 2.5 hours of direct care per resident per day while maintaining the requirement of a minimum licensed nursing staffing of 1.0 hour of direct care per resident per day and the prohibition that a facility may not staff below one certified nursing assistant per 20 residents and below one licensed nurse per 40 residents.

The bill also modifies the formula for calculating the direct care subcomponent of the nursing home reimbursement to allow minimum data set and care plan coordinator staff performing direct care functions to be recognized as part of the minimum staffing requirements.

Optional Medicaid Eligibility and Coverage

Current law allows Medicaid reimbursement for medical assistance and related services for beneficiaries deemed eligible subject to income, assets, and categorical eligibility tests set forth in federal and state law. Payment on behalf of these Medicaid eligible beneficiaries is subject to the availability of moneys and any limitations established by the GAA or chapter 216, F.S.

- **The Medicaid Aged and Disabled Program (MEDS-AD)** eligibility category is an optional Medicaid eligibility group. The program provides Medicaid coverage to individuals who are age 65 or older or totally and permanently disabled, have incomes less than 88 percent of the federal poverty level, not eligible for Medicare and meet

asset limits. The 2005 Legislature through chapter 2005-60, L.O.F, directed the Agency for Health Care Administration (AHCA) to seek federal waiver authority to revise Medicaid eligibility coverage for the Medicaid MEDS-AD eligibility group beginning January 1, 2006. The AHCA received approval of the 1115 Research and Demonstration Waiver on November 22, 2005. The waiver was subsequently renewed on January 1, 2011. In accordance with the approved waiver, the revised program covers:

- Individuals without Medicare residing in the community or receiving Medicaid-covered institutional care services, hospice services, or home and community based services (HCBS), and
- Individuals eligible for Medicare and also eligible for and receiving Medicaid-covered institutional care services, hospice services, or home and community based waiver services.

Medicaid is required to provide Medicare "buy-in" coverage for aged and disabled individuals who are Medicare beneficiaries. Therefore, if Medicaid coverage is eliminated for persons eligible under the criteria for the MEDS-AD program, those who are eligible for Medicare will continue to have Medicaid coverage for Medicare premiums, deductibles, and coinsurance. This program is expected to have an average monthly enrollment of approximately 42,115 individuals in Fiscal Year 2011-12.

- **The Medically Needy** eligibility category is an optional Medicaid eligibility group. Title XIX of the Social Security Act specifies categories of individuals that the federal government gives state Medicaid programs the option of covering through their state plan. The Medically Needy program covers persons who have experienced a catastrophic illness and either have no health insurance, or have exhausted their benefits. On a month by month basis, the individual's medical expenses are subtracted from his or her income. If the remainder falls below Medicaid's income limits, the individual may qualify for Medicaid for the full or partial month depending on the date the medical expenses were incurred. The amount of expenses that must be deducted from the individual's income to make him or her eligible for Medicaid is called "share of cost." A person eligible for the Medically Needy Program is eligible for all Medicaid services with the exception of skilled nursing facility, state mental hospital, intermediate care facility for the developmentally disabled, assistive care services, community-based waiver services, or the payment of Medicare premiums by Medicaid. This program is expected to serve an average monthly enrollment of approximately 46,096 individuals in Fiscal Year 2011-12.

The bill repeals the June 30, 2011 sunset date for the MEDS-AD and Medically Needy programs, restoring Medicaid coverage to eligible individuals with recurring funds.

Reimbursement Rates for Medicaid Providers

Currently, Medicaid reimburses Medicaid providers in one of the following 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 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 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.

The bill repeals the sunset date for unit cost rate freeze on Medicaid provider rates for hospitals, nursing homes, community intermediate care facilities for the developmentally disabled and county health departments. The bill also repeals an obsolete provision to establish workgroups to evaluate alternate reimbursement and payment methods for hospitals, nursing facilities, and managed care plans and the reporting requirement on its evaluation.

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 September, 2011.

This bill modifies the reimbursement formula for prescribed drugs by adjusting the WAC-based formula to WAC plus 1.5 percent. Upon the loss of the AWP-based formula, WAC plus 1.5 percent will be the reimbursement rate used to reimburse Medicaid pharmacy providers.

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 Hospital Program funding distributions to hospitals that provide a disproportionate share of the Medicaid or charity care services to uninsured individuals. However, the legislature delineates how the funds will be distributed to each eligible facility.

The bill amends several provisions of chapter 409, F.S., to update for the most recent years of audited data used to implement the changes in DSH program funding for Fiscal Year 2011-2012. The bill:

- Revises the method for calculating disproportionate share payments to hospitals for Fiscal Year 2011-2012 by changing the years of averaged audited data from 2003, 2004, and 2005 to 2004, 2005, and 2006;
- Revises the time period from Fiscal Year 2010-2011 to 2011-2012 during which the AHCA is prohibited from distributing funds under the Disproportionate Share Program for regional perinatal intensive care centers;
- Requires that funds for statutorily defined teaching hospitals in Fiscal Year 2011-2012 be distributed as provided in the GAA;
- Revises the time period from Fiscal Year 2010-2011 to Fiscal Year 2011-2012 during which the AHCA is prohibited from distributing funds under the primary care disproportionate share program; and
- Allows any nonstate government owned or operated hospital eligible for disproportionate share payments on July 1, 2011 to remain eligible for payments during the entire state fiscal year.

Program of All-Inclusive Care for the Elderly (PACE)

PACE is a capitated benefit model authorized by the federal Balanced Budget Act of 1997 that features a comprehensive service delivery system and integrated federal Medicare and state Medicaid financing. The model was tested through CMS demonstration projects that began in the mid-1980s.[1] The PACE model was developed to address the needs of long-term care clients, providers, and payors.

For most participants, the comprehensive service package permits them to continue living at home while receiving services rather than receiving services in other more costly long term care settings. Capitated financing allows providers to deliver all the services that participants need rather than being limited to those services reimbursable under the Medicare and Medicaid fee-for-service systems. [2]

The Balanced Budget Act of 1997 established the PACE model of care as a permanent entity within the Medicare program and enabled states to provide the PACE services to Medicaid beneficiaries as a state option without a Medicaid waiver. The state plan must include PACE as an optional Medicaid benefit before the State and the Secretary of the Department of Health and Human Services can enter into program agreements with PACE providers.[3]

[1] Centers for Medicare and Medicaid Services website: http://www.cms.hhs.gov/PACE/ (last visited on March 17, 2011).
[2] *Id.*
[3] *Id.*

A PACE organization is a not-for-profit private or public entity that is primarily engaged in providing the PACE services and must:[4]

- Have a governing board that includes community representation;
- Be able to provide the complete service package regardless of frequency or duration of services;
- Have a physical site to provide adult day services;
- Have a defined service area;
- Have safeguards against conflicts of interest;
- Have demonstrated fiscal soundness; and
- Have a formal participant bill of rights.

The PACE project is a unique federal/state partnership. The federal government establishes the PACE organization requirements and application process. The state Medicaid agency or other state agency is responsible for oversight of the entire application process, which includes reviewing the initial application and providing an on-sight readiness review before a PACE organization can be authorized to serve patients. An approved PACE organization must sign a contract with the CMS and the state Medicaid agency.[5]

Florida PACE Project

The Florida PACE project is one project among many that provide alternative, long-term care options for elders who qualify for Medicare and the state Medicaid program. The PACE project was initially authorized in chapter 98-327, Laws of Florida, and is codified in s. 430.707(2), F.S. The PACE model targets individuals who would otherwise qualify for Medicaid nursing home placement and provides them with a comprehensive array of home and community based services at a cost less than the cost of nursing home care. The PACE project is administered by DOEA in consultation with AHCA.

Section 3, chapter 2006-25, L.O.F., included proviso language in the 2006-2007 GAA to authorize 150 additional clients for the existing PACE project in Miami-Dade County and funding for the development of PACE projects to serve 200 clients in Martin and St. Lucie counties, and 200 clients in Lee County.

Section 3, chapter 2008-152, L.O.F., included proviso language in the 2008-09 GAA to reallocate 150 unused PACE slots to Miami-Dade, Lee and Pinellas Counties. Each site received 50 slots.

Section 20, chapter 2009-55, L.O.F., directed the AHCA, upon federal approval of an application to be a site for PACE, to contract with one private, not-for-profit hospice organization located in Hillsborough County, which provides comprehensive services, including hospice care for frail and elderly persons. This section also authorized the AHCA, in consultation with DOEA and subject to an appropriation, to approve up to 100 slots for the program.

Section 14, chapter 2010-156, L.O.F., directed the AHCA to contract with a private health care organization to provide comprehensive services to frail and elderly persons residing in Polk,

[4] PACE Fact Sheet, available at http://www.cms.hhs.gov/PACE/Downloads/PACEFactSheet.pdf.
[5] *Id*.

Highlands, Hardee, and Hillsborough Counties. This section also authorized 150 initial slots for the program.

Section 15, chapter 2010-156, L.O.F., directed AHCA to contract for a new PACE site in Southwest Miami-Dade County and approved 50 initial slots for the program.

In addition to receiving the necessary legislative authority, the development of a new PACE organization or the expansion of an existing program is a lengthy process that includes: identifying a service area, acquiring and renovating a PACE facility and processing the PACE application through the state and the federal review system.

The bill authorizes, subject to an appropriation, up to 150 initial enrollee slots for a new PACE project in Palm Beach County.

Entities Contracting with the Medicaid Program

Chapter 636, F.S., regulates the operation and administration of prepaid limited health service organizations[6] (PLHSO) and discount medical plan organizations in the state of Florida. PLHSOs solely providing services to Medicaid recipients under a contract with Medicaid are exempt from several provisions of Chapter 636, F.S., including those related to rates and charges[7]; changes in rates and benefits, material modifications, and the addition of limited health services[8]; restrictions upon expulsion or refusal to issue or renew a contract[9]; notice of cancellation of contract[10]; and extension of benefits.[11]

Since 1994, Florida law has imposed a tax on the insurance premiums, contributions, and assessments received by a PLHSO.[12] The premium tax is to be paid annually and is calculated at a rate of 1.75 percent of the gross amount of premiums, contributions, and assessments collected on health insurance policies issued by PLHSOs.[13]

There are five PLHSOs which provide mental health services to Medicaid recipients through a contract with AHCA that are subject to this tax.[14] One organization, Lakeview Center, Inc. (Lakeview), filed a legal challenge in 2007 to the imposition of the tax by the Department of Revenue(DOR).[15] According to the court's order, Lakeview had been paying the premium tax

[6] Section 636.003(7), F.S., defines a "prepaid limited health service organization" as "any person, corporation, partnership, or any other entity which, in return for a prepayment, undertakes to provide or arrange for, or provide access to, the provision of a limited health service to enrollees through an exclusive panel of providers; s. 636.003(5), F.S., defines a "limited health service" as ambulance services, dental care services, vision care services, mental health services, substance abuse services, chiropractic services, podiatric care services, and pharmaceutical services.
[7] Section 636.017, F.S.
[8] Section 636.018, F.S.
[9] Section 636.022, F.S.
[10] Section 636.028, F.S.
[11] Section 636.034, F.S.
[12] Section 636.066(1), F.S.
[13] Section 624.509(1)(a), F.S.
[14] Agency for Health Care Administration, 2011 Bill Analysis and Economic Impact Statement for SB 472/HB 467; the five vendors are: Lakeview Center, Inc. (d/b/a Access Behavioral Health), Magellan Behavioral Health of Florida, Inc., North Florida Behavioral Health Partners, Inc., Florida Health Partners, Inc., and The Community Based Care Partnership, LLC.
[15] See Lakeview Center, Inc. v. State of Florida, Dept. of Revenue, No. 2007-CA-1255 (Fla. 2nd Cir. Co. Jan 23, 2008), per curiam affirmed, Lakeview Center, Inc. v. State of Florida, Dept. of Revenue, 8 So.3d 1136 (Fla. 1st DCA 2009)(unpublished disposition).

under s. 624.509, F.S., since 2003. Subsequently, Lakeview determined that the tax was paid in error and sought a refund from DOR. The request for refund was denied and Lakeview timely filed a Complaint with the Circuit Court for the Second Circuit in Tallahassee. The court found that Lakeview contracted with the Agency for Health Care Administration (AHCA) to provide mental health and other services to Medicaid recipients. Lakeview was paid a fixed sum by AHCA to provide the stated services. Lakeview argued that the fixed sum paid by AHCA under the contract did not constitute a premium to trigger the imposition of the premium tax under s. 624.509, F.S. The court disagreed, finding that a rule established by the Office of Insurance Regulation (OIR), which regulated Lakeview as an insurer in the state of Florida, defined "premium"[16] and concluded that the fixed rate paid to Lakeview by AHCA met the definition and was taxable.

Currently, some PLHSOs are paying the premium tax and some are not. Additional information regarding the identity of those PLHSOs and the amount being paid or owed is not available due to state confidentiality provisions.[17]

The bill exempts any entity providing services solely to Medicaid recipients through a contract with Medicaid from payment of the premium tax required by s. 624.509, F.S. The bill provides that the provisions within the bill will operate prospectively. The prospective operation of the bill does not provide a basis for an assessment of taxes not paid, or a basis for determining any right to a refund of taxes paid, prior to July 1, 2011.

Exempting PLHSOs from premiums, contributions, and assessments will impact the way in which AHCA determines the capitation rate for the organizations that provide mental health services to Medicaid recipients. The rates will be adjusted for the 2011-12 year, effective September 1, 2011, and would result in a reduction to the rates paid to the plans by Medicaid.

Cap on Appeal Bonds Posted by Tobacco Companies

In civil litigation, a successful plaintiff may execute (initiate collection) on a judgment when it is entered by the trial court. An appeal by the defendant does not restrict the right of the plaintiff to collect, unless the court enters a stay of execution pending the appeal. Under Florida court rules, a stay is also to be automatically granted if the defendant posts a bond or other surety in an amount equal to the judgment plus two years' interest at a rate set by law. When the state is the defendant, a stay of collection pending appeal is automatic as a matter of law.

Based upon equitable principles, a court may alter the surety required for continuance of the stay. In addition, statutory caps on appeals bonds have been enacted to regulate punitive damages, large cases, and class actions. In 2003, a $100,000,000 appeal bond cap was enacted for class action cases in which certain tobacco companies were the defendants appealing the judgment. These companies settled certain claims in 1997 and are now making annual payments to the state.

The equitable purpose of the $100,000,000 limitation is to keep from bankrupting the tobacco companies during the pendency of appeals of individual plaintiff awards that may prove to be excessive as a matter of law.

[16] Rule 69O-203.013(6), F.A.C. (2007), defined "premium" as "[t]he contracted sum paid by or on behalf of a subscriber or group of subscribers on a prepaid per capita or a prepaid aggregate basis for limited health services rendered by or through the PLHSO."
[17] Section 213.053(2)(a), F.S.

Bankruptcy would disrupt the payments under the 1997 settlement with Florida in its Medicaid lawsuit. Florida has sought to prevent that unless private case judgments are affirmed on appeal.
Legislation enacted in 2009 made the limitations on supersedeas bonds in s. 569.23, Florida Statutes, applicable to a group of cases arising out of a formerly certified class action that the original appeal bond limits would have affected. The law apportions the cap between settling manufacturers and among successful plaintiffs while their cases are on appeal.

The 2009 law had an automatic repealer intended to come into effect after the cases had matured to an extent that courts would know the correct law to apply to liability and damages. The provision provided the law would be repealed effective December 31, 2012.

This bill creates an undesignated section of law deleting the automatic repealer provision that sunsets the ability of tobacco companies to deposit a limited amount of security with the Florida Supreme Court.

Nursing Home Facility Providers Quality Assessment Program

Section 409.9082, F.S., establishes a quality assessment program for nursing home facility providers. The program had an effective date of April 1, 2009. Current federal regulations provide that assessment revenues cannot exceed 5.5 percent of the total aggregate net patient service revenue of the assessed facilities. The AHCA was authorized to calculate the assessment annually on a per-resident-day basis, exclusive of those days funded by the Medicare program. Certain nursing home facilities are exempt from the imposition of the quality assessment. The purpose of the nursing home quality assessment is to ensure continued quality of care and that the collected assessments are 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.

Subsection 3 of section 409.9082, F.S., outlines the criteria for exempting or applying a lower quality assessment rate to nursing home facilities. This subsection allows the exemption or application of a lower quality assessment rate to a qualified public, nonstate-owned or operated nursing home facility whose total annual indigent census days are greater than 25 percent of the facility's total annual census days. Currently, three nursing home facilities are exempted from the quality assessment under this provision.

Effective October 1, 2011, federal regulations will allow the total aggregate amount of assessment for all nursing home facilities to increase to 6.0 percent. This bill modifies statutory authority to conform to federal regulations.

This bill also revises the criteria for exempting qualified public, nonstate-owned or operated nursing home facilities from the quality assessment by changing the total annual indigent census day from 25 percent to 20 percent effective July 1, 2011.

Privately Operated Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) Quality Assessment Program

Section 409.9083, F.S., establishes a quality assessment program for intermediate care facilities for the developmentally disabled. Federal regulations set the total allowable aggregate

assessment amount. Current federal regulations provide that assessment revenues cannot exceed 5.5 percent of the total aggregate net patient service revenue of the assessed facilities. However, effective October 1, 2011, federal regulation will allow the total aggregate amount of assessment to increase from 5.5 percent to 6.0 percent. The AHCA was authorized to calculate the quality assessment rate annually on a per-resident-day basis. The purpose of the facility quality assessment is to ensure continued quality of care and that the collected assessments are used to obtain federal financial participation through the Medicaid program in order to make Medicaid payments for ICF/DD services up to the amount of the Medicaid rates as calculated in accordance with the approved state Medicaid plan in effect on April 1, 2008. The quality assessment on ICF/DD facilities is set to repeal on October 1, 2011.

This bill eliminates the repeal date of the quality assessment on ICF/DD facilities.

Licensure Denial and Revocation

Section 408.815(4), F.S., gives AHCA authority to deny an application for a license or license renewal if the applicant or a person having a controlling interest in an applicant has been convicted of a felony, terminated from the Florida Medicaid program, or terminated from the federal Medicare program. The denial or revocation of a license by AHCA is subject to challenge under the Administrative Procedures Act (chapter 120, F.S.) If a licensee challenges the action taken by the agency, s. 408.815(2), F.S., allows the license to continue to exist and the provider to continue to operate during the pendency of the case. Once a final order is issued on the denial or revocation, if the original licensure expiration date has passed, there is no valid license and the provider must cease operations immediately. According to AHCA, this can be problematic for residents or clients who must immediately be moved to another facility or find another health care provider.

The bill authorizes AHCA to extend a license expiration date up to 30 days for all provider types beyond the final order date in the event of a licensure denial or revocation to allow for the safe and orderly discharge of residents.

The bill also allows AHCA to consider certain mitigating circumstances for applications subject to denial. The mitigating circumstances include, but are not limited to:

- Completion or lawful release from confinement, supervision, or sanction, including any terms of probation, and full restitution;
- Execution of a compliance plan with AHCA;
- Compliance with any integrity agreement or compliance plan with any other government agency;
- Determination by any state Medicaid program or the Medicare program that the controlling interest is currently allowed to participate in the state Medicaid program or the Medicare program;
- Continuation of licensure by the controlling interest;
- Overall impact on public health, safety or welfare; or
- Determination that license denial is not commensurate with the prior action taken by the state Medicaid program or the Medicare program.

Modifications in Contractual Arrangements

- **Wireless Handheld Devices –** Pursuant to s. 409.912 (16)(b), F.S., the AHCA 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.

  The bill removes the requirement for the AHCA to implement a wireless handheld program and grants the AHCA 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.

- **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.

  This bill eliminates specific components of the prescription drug management system, but continues general authority that allows the AHCA to implement a drug management system.

- **Home Delivery of Pharmacy Products -** During Special Session 2001C Session, the Legislature expanded the home delivery of pharmacy products. The AHCA was directed to expand the current mail-order-pharmacy diabetes supply program to include all generic and brand name drugs used by Medicaid patients with diabetes. The program was established as voluntary participation for Medicaid recipients with diabetes. Pharmacies were prohibited from charging higher reimbursement rate for this expansion in service. The initiative was limited to the geographic area covered by the current contract.

  In 2010, the Legislature directed the AHCA, through specific proviso language, to issue an invitation to negotiate with a pharmacy or pharmacies to provide mail order delivery services at no cost to the patients who elect to receive their drugs by mail order delivery services for patients with chronic disease states. Participation was limited to 20,000 patients statewide.

This bill grants statutory authority to the AHCA to implement a mail order home delivery pharmacy program with a focus on serving recipients with chronic diseases. The bill also eliminates the requirement to expand the current mail-order-pharmacy diabetes-supply program.

- **Hospitalist Program Replacement of Existing Utilization Review -** The 2004 Legislature authorized the implementation of a Medicaid hospitalist pilot program. The program was created to manage the inpatient hospital length of stay for fee-for-service and MediPass Medicaid recipients. 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 program became operational in 15 participating hospitals located in Miami-Dade and Palm Beach counties in May 2007.

  The hospitalist pilot program was originally designed to replace the existing utilization management program; however, the agency was unable to eliminate the current program in Miami-Dade and Palm Beach counties due to federal requirements. Currently, the agency has multiple contracts to manage the length of stay for inpatient services.

  This bill eliminates the requirement to implement the Medicaid hospitalist pilot program.

Medicaid Managed Care Alternatives

Florida Medicaid costs have increased significantly since its inception, due to substantial eligibility expansion as well as the broad range of services and programs funded by Medicaid expenditures. Current estimates indicate that the program will cost $21.4 billion in FY 2011-2012. Florida has made numerous and repeated efforts to control costs in the program.[18] Since 1996, the Legislature has reduced $5.2 billion from the program through rate reductions, utilization limits, fraud and abuse efforts, and other cost control initiatives.
Florida, like other states, turned to managed care for improving access to care, containing costs, and enhancing quality. This bill authorizes the following managed care alternatives:

- Directs AHCA to contract with a single provider service network (PSN) to serve as a third party administrator for the Medipass program in all counties with less than two prepaid plans. The contractor will be responsible for implementing preauthorization procedures, case management programs, and utilization management initiatives. The contractor may earn an administrative fee if the fee is less than any cost savings achieved.

- Authorizes AHCA to assign Medicaid recipients diagnosed with HIV/AIDS and residing in Broward, Miami-Dade, or Palm Beach counties into a managed care plan which offers a delivery system through a university-based teaching and research-oriented organization that specializes in providing health care services and treatment for individuals diagnosed with HIV/AIDS.

- Authorizes AHCA to work with a specialty plan to develop clinically effective, evidence-based alternatives as downward substitution for the statewide inpatient psychiatric program and similar residential care and institutional services.

[18] See, Florida Medicaid Budget Reduction History, presented by staff of the House Health Care Appropriations Committee in Select Council on Strategic and Economic Planning, October 1, 2009.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:
$138,178,151 million in federal Medicaid funds will be generated through the implementation of the DSH programs.

2. Expenditures:

	FY 2011-12
OPTIONAL MEDICAID ELIGIBILITY AND COVERAGE	
MEDS-AD Program	
General Revenue	$ 199,733,536
Grants and Donations Trust Fund	$ 40,548,529
Public Medical Assistance Trust Fund	$ 182,000,000
Medical Care Trust Fund	$ 467,043,395
Total	**$ 889,325,460**
Medically Needy Program	
General Revenue	$ 487,238,897
Grants and Donations Trust Fund	$ 80,315,819
Medical Care Trust Fund	$ 594,402,255
Total	**$1,161,956,971**
INSTITUTIONAL PROVIDERS UNIT COST FREEZE	
General Revenue	($ 137,016,867)
Grants and Donations Trust Fund	($ 35,718,646)
Medical Care Trust Fund	($ 219,925,441)
Refugee Assistance Trust Fund	($ 1,226,741)
Total	**($ 393,887,695)**
PHARMACY PROGRAM REDUCTION	
General Revenue	($ 9,786,889)
Medical Care Trust Fund	($ 12,425,750)
Refugee Assistance Trust Fund	($ 48,976)
Total	**($ 22,261,615)**
DISPROPORTIONATE SHARE PROGRAM	
General Revenue	$ 750,000
Grants and Donations Trust Fund	$ 107,642,426
Medical Care Trust Fund	$ 138,178,151
Total	**$ 246,570,577**

MODIFICATIONS IN CONTRACTUAL SERVICES

Wireless Handheld Devices	
General Revenue	($ 610,672)
Grants and Donations Trust Fund	($ 551,530)
Medical Care Trust Fund	($ 1,162,206)
Total	**($ 2,324,408)**
Therapy Management (Prescribed Drugs)	
General Revenue	($ 520,000)
Medical Care Trust Fund	($ 520,000)
Total	**($ 1,040,000)**
Hospitalist Contracts	
General Revenue	($ 2,724,050)
Medical Care Trust Fund	($ 3,510,901)
Total	**($ 6,234,951)**

BUDGETARY INCREASES	
General Revenue	**$ 687,722,433**
Grants and Donations Trust Fund	**$ 228,506,774**
Public Medical Assistance Trust Fund	**$ 182,000,000**
Medical Care Trust Fund	**$1,199,623,801**
Grand Total – Increases	**$2,297,853,008**

BUDGETARY DECREASES	
General Revenue	**($ 152,284,716)**
Grants and Donations Trust Fund	**($ 36,270,176)**
Medical Care Trust Fund	**($ 239,608,795)**
Refugee Assistance Trust Fund	**($ 1,279,109)**
Grand Total – Decreases	**($ 429,442,796)**

TOTAL BUDGETARY IMPACT	
General Revenue	**$ 535,437,717**
Grants and Donations Trust Fund	**$ 192,236,598**
Public Medical Assistance Trust Fund	**$ 182,000,000**
Medical Care Trust Fund	**$ 960,015,006**
Refugee Assistance Trust Fund	**($ 1,279,109)**
Grand Total – All	**$ 1,868,410,212**

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. **Revenues:**
   None.

2. **Expenditures:**

Local governments and other local political subdivisions may provide $107,642,426 million in contributions for the DSH programs.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

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:

None.