SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

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

BILL: SB 22-A

SPONSOR: Senator Peaden

SUBJECT: Health Care

DATE: May 9, 2003 REVISED: 05/14/03

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Peters	Coburn	AP	Fav/1 amendment
2.				
3.				
4.				
5.				
6.				

I. Summary:

The bill makes a number of changes to health care programs that are required in order to implement the proposed General Appropriations Act for FY 2003-04. Specifically, the bill:

- Continues nursing facility lease bond alternatives;
- Revises the definition of "third-party" for purposes of the Medicaid program to include third party administrators and pharmacy benefit managers;
- Delays the certified nursing assistant staffing increase of 2.9 hours of direct care per resident per day from January 1, 2004 to July 1, 2004;
- Revises the Medically Needy Program to eliminate the prohibition for Medicaid reimbursement of expenses to meet spend down liability and eliminates the additional monthly income disregard of $270 for certain individuals;
- Eliminates Medicaid coverage of Adult Dental, Visual and Hearing Services;
- Authorizes a supplemental pharmaceutical dispensing fee to be paid to providers returning unused unit-dose packaged medications;
- Requires Medicaid recipients to pay a $15 co-payment for non-emergency use of a hospital emergency department;

- Revises the formula for distributing disproportionate share funds under the regular program, the regional perinatal intensive care center program, the rural and financial assistance program and the primary care program and eliminates the disproportionate share program for specialty hospitals for children;

- Removes the limit on the number of Medicaid provider service networks;

- Requires the prescriber (not the long-term care pharmacy) to request an exception to the limit of four-brand drugs for Medicaid nursing home residents and other institutionalized adults;

- Eliminates value-added agreements with pharmaceutical manufacturers in lieu of supplemental rebates in the Medicaid program as of July 1, 2003;

- Provides for a utilization management and prior authorization program for children targeted at the management of occupational, physical, respiratory and speech therapies;

- Revises the Medicaid program enrollment goal for managed care to 60 percent managed care and 40 percent MediPass; and

- Implements a maximum annual dental benefit of $500 per enrollee in the Florida Healthy Kids program.

The bill amends sections 400.179, 400.23, 409.901, 409.904, 409.906, 409.908, 409.9081, 409.911, 409.9112, 409.9116, 409.9117, 409.912, 409.9122, and 409.815, Florida Statutes.

The bill repeals section 409.9119, Florida Statutes.

II. Present Situation:

Nursing Home Overpayment Bonds

Since 1993, section 400.179, F.S., has required a performance bond as a condition of licensure for leased nursing homes to ensure that providers operating leased facilities satisfy their Medicaid overpayment liabilities. The statute requires a bond equal to three months Medicaid payments to the facility, roughly $700,000. Initially, the bonds could be purchased for about 1% of value and currently cost about 6% to 8% of the value. Many nursing homes are having financial difficulty obtaining the bonds. Chapter 2002-400, Laws of Florida, amended the law to allow continuing care retirement communities and nonprofit nursing homes to meet the bond requirements by payment of a nonrefundable fee, paid at initial licensure, paid at the time of any subsequent change of ownership, and paid at the time of any subsequent annual license renewal, in the amount of 2% of the total of three months Medicaid payments to the facility computed on the basis of the preceding 12-month average Medicaid payments to the facility. The fee is deposited into the Health Care Trust Fund and accounted for separately as a Medicaid nursing home overpayment account. These fees are used at the sole discretion of the Agency to repay nursing home Medicaid overpayments. Payment of this fee does not release the operator from any liability for any Medicaid overpayments nor does it bar the Agency from

seeking to recoup overpayments from the operator and any other liable party. The money remains in the fund to protect the state's interest in recovering overpayments. This, in essence, creates a self-insurance pool for Medicaid overpayment liabilities. Current law repeals this language on June 30, 2003.

Nursing Home Staffing Levels

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. The task force heard public testimony and research findings in its deliberations; and although consensus was not reached, recommendations were drafted as a staff report of information discussed by and presented to the task force. Much of the staff report served as a basis for Chapter 2001-45, L.O.F., (Senate Bill 1202). 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.

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. Additional Medicaid funding for reimbursement of the increased staffing was authorized for each year. Staffing was also enhanced by increased training and documentation requirements in nursing homes.

Third Party Liability

Third party liability (TPL) refers to the legal obligation of third parties, i.e., certain individuals, entities, or programs, to pay all or part of the expenditures for medical assistance furnished under a State plan. The Medicaid program by law is intended to be the payer of last resort; that is, all other available third party resources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid. Examples of third parties which may be liable to pay for services include employment-related health insurance, court-ordered health insurance derived by noncustodial parents, workers' compensation, longterm care insurance, and other state and federal programs (unless specifically excluded by Federal statute).

The Medicaid program is responsible for billing insurance companies for services paid by Medicaid for which the insurance company may have been liable. Many insurance companies contract their claims processing functions to either Third Party Administrators (TPA) or Pharmacy Benefit Managers (PBM). Many TPAs and PBMs claim they are not "third parties", and therefore are exempt from federally required data matching and billing. The Neurological Injury Compensation Association (NICA) has argued that through the litigation process that they are not a "third-party benefit" and are therefore secondary to Medicaid for payment of medical services.

The Medicaid Program

Medicaid is a medical assistance program that pays for health care for persons who are poor or disabled. The federal government, the state, and the counties jointly fund the program. The federal government, through law and regulations, has established extensive requirements for the Medicaid Program. The Agency for Health Care Administration (AHCA) is the single state agency responsible for the Florida Medicaid Program. The Department of Children and Family Services is responsible for determining Medicaid eligibility and managing Medicaid eligibility policy, with approval of any changes by AHCA.

The statutory provisions for the Medicaid Program appear in ss. 409.901 through 409.9205, F.S. Section 409.903, F.S., specifies categories of individuals who are required by federal law to be covered, if determined eligible, by the Medicaid Program (mandatory coverage groups). Section 409.904, F.S., specifies categories of individuals that the federal government gives state Medicaid programs the choice of covering (optional coverage groups). Sections 409.905 and 409.906, F.S., specify the medical and other services the state may provide under the state Medicaid plan.

Medicaid is an entitlement program. Federal laws and regulations require states to make all Medicaid services available to all categorically eligible recipients regardless of diagnosis. If the Medicaid recipient is a child, however, Medicaid is required to provide additional services (which may not be available to adult Medicaid recipients) to treat an illness identified through health screening.

Medically Needy Program

Section 409.904, F.S., specifies categories of individuals that the federal government gives state Medicaid Programs the choice of covering (optional coverage groups). The Medically Needy program is an optional program under Medicaid that primarily 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, but to be eligible for Medicaid payment, 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. A person eligible for the Medically Needy Program is eligible for all Medicaid services with the exception of services in a skilled nursing facility or an intermediate care facility for the developmentally disabled, and home and community-based services.

About two-thirds of the individuals eligible for the Medically Needy program are in the Temporary Assistance for Needy Families (TANF)-related group. The TANF-related group is primarily families with higher incomes who have undergone an illness or injury with substantial medical cost that would reduce their incomes to the income standard. For example, a family of four would have to incur medical bills that, if deducted from their income, would reduce their income to $364 per month. The income eligibility standard of $364 per month for a family of four is about one-fifth of the 2003 federal poverty level of $1,534 per month for a family of four.

The Supplemental Security Income (SSI) related group is usually without Medicare or other forms of insurance and primarily receives services for critical needs relating to AIDS, cancer, organ transplants, and other catastrophic illness. These individuals must incur medical bills that, if deducted from their income, would reduce their income to $180 per month for an individual or $241 per month for a family of two. This monthly income standard is about one-fourth of the 2003 federal poverty level for an individual ($749 per month) for a family of two ($1,010 per month).

Eligibility is determined based on medical and pharmacy bills presented to the Department of Children and Family Services. Once determined eligible, the state reimburses providers based on the current Medicaid reimbursement rates. Individuals may not actually "spend-down" to the income standards in order to qualify for the program. Bills incurred before the first day of eligibility and used to meet spend-down are never paid by Medicaid; it is only those bills incurred on the first day of eligibility for which Medicaid may have paid all of the expense.

The Medically Needy program for adults was eliminated, effective July 1, 2002, in the 2001 Special Session 'C" (Chapter 2001-377, Laws of Florida). Subsequently, it was restored in the 2002 Special Session "E" (Chapter 2002-400, Laws of Florida) with non-recurring funds. The law revised program policy effective May 1, 2003 to disregard an additional $270 monthly income for pregnant women, children, aged, blind and disabled (this has the effect of raising the Medically Needy spend-down income level for an individual to $450; current level is $180 for an individual) and prohibits Medicaid reimbursement for expenses used to meet the spend-down liability. The 2003 Legislature delayed the May 1, 2003 policy changes to July 1, 2003 and provided an appropriation for the months of May and June, 2003 (Chapter 2003-9, Laws of Florida). Non-recurring funds were used in FY 2002-03 to restore the program and were automatically deducted from the FY 2003-04 start–up budget. Therefore, the 2003 Legislature would have to specifically appropriate funds in FY 2003-04 in order to continue the program.

Optional Adult Dental, Visual and Hearing Services

Effective July 1, 2002, adult dental services included the following services provided by licensed, Medicaid participating dentists for services provided to recipients age 21 and older.

- Medically necessary emergency dental procedures to alleviate pain or infection.
- Emergency oral exam, necessary x-rays, extractions, incision and drainage of an abscess.

Prior to July 1, 2002, Medicaid covered complete dentures and the reline and repair of dentures and extractions and surgery necessary to prepare the mouth for complete dentures, diagnostic examinations and radiographs necessary for dentures and one oral prophylaxis (cleaning) per year. Dentures were limited to one set of complete dentures for the life of the recipient.

Medicaid covers hearing services rendered by licensed, Medicaid participating otolaryngologists, otologists, audiologists, and hearing aid specialists. Hearing services include cochlear implants, diagnostic testing, hearing aids, hearing aid evaluations, hearing aid fitting and dispensing, and hearing aid repairs and accessories. Medicaid does not pay for routine maintenance, batteries, cord or wire replacement, or cleaning. Beneficiaries are required to pay a 5 percent coinsurance for hearing aids/dispensing.

Medicaid covers visual services rendered by licensed, Medicaid participating ophthalmologists, optometrists, and opticians. Medicaid reimbursable services include eyeglasses, eyeglass repairs, prosthetic eyes, and contact lenses.

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Prescribed Drugs

A provider of prescribed drugs is reimbursed the least of the amount billed by the provider, the provider's usual and customary charge, or the Medicaid maximum allowable fee established by the agency, plus a dispensing fee. The agency is directed to implement a variable dispensing fee for payments for prescribed medicines while ensuring continued access for Medicaid recipients. The variable dispensing fee may be based upon, but not limited to, either or both the volume of prescriptions dispensed by a specific pharmacy provider, the volume of prescriptions dispensed to an individual recipient, and dispensing of preferred-drug-list products. The agency is directed to increase the pharmacy dispensing fee authorized by statute and in the annual General Appropriations Act by $0.50 for the dispensing of a Medicaid preferred-drug-list product and reduce the pharmacy dispensing fee by $0.50 for the dispensing of a Medicaid product that is not included on the preferred-drug list. The agency is authorized to limit reimbursement for prescribed medicine in order to comply with any limitations or directions provided for in the General Appropriations Act, which may include implementing a prospective or concurrent utilization review program.

Medicaid Co-Payments

Section 409.9081, F.S., requires the Agency for Health Care Administration, subject to federal regulations and any directions or limitations provided in the General Appropriations Act, to require copayments for the following services: hospital outpatient, physician, hospital inpatient, laboratory and X-ray services, transportation services, home health care services, community mental health services, rural health services, federally qualified health clinic services, and nurse practitioner services. The Agency may only establish copayments for prescribed drugs or for any other federally authorized service if such copayment is specifically provided in the General Appropriations Act or other law. Certain Medicaid recipients, as specified in s. 409.9081(3), F.S., are exempt from paying a copayment.

Disproportionate Share Hospital Programs

There are currently seven separate Medicaid disproportionate share hospital programs operated in Florida by the Agency for Health Care Administration. They are the Regular program established in s. 409.911, F.S.; the Regional Perinatal Intensive Care Center (RPICC) program established in s. 409.9112, F.S.; the Teaching Hospital(GME) 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.; the Specialty Hospital program established in s. 409.9118, F.S.; and the Specialty Hospitals for Children established in s. 409.9119, F.S. These programs provide special payments to hospitals that serve a large portion of Medicaid and uninsured patients. These disproportionate share hospital programs are essential to maintaining the health care safety net for vulnerable populations.

Provider Service Networks

Florida law mandates that Medicaid recipients (low- income family and child recipients and SSI recipients without Medicare) eligible for managed care must enroll with a MediPass provider, in a Medicaid health maintenance organization (HMO), Provider Service Network (PSN), or the Children's Medical Services (CMS) Network. Eligible recipients are given 30 days from the date that Medicaid eligibility begins to select a managed care option. If recipients do not select MediPass, an HMO, a PSN, or the CMS Network, AHCA assigns them to MediPass, an HMO, or a PSN.

A PSN is an integrated health care delivery system owned and operated by Florida hospitals and physician groups. The PSN is a Medicaid managed care option for Medicaid recipients in Miami-Dade and Broward Counties, along with HMOs, MediPass, and the CMS Network. The South Florida Community Care Network (SFCCN) PSN is composed of the Public Health Trust of Miami-Dade County (PHT), Memorial Healthcare System (MHS), and the North Broward Hospital District (NBHD). The PSN is paid a monthly administrative allocation payment for the management of its enrollees. PSN primary care providers are paid a monthly case management fee of $3. Providers rendering services to PSN enrollees are reimbursed on a fee-for-service basis.

Managed Care Mandatory Assignment

The current law provides that Medicaid recipients who are already enrolled in a managed care plan or MediPass shall be offered the opportunity to change managed care plans or MediPass providers on a staggered basis, as defined by the Agency. Section 409.9122, F.S., governs Medicaid enrollment procedures. Recipients are allowed to choose between a managed care plan and a MediPass provider at the time of enrollment, with certain exceptions. Recipients have 90 days in which to make a choice of managed care plans or MediPass providers. MediPass is a case management program in which physician case managers receive a monthly fee for overseeing and referring their enrollees for appropriate care. Each physician is paid a monthly $3 fee for each recipient. Paragraph (f) of s. 409.9122, F.S., allows for the diversion of recipients who fail to choose a managed care plan or MediPass provider to managed care plans until an enrollment of 45 percent in MediPass and 55 percent in managed care plans is achieved.

Medicaid Prescribed Drug Spending Controls

Section 409.912, F.S., provides requirements for cost-effective purchasing of services under the Medicaid program. The section requires that the agency purchase goods and services in the most cost-effective manner consistent with the delivery of quality medical care. The Agency is authorized to establish prior authorization requirements for certain populations and certain drugs. The Pharmaceutical and Therapeutics Committee is responsible for making recommendations to

the Agency on drugs for which prior authorization is required. The Medicaid program is mandated to implement a prescribed-drug spending-control program that includes various components. The Agency is required to submit a report to the Governor and Legislature by January 15 of each year on the progress made in implementing cost-containment measures and their effect on Medicaid prescribed-drug expenditures.

Section 409.912 (38), F.S., requires the agency to implement a Medicaid prescribed-drug spending-control program that includes various components. One of those components is a preferred drug formulary, and the Agency is authorized to negotiate supplemental rebates from manufacturers that are in addition to those required by Title XIX of the Social Security Act and at no less than 10 percent of the average manufacturer price as defined in 42 U.S.C. s. 1936 on the last day of a quarter unless the federal or supplemental rebate, or both, equals or exceeds 25 percent. There is no upper limit on the supplemental rebates the Agency may negotiate. The Agency may determine that specific products, brand-name or generic, are competitive at lower rebate percentages. Agreement to pay the minimum supplemental rebate percentage will guarantee a manufacturer that the Medicaid Pharmaceutical and Therapeutics Committee will consider a product for inclusion on the preferred drug formulary. However, a pharmaceutical manufacturer is not guaranteed placement on the formulary by simply paying the minimum supplemental rebate. Agency decisions will be made on the clinical efficacy of a drug and recommendations of the Medicaid Pharmaceutical and Therapeutics Committee, as well as the price of competing products minus federal and state rebates. The Agency is authorized to contract with an outside agency or contractor to conduct negotiations for supplemental rebates. For the purposes of this section, the term "supplemental rebates" may include, at the Agency's discretion, cash rebates and other program benefits that offset a Medicaid expenditure. Such other program benefits may include, but are not limited to, disease management programs, drug product donation programs, drug utilization control programs, prescriber and beneficiary counseling and education, fraud and abuse initiatives, and other services or administrative investments with guaranteed savings to the Medicaid program in the same year the rebate reduction is included in the General Appropriations Act. The agency is authorized to seek any federal waivers to implement this initiative.

KidCare Program

Florida's KidCare program was created by the 1998 Legislature to make affordable health insurance available to low and moderate income Florida children. KidCare is an "umbrella" program that currently includes the following four components: Medicaid for children; Medikids; Florida Healthy Kids; and Children's Medical Services (CMS) Network, which includes a behavioral health component. The KidCare program outlined in ss. 409.810 through 409.821, F.S., is designed to maximize coverage for eligible children and federal funding participation for Florida, while avoiding the creation of an additional entitlement program under Medicaid. Eligibility for the program is outlined in s. 409.814, F.S., and health benefits coverage is outlined in s. 409.815, F.S. The KidCare Coordinating Council, located in the Department of Health, is charged with responsibility for making recommendations concerning the implementation and operation of the program.

The Florida Healthy Kids program component of KidCare is administered by the non-profit Florida Healthy Kids Corporation (FHKC), established in s. 624.91, F.S. The Florida's Healthy

Kids program existed prior to the implementation of the federal Title XXI State Child Health Insurance Program. Florida was one of three states to have the benefit package of an existing child health insurance program grandfathered as part of the Balanced Budget Act of 1997, which created the federal State Child Health Insurance Program. The Healthy Kids Corporation contracts with a fiscal agent to perform initial eligibility screening for the program and final eligibility determination for children who are not Medicaid eligible. The fiscal agent refers children who appear to be eligible for Medicaid to the Department of Children and Family Services (DCF) for Medicaid eligibility determination and refers children who appear to have a special health care need to Children's Medical Services for evaluation. The Healthy Kids Corporation fiscal agent generates bills for co-payments for those participants who are required to pay a portion of the premium for their coverage.

Medikids uses the Medicaid infrastructure, offering the same provider choices and package of benefits. Healthy Kids contracts with managed care plans throughout the state. All applicants for Florida KidCare complete one simplified application. Pursuant to federal law, each application is screened for the child's eligibility for Title XIX Medicaid. If eligible, the child is enrolled immediately into that program. If not eligible, the application is processed for Title XXI and, if eligible, the child is enrolled into the appropriate KidCare component. With the exception of the Medicaid component, the Florida KidCare program is not an entitlement.

III. Effect of Proposed Changes:

Section 1. Amends s. 400.179 (5), F.S., related to transfer of ownership of a nursing facility and liability for overpayments, to remove the June 30, 2003 repealer so that the lease bond alternative may continue to be available.

Section 2. Amends s. 400.23 (3)(a), F.S., to delay the minimum certified nursing assistant staffing requirements of 2.9 hours of direct care per resident per day to July 1, 2004 (previously January 1, 2004).

Section 3. Amends s. 409.901 (25), F.S., to revise the definition, for Medicaid purposes, of "third-party" to include a third party administrator or a pharmacy benefits manager.

Section 4. Amends s. 409.904 (2), F.S., related to the Medically Needy Program to delete language that effective July 1, 2003 prohibits Medicaid from reimbursing expenses to meet spend down liability and provides an additional monthly income disregard of $270 for certain individuals.

Section 5. Amends s. 409.906, F.S., to eliminate Medicaid coverage for Adult Dental, Visual and Hearing services.

Section 6. Amends ss. 409.908 (14) and (20), F.S., to authorize a supplemental pharmaceutical dispensing fee to be paid to providers returning unused unit-dose packaged medications to stock and credit the Medicaid program for the ingredient cost of those medications, provided the ingredient costs to be credited exceed the value of the supplemental dispensing fee. Also

conforms a cross reference related to dialysis facility services resulting from changes made in Section 5.

Section 7. Amends s. 409.9081 (1), F.S., to authorize a $15 copayment for Medicaid funded hospital emergency department visits for non-emergency care.

Section 8. Amends s. 409.911, F.S., to revise the formula for allocating payments to hospitals under the disproportionate share program.

Section 9. Amends s. 409.9112, F.S., to revise the formula for allocating payments to hospitals under the disproportionate share program for regional perinatal intensive care centers.

Section 10. Amends s. 409.9116, F.S., to revise the formula for allocating payments to hospitals under the rural disproportionate share and financial assistance programs and requires the Agency to provide to rural hospitals by August 31 of each state fiscal year preliminary estimates of payments to allow for review and correction of errors prior to computation of payments.

Section 11. Amends s. 409.9117, F.S., to revise the formula for allocating payments to hospitals under the primary care disproportionate share program.

Section 12. Repeals s. 409.9119, F.S., related to the disproportionate share program for specialty hospitals for children.

Section 13. Amends ss. 409.912 (3)(d), (38)(a), F.S., and creates (41), F.S., to remove the limit on the number of provider service networks, to require the prescriber (not the long-term care pharmacy) to request an exception to the limit of four-brand drugs for nursing home residents and other institutionalized adults, and prohibits value-added agreements with pharmaceutical manufacturers as a substitution for supplemental rebates effective July 1, 2003. Requires the Agency to develop and implement a utilization management and prior authorization program for children targeted at the management of occupational, physical, respiratory and speech therapies. Authorizes the Agency to submit a federal waiver or state plan amendment to operate the program. Provides for a competitive procurement of these services from an outside vendor on a regional or statewide basis.

Section 14. Amends ss. 409.9122 (2)(f) and (k), F.S., to change the assignment of Medicaid recipients subject to mandatory assignment who fail to make a choice to a goal of 60 percent in managed care and 40 percent in MediPass (current law requires a ratio of 55/45 respectively).

Section 15. Amends s. 409.815 (2)(q), F.S., to limit dental benefits to a maximum benefit of $500 per enrollee per year in the Florida Healthy Kids program.

Section 16. Provides that a permanent change made by another law in the 2003 Regular Session of the Legislature to any of the same statutes amended by this bill be given equal precedence to the provision in this bill.

Section 17. Provides an effective date of July 1, 2003, except as otherwise provided.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Elimination of dental, visual and hearing services for adults in Medicaid will decrease revenues to these providers. Families will be required to pay an additional $5 per family per month premium (from $15 to $20) in the KidCare program. The elimination of value-added programs in lieu of supplemental rebates may impact disease case managers outposted at hospitals. Pharmaceutical manufacturers currently enrolled in value-added programs would have to pay supplemental rebates if they did not want their drugs subject to prior authorization.

C. Government Sector Impact:

The proposed Senate Budget for FY 2003-04 includes the following fiscal changes that require statutory change.

SUMMARY

	FY 2003-04	FY 2004-05
RECURRING EXPENDITURES		
Medically Needy Program		
General Revenue	$162,965,943	$162,965,943
Grants & Donations Trust Fund	$51,848,174	$51,848,174
Medical Care Trust Fund	$233,980,747	$233,980,747
Total	$448,794,864	$448,794,864
Third Party Liability (TPA and PBM)		
General Revenue	($1,587,413)	($1,587,413)
Medical Care Trust Fund	$1,587,413	$1,587,413
Total	$0	$0
LTC Pharmacy 4-Brand Prior Authorization		
General Revenue	($3,227,916)	($3,227,916)
Grants & Donations Trust Fund	($2,625,000)	($2,625,000)
Medical Care Trust Fund	($4,629,718)	($4,629,718)
Refugee Assistance Trust Fund	($17,366)	($17,366)
Total	($10,500,000)	($10,500,000)
Restocking of Nursing Home Pharmaceuticals		
General Revenue	($1,483,045)	($1,483,045)
Medical Care Trust Fund	($2,127,094)	($2,127,094)
Total	($3,610,139)	($3,610,139)
Increase Managed Care Enrollment (60% HMO)		
General Revenue	($3,983,667)	($3,983,667)
Grants & Donations Trust Fund	($1,860,441)	($1,860,441)
Medical Care Trust Fund	($5,737,299)	($5,737,299)
Refugee Assistance Trust Fund	($109,118)	($109,118)
Total	($11,690,525)	($11,690,525)
Limit Florida Healthy Kids Dental Benefits		
General Revenue	($6,127,212)	($6,127,212)
Medical Care Trust Fund	($12,625,950)	($12,625,950)
Total	($18,753,162)	($18,753,162)
Co-Payments for Emergency Room Use		
General Revenue	($9,988,731)	($9,988,731)
Medical Care Trust Fund	($14,273,428)	($14,273,428)
Refugee Assistance Trust Fund	($73,006)	($73,006)
Total	($24,335,165)	($24,335,165)

Delay Nursing Home Staffing Increases		
General Revenue	($11,998,411)	
Medical Care Trust Fund	($17,209,016)	
Total	($29,207,427)	
Eliminate Value-Added Contracts		
General Revenue	($7,887,360)	($7,887,360)
Grants & Donations Trust Fund	($8,628,332)	($8,628,332)
Administrative Trust Fund	($8,628,332)	($8,628,332)
Medical Care Trust Fund	($11,312,640)	($11,312,640)
Total	($36,456,664)	($36,456,664)
Utilization Management of Therapies		
General Revenue	($4,393,739)	($4,393,739)
Medical Care Trust Fund	($6,301,828)	($6,301,828)
Total	($10,695,567)	($10,695,567)
TOTAL EXPENDITURES		
General Revenue	$112,288,449	$124,286,860
Grants & Donations Trust Fund	$38,734,401	$38,734,401
Administrative Trust Fund	($8,628,332)	($8,628,332)
Medical Care Trust Fund	$161,351,187	$178,560,203
Refugee Assistance Trust Fund	($199,490)	($199,490)
Total	$303,546,215	$332,753,642

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Amendments:

#1 by Appropriations – Technical title amendment amending s. 409.815, F.S., related to a maximum annual dental benefit for children under the KidCare program.