STORAGE NAME: h1753.frc
DATE: March 22, 2001

HOUSE OF REPRESENTATIVES

FISCAL RESPONSIBILITY COUNCIL ANALYSIS

BILL #: HB 1753

RELATING TO: Agency for Health Care Administration

SPONSOR(S): Fiscal Responsibility Council and Representative Maygarden

TIED BILL(S):

ORIGINATING COMMITTEE(S)/COUNCIL(S)/COMMITTEE(S) OF REFERENCE:

(1) FISCAL RESPONSIBILITY COUNCIL YEAS 13 NAYS 7
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I. SUMMARY:

This bill makes a number of changes pertaining to the Medicaid Program in the Agency for Health Care Administration (AHCA). These statutory changes implement Medicaid program funding decisions made by the Health and Human Services Appropriations Committee. Specifically, the bill:

- Expands the managed behavioral health care program statewide.
- Eliminates the requirement for Medicaid recipients to receive one-on-one counseling regarding choice among health care provider options.
- Permits AHCA to competitively bid Medicaid hospital services, nursing home services, individual provider services (private duty nursing), laboratory services, and pharmacy services.
- Limits Medicaid cross-over payments for nursing home and hospital outpatient care to 20% of Medicare allowable fees (rather than provider charges).
- Permits AHCA to establish a Medicaid restricted drug formulary and negotiate supplemental rebates.
- Eliminates optional Medicaid coverage for adult dental, visual and hearing services.
- Reduces eligibility for pregnant women from 185% to 150% of poverty.
- Reduces eligibility for elderly/disabled from 90% to 85% of poverty.
- Restricts nursing home rate adjustments associated with changes in ownership.
- Requires prior authorization for all non-emergency hospital inpatient admissions.
- Reduces the number of state paid days for hospital inpatient services.
- Reduces hospital institutional provider rates by 5%.
- Shifts general nursing home care to the assisted living waiver.

The bill also readopts provisions from the 2000-01 General Appropriations Act implementing bill:

- Updates the formulas relating to disproportionate share and to disproportionate share for rural hospitals.
- Prevents including payment increases to hospitals in Medicaid managed care payments, and prevents assessing counties for such increases.

This bill requires a 2/3 vote of each house of the Legislature in order to bind counties, pursuant to Article VII, Section 18(a) of the Florida Constitution. See section IV of this analysis.

The budget impact of the various reduction decisions total ($287.8) million in General Revenue and ($449.3) million in trust funds, and the projected revenue impact is $13.5 million to the General Revenue Fund.

II. SUBSTANTIVE ANALYSIS:

A. DOES THE BILL SUPPORT THE FOLLOWING PRINCIPLES:

1.	Less Government	Yes [X]	No []	N/A []
2.	Lower Taxes	Yes [X]	No []	N/A []
3.	Individual Freedom	Yes []	No []	N/A [X]
4.	Personal Responsibility	Yes [X]	No []	N/A []
5.	Family Empowerment	Yes []	No []	N/A [X]

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

B. PRESENT SITUATION:

See SECTION-BY-SECTION ANALYSIS.

C. EFFECT OF PROPOSED CHANGES:

See SECTION-BY-SECTION ANALYSIS.

D. SECTION-BY-SECTION ANALYSIS:

Section 1: Amends s. 409.8132, F.S., relating to MediKids. Eliminates the requirement to provide choice counseling. Instead, offers applicants a choice between a managed care plan or MediPass.

Section 2: Amends s. 409.815, F.S., relating to health benefits coverage limitations. Corrects a cross reference on optional Medicaid services.

Section 3: Amends s. 409.903, F.S., relating to mandatory payments and eligibility for pregnant women. Reduces the maximum percent of poverty level to be eligible for services from 185 percent to 150 percent.

Section 4: Amends s. 409.904, F.S., relating to optional payments for eligible persons. Changes eligibility for people age 65 or older, or determined to be disabled, from 100 percent of poverty to 85 percent. Changes eligibility for family planning services for postpartum women from 185 percent of poverty to 150 percent. Authorizes AHCA to pay health insurance premiums for persons eligible for Medicaid if doing so is cost effective.

Section 5: Amends s. 409.905, F.S., relating to mandatory Medicaid services for hospital inpatient services. Corrects a cross reference to Chapter 395, F.S. Allows AHCA to require prior authorization for nonemergency inpatient admissions. Adds language to permit behavioral health facilities to participate in inpatient Medicaid services if so provided in a federally approved waiver but prohibits implementation of a behavioral health waiver proposal from being the basis for adjusting a hospital's Medicaid inpatient or outpatient rate. Deletes outdated language relating to adjustment of hospital inpatient per diem rates.

Section 6: Amends s. 409.906, F.S., relating to optional Medicaid services. Deletes adult denture services as an optional service. Restricts eligibility for hearing and visual services to people under age 21. Adds a new requirement to AHCA paying for 24-hour-a-day intermediate care nursing and rehabilitation services in nursing facilities -- the facilities must meet Comprehensive Assessment and Review for Long-Term Care criteria and the services must not meet the definition of "general care" as used in the Medicaid budget estimating process. Authorizes AHCA to pay for assistive care services to recipients with functional or cognitive impairments living in assisted living, adult family care or residential treatment facilities with 16 or fewer beds and specifies the services.

Section 7: Amends s. 409.9065, F.S., relating to pharmacy benefits. Corrects a cross reference.

Section 8: Amends s. 409.908, F.S., relating to provider reimbursement to allow reimbursement to hospitals to be made prospectively, on the basis of negotiation, or on the basis of competitive bids (Currently competitive bidding is not allowed.)

Requires rates to be no greater than 95 percent of the rates in effect for FY 2000-01. (Current rates are 100 percent of that amount.)

Deletes language that exempts counties from contributing toward the cost of special exception reimbursement for hospitals that serve a disproportionate share of low-income people and provide graduate medical education. Deletes a requirement for prospective reimbursement or competitive bidding for state-owned and operated intermediate care facilities for the developmentally disabled, but maintains those requirements for nursing homes licensed under part II of chapter 400. Prohibits rate increases to nursing homes associated with changes in ownership.

Authorizes competitive bidding for the following services: advanced registered nurse practitioners, birth centers, chiropractic, community mental health, dental, durable medical equipment, hearing, occupational therapy, optometric, orthodontic, personal care, physical therapy, physician assistant, podiatric, portable x-ray, private duty nursing, registered nurse first assistants, respiratory therapy, speech therapy and visual services. (Currently, these services are only reimbursed on a fee-for-service basis.)

Prohibits the cost of exempting statutory teaching hospitals, specialty hospitals, and community hospital education program facilities from reimbursement ceilings and the cost of special Medicaid payments from being included in premiums paid to health maintenance organizations or prepaid health care plans.

Authorizes competitive bidding to be used as the basis for reimbursement of home health care services, medical supplies and appliances, and independent laboratory services. (Currently reimbursement is the lesser of the amount billed or AHCA's maximum allowable amount.)

Specifies that physician fee schedules cannot increase the total cost of Medicaid physician expenditures unless funds are specifically appropriated for such an increase and prohibits any such increase from making the physician fee under Medicaid more than the Medicare fee. Deletes advisory panel created to advise on physician fee schedules. (Currently, increases are limited to appropriations.)

Limits Medicaid cross-over payments for nursing home and hospital outpatient care to 20% of Medicare allowable fees (rather than provider charges).

Adds competitive bidding as a basis for reimbursement of prescribed drug providers. (Currently, the least of the amount billed, the usual and customary charge, or the Medicaid maximum allowable fee, plus a dispensing fee, are allowed.)

Authorizes AHCA to competitively procure transportation services or to make other changes needed to get federal approval of waivers that would secure federal match at the service rate rather than the administrative rate.

Permits elementary, middle and secondary schools affiliated with Florida universities to separately enroll in the Medicaid certified school match program and certify local expenditures for Medicaid school health services and administrative claiming.

Requires reimbursement to state-owned-and-operated ICF/DDs to be made prospectively.

Section 9: Amends s. 409.911, F.S., regarding disproportionate share. Requires the use of 1994 audited financial data to calculate disproportionate share payments and establishes new percentage factors for those calculations. (Currently the most recent year's audited financial data must be used.)

Section 10: Amends s. 409.91195, F.S., on the Medicaid pharmaceutical and therapeutics committee. Changes the purpose of the committee from developing a voluntary preferred drug list to developing a restricted drug formulary. Requires the composition of the committee members to conform to federal law, rather than being specified in Florida Statutes. Directs AHCA, with the advice of the committee, to establish a restricted drug formulary, rather than the current voluntary Medicaid preferred prescribed drug list, and provides for committee recommendations on changes to the formulary. Requires AHCA to distribute the formulary information to all Medicaid prescribing providers.

Section 11: Amends s. 409.9116, F.S., relating to disproportionate share for rural hospitals. Establishes a new formula for fund distribution.

Section 12: Amends s. 409.912, F.S., relating to cost-effective purchasing of health care. Authorizes AHCA to reimburse for substance abuse treatment on a fee-for-service basis until funding is available for capitated, prepaid arrangements, or (new requirement) until AHCA determines that a capitated arrangement will not adversely affect the availability of such services. Deletes outdated language.

Deletes the current requirement for enrollment choice counseling for MediPass or managed care plans. Deletes the current authorization for testing of new marketing initiatives to inform Medicaid recipients about managed care options.

Conforms this section to permit competitive bidding, rather than negotiation, for services related to hospital inpatient and outpatient, private duty nursing, independent laboratory, durable medical equipment and supplies, nursing homes and other long-term care, and prescribed drugs. Allows AHCA to exclude providers not selected through the bidding process from the Medicaid network.

Allows AHCA to authorize exceptions to the restricted drug formulary as part of the Medicaid prescribed-drug spending-control program. Requires pharmacy reimbursement to be at the lowest of the average wholesale price minus 13.25 percent, the wholesaler acquisition cost plus 7 percent, the federal or state pricing limit, or the provider's usual and customary charge. (Currently only average wholesale price minus 13.25 percent is allowed.) Adds a requirement that any prescriber who writes prescriptions for Medicaid recipients to use counterfeit-proof prescription pads. Permits AHCA to establish a restricted drug formulary that meets federal guidelines and to negotiate supplemental manufacturer rebates, invoiced concurrently with federal rebates, at no less than 10 percent of the average wholesale price on the last date of each quarter.

Section 13: Amends s. 409.915, F.S., relating to county contributions to Medicaid. Changes the period for which counties pay for inpatient hospitalization from days 13 through 45 to days 11 through 45. Exempts counties from contributing toward the cost of new exemptions on inpatient ceilings for

statutory teaching hospitals, specialty hospitals, and community hospital education program hospitals that came into effect July 1, 2000, and for special Medicaid payments that came into effect on or after July 1, 2000.

Section 14: Repeals s. 636.0145, F.S., relating to licensure of prepaid mental health services in Hillsborough, Highlands, Hardee, Manatee and Polk Counties.

Section 15: Declares that this bill fulfills an important state interest.

Section 16: Provides an effective date of July 1, 2001.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

	General Revenue Unallocated
Reduce Number of State Paid Days for Hospital Inpatient – Increase county billing	13,543,645

2. Expenditures:

	FY 2001-02		Annualized	
	GENERAL REVENUE	TRUST FUNDS	GENERAL REVENUE	TRUST FUNDS
State Expenditures:				
Drug Formulary With Rebates	(79,647,821)	(131,918,552)	(106,197,095)	(175,891,402)
Limit Medicaid Reimbursement For Hospital Outpatient Medicare Crossover Claims	(25,786,590)	(33,424,867)	(25,786,590)	(33,424,867)
Competitively Bid Hospital Services	(10,589,878)	(13,885,832)	(31,769,634)	(41,657,496)
Set Health Maintenance Organization (HMO) Rates Based On The Net Cost Of Drugs	(13,963,013)	(18,552,773)	(13,963,013)	(18,552,773)
Competitively Bid Or Capitate Nursing Home	(2,814,288)	(3,647,912)	(11,257,152)	(14,591,648)
Competitively Bid Medicaid Prescribed Medicine/Drug Services	(4,535,256)	(5,913,583)	(18,141,021)	(23,654,327)
Capitate Medicaid Payments For Behavioral	(7,351,523)	(13,632,039)	(7,351,523)	(13,632,039)
Medicaid Choice Counseling	(6,600,000)	(6,600,000)	(6,600,000)	(6,600,000)
Eliminate Administrative Costs Rate Component Included In Capitation Rate Paid To Health Maintenance Organizations	(6,576,659)	(8,738,467)	(6,576,659)	(8,738,467)
Limit Medicaid Reimbursement For Nursing Home Medicare Crossover Claims	(1,763,917)	(2,286,409)	(1,763,917)	(2,286,409)
Competitively Bid Or Capitate Nursing Services	(755,195)	(979,075)	(3,020,777)	(3,916,298)
Eliminate Adult Dental, Visual And Hearing	(13,813,905)	(23,175,280)	(13,813,905)	(23,175,280)
Reduce Eligibility For Pregnant Women From 185% To 150% Of FPL	(14,743,307)	(19,600,533)	(14,743,307)	(19,600,533)
Reduce Eligibility For Elderly/Disabled from 90% To 85% Of FPL	(37,924,632)	(87,682,906)	(37,924,632)	(87,682,906)
Restrict Nursing Home Rate Adjustments associated with Changes in Ownership	(5,763,073)	(7,470,161)	(5,763,073)	(7,470,161)
Require Prior Authorization For And Concurrent Review Of All Non-Emergency, Non-Psychiatric Hospital Inpatient Admissions	(7,006,063)	(8,740,484)	(18,012,127)	(23,480,967)
Reduce Hospital Provider Rates	(42,362,582)	(55,547,001)	(42,362,582)	(55,547,001)
Shift General Nursing Home to Community	(5,992,955)	(7,521,726)	(5,992,955)	(7,521,726)

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

N/A

2. Expenditures:

Increased county billing for inpatient hospitalization $13,543,645

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

N/A

D. FISCAL COMMENTS:

N/A

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

This bill will require counties to spend approximately $13.5 million. Section 13, which amends s. 409.915, F.S., requires counties to pay for Medicaid inpatient hospitalization from days 11 through 45 rather than from days 13 through 45.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

This bill does not reduce the authority that counties or municipalities have to raise revenues in the aggregate.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

This bill does not reduce the percentage of a state tax shared with counties or municipalities.

V. COMMENTS:

A. CONSTITUTIONAL ISSUES:

None.

B. RULE-MAKING AUTHORITY:

None.

C. OTHER COMMENTS:

None.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

On March 16, 2001, the Fiscal Responsibility Council adopted one amendment to PCB FRC 01-27 which became section 15 of the bill, and is now reflected in this analysis.

VII. SIGNATURES:

FISCAL RESPONSIBILITY COUNCIL:

Prepared by:	Staff Director:
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