HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: H0035A Health Care
SPONSOR(S): Green
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Appropriations		Speir	Hansen
2)			
3)			
4)			
5)			

SUMMARY ANALYSIS

This bill makes a number of changes to the Medicaid Program. These statutory changes implement Medicaid Program funding decisions included in the House General Appropriations Act. Specifically, the bill does the following:

- Eliminates the sunset date on the two-percent reserve fund that serves as an alternative to the nursing home lease bond requirement.
- Continues the Medically Needy Program in its current form.
- Makes the Agency for Health Care Administration (AHCA) responsible for contracting for health care services for Florida Healthy Kids members.
- Adds items to the definition of third-party and third-party benefit.
- Amends disproportionate share language to conform to the budget.
- Provides full Medicaid dental benefits to individuals age 65 and older.
- Requires an emergency room copayment for nonemergency visits.
- Requires a five-percent prescription drug coinsurance on purchases capped at $15.
- Removes sunset on provider service networks.
- Allows AHCA to contract with dental organizations of a prepaid or fixed sum basis.
- Requires AHCA to assign all undecided Medicaid enrollees to a managed care plan.
- Outsources the Medicaid Program Integrity investigations.
- Implements a Medicaid home and community-based waiver for persons with Alzheimer's disease.
- Increases Medicaid spending by over $371 million (more than $111 million in state funds).

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. DOES THE BILL:

1. Reduce government?	Yes[]	No[]	N/A[]
2. Lower taxes?	Yes[]	No[]	N/A[]
3. Expand individual freedom?	Yes[]	No[]	N/A[]
4. Increase personal responsibility?	Yes[]	No[]	N/A[]
5. Empower families?	Yes[]	No[]	N/A[]

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

B. EFFECT OF PROPOSED CHANGES:

Alternative to Nursing Home Lease Bond Requirement

The Legislature in Special Session 2002 “E” added language to section 400.179(5)(d)2, F.S., to provide an alternative to the nursing home lease bond requirement because many nursing homes had been unable to obtain the necessary lease bond. The added language contained a sunset date of June 30, 2003, on the 2-percent reserve fund that serves as an alternative to the nursing home lease bond requirement contained in the same section. More than 200 nursing facilities are using this arrangement to meet their lease bond requirement. Without continuation of this provision, hundreds of nursing facilities may be unable to continue to participate in the Medicaid nursing home program, substantially harm beneficiary access to the Medicaid budgeted nursing home service, and diminish Medicaid’s ability to recover Medicaid funds from nursing facilities for overpayments. This bill eliminates the sunset language.

Medically Needy

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. To be eligible for Medicaid to pay for care, however, 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.

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) or for a family of two ($1010 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 do not actually “spend down” to the above income standards in order to qualify for the program.

The Medically Needy Program was changed effective May 1, 2003, in the 2002 Special Session “E” to require a true spend down to $450 of income before the Medicaid Program would begin providing benefits. The Legislature in the 2003 Session changed the effective date of the true spend down to July 1, 2003. This bill amends section 409.904, F.S., to avoid implementation of the true spend down.

Florida KidCare Reorganization

Florida's KidCare Program is an umbrella program that currently includes the following four components: Medicaid for children; Medikids; Florida Healthy Kids; and the Children's Medical Services Network, which includes a behavioral health component.

The Florida Healthy Kids component of KidCare is administered by the non-profit Florida Healthy Kids Corporation, established in s. 624.91, F.S. The Healthy Kids program existed prior to the implementation of the federal Title XXI child health insurance program.

The Healthy Kids Program operates with a combination of local, state, federal, and family contributions. Healthy Kids has required counties to contribute funds to support the health insurance subsidy for families since 1993. The original concept of the program was that state monies were to be considered seed funds, which would eventually be supplanted entirely by local funds. Early Healthy Kids contracts for local programs required counties in which the program operated to develop a plan to gradually increase county matching contributions from a base amount of five percent of total program costs, with a goal of eventually funding local program operations 100 percent from local funds.

Congress, in response to concerns about the millions of uninsured children in the nation, allotted approximately $40 billion over 10 years to help states expand health insurance coverage to children through the Balanced Budget Act of 1997. The act, which created Title XXI of the Social Security Act, allows states to expand coverage for children through expanding the existing Medicaid program or creating or expanding a separate program specific to the children's initiative.

The federal Title XXI program allowed Florida to access an enhanced federal match rate of 69 percent. The 1998 Legislature authorized implementation of KidCare, and modified operations of the Healthy Kids Program to expand the program statewide, and alignment of its operations with the requirements of Title XXI to use Healthy Kids funding to gain the enhanced federal match.

At the time of implementation of Florida's Title XXI expansion of Healthy Kids, approximately $7,000,000 in local matching funds were committed to the program. Restrictions on provider donations for Title XXI required the Healthy Kids Program to review the sources of local matching funds.

The corporation has operating sites in all 67 counties. As of February 1, 2003, more than 249,000 children were covered through Florida Healthy Kids. The average cost per child per month is $117.33 for health and dental benefits.

Research has determined that these children can receive the same benefits through AHCA contracts at a cost of $96.42 per child per month. This bill changes the KidCare statute to have AHCA contract for Healthy Kids benefits while maintaining administrative duties with the Florida Healthy Kids Corporation. It is estimated that this change will save more than $73.7 million ($24,059,646 in state funds).

When KidCare was created in section 57, ch. 98-288, Laws of Florida, a sunset was built into the KidCare Program. The language states:

> "Sections 409.810 through 409.820, Florida Statutes, as created by this act, are repealed, subject to prior legislative review, on the first July 1 occurring at least 1 year after the effective date of an act of the United States Congress or the federal Health Care Financing Administration which:
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> "(1) Reduces Florida's federal matching rate under Title XXI of the Social Security Act to less than 65 percent federal match; or
>
> "(2) Reduces the federal funds allotted to Florida under Title XXI of the Social Security Act to less than $250 million annually."

The federal funds allotted to Florida under Title XXI of the Social Security Act is now less than $250 million. Section 22 of this bill repeals the sunset language.

Definition of Third-Party and Third-Party Benefit

Federal law requires the Medicaid Program to be the payor of last resort. To comply with this mandate, Florida's Medicaid Program bills insurance companies for services paid by Medicaid in 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," therefore, are exempt from federally required data matching and billing.

The Neurological Injury Compensation Association (NICA) through the litigation process has argued they are not a "third-party benefit" and are, therefore, secondary to Medicaid for payment of medical services.

Florida's duty under federal law is codified in section 409.910(1), Florida Statutes, which states, "It is the intent of the Legislature that Medicaid be the payor of last resort for medically necessary goods and services furnished to Medicaid recipients." Section 409.910(4), Florida Statutes states, "After the agency has provided medical assistance under the Medicaid program it shall seek recovery of reimbursement from third-party benefits to the limit of legal liability and for the full amount of third-party benefits, but not in excess of the amount of medical assistance paid by Medicaid,…"

This bill amends the definition of "third-party" in section 409.901(25), Florida Statutes, to include TPAs and PBMs and amends the definition of "third-party benefit" in section 409.901(26) to include NICA.

Dental 65+

Adult Medicaid recipients receive emergency dental services. This bill proposes to provide full Medicaid benefits to recipients age 65 or older, but no dental benefits to individuals between the ages of 21 and 64. Full Medicaid dental benefits include dentures, the procedures required to seat dentures, the repair and reline of dentures, emergency dental procedures necessary to alleviate pain or infection, and basic dental preventive procedures.

Copayments

This bill amends section 409.9081, Florida Statutes, to add an emergency room copayment and a prescription drug coinsurance requirement. The intent of these copayments is to change the behavior of Medicaid recipients so that they will only use these benefits when they are truly necessary.

The emergency room copayment will be $15 for each use of an emergency room by a Medicaid recipient for nonemergency services. The emergency room physician will determine whether the event is an emergency or not.

Hospitals maintain that the $15 copayment will actually result in a loss of $15 to them because they can not require the recipient to pay the fee. A study of Area 6 by AHCA shows direct costs of emergency departments were $84 per visit in 2001 according to the data submitted by the hospitals, while Medicaid paid $233 per emergency department visit in Fiscal Year 2001-2002.

The prescription drug coinsurance will be 5 percent of the Medicaid cost of the medication. The coinsurance amount will be capped at $15 per medication.

Provider Service Networks

Section 409.912 (3)(d) allows AHCA to contract with "no more than four provider service networks for demonstration projects to test Medicaid direct contracting." These demonstration projects are to sunset after four years. The fourth year is about to expire. This bill amends the statute to allow AHCA to continue contracting with exclusive provider organizations, minority physician networks, and pediatric emergency department diversion programs.

HMO Diversion

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 recipients, 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 or provider service networks until an enrollment of 45 percent in MediPass and 55 percent in managed care plans is achieved.

This bill amends paragraph (f) of subsection (2) of s. 409.9122, F.S., to allow for the diversion of all Medicaid enrollees into managed care plans. AHCA maintains that the managed care plans provide services to recipients at 92 percent of the cost of MediPass.

Alzheimer's Disease Waiver

The ability of a person suffering from dementia to remain at home is dependent on the availability of a capable caregiver. In fact, an analysis of the most frequent services provided to clients with dementia indicates that the most prevalent services are related to caregiver relief and support. In-home and facility respite and adult day care are the major services providing caregiver relief.

However, while $4.8 million was spent last year providing these caregivers relief services to maintain the dementia client in the community, more than $14 million was needed to serve 2,400 dementia clients in assisted living facilities (ALFs). Providing services that delay or prevent the institutionalization of persons afflicted with Alzheimer’s and related dementias is cost-effective and maintains the client in familiar, least restrictive environments as long as possible.

Currently, there is no single program that combines all of the services appropriate for persons with Alzheimer’s disease and their caregivers under one point of entry and supports them with funding. The purpose of this waiver will be to enhance and coordinate community-based support for people with dementia and their caregivers. The waiver will target services that provide caregiver relief, support and training and provide funding support under Medicaid.

The goal is receive a Medicaid home and community-based waiver targeted to persons with Alzheimer's disease that will allow the creation of three pilot projects, composed of 100 eligible clients in three different parts of the state. The location selected would need to allow comparison to a control group of similar clients served through different waivers or programs providing different services. The intent would be to determine if the Alzheimer’s waiver successfully provides a targeted package of services that supports Alzheimer’s clients and caregivers, reduces medical costs, and delays institutional placement. The project would assign new clients to the pilot program and dedicate new revenue to serve additional clients currently on DOEA waiting lists. The estimated cost of the waiver is $5.6 million ($2.3 million in state funds).

C. SECTION DIRECTORY:

Section 1. Effective upon this act becoming a law, subsection (5) of section 400.179, Florida Statutes, is amended to eliminate the sunset of the lease bond alternative for nursing homes. :

Section 2. Section 409.811, Florida Statutes, is amended to add a definition of Florida Healthy Kids and managed care plan.

Section 3. Section 409.813, Florida Statutes, is amended to change a cite reference and reference from Florida Healthy Kids Corporation to Florida Healthy Kids Program.

Section 4. Subsection (7) of section 409.8132, Florida Statutes, is amended to add a clarification reference.

Section 5. Section 403.8133, Florida Statutes, is created to add the Florida Healthy Kids program component to the KidCare statute.

Section 6. Section 409.814, Florida Statutes, is amended to change references as a result of the KidCare reorganization.

Section 7. Section 409.818, Florida Statutes, is amended to change references and clarify changes in the administration of the KidCare program.

Section 8. Subsections (25) and (26) of section 409.901, Florida Statutes, are amended to add third party administrators and pharmacy benefits managers to the definition of third-party, and neurological injury compensation association funds to the definition of third-party benefit.

Section 9. Subsection (2) of section 409.904, Florida Statutes, is amended to continue the current Medically Needy Program.

Section 10. Subsections (1), (12), and (23) of section 409.906, Florida Statutes, are amended to limit adult benefits to recipients age 65 and older, and to limit hearing and vision benefits to children.

Section 11. Subsection (1) of section 409.9081, Florida Statutes, is amended to add an emergency room copayment and prescription drug coinsurance.

Section 12. Section 409.911, Florida Statutes, is amended to conform the disproportionate share language to the budget.

Section 13. Section 409.9112, Florida Statutes, is amended to conform the disproportionate share language to the budget.

Section 14. Section 409.9117, Florida Statutes, is amended to conform the disproportionate share language to the budget.

Section 15. Section 409.9119, Florida Statutes, is amended to conform the disproportionate share language to the budget.

Section 16. Subsection (3) of section 409.912, Florida Statutes, is amended to continue provider service networks, and allow AHCA to contract with dental organizations of a prepaid or fixed sum basis.

Section 17. Subsection (2) of section 409.9122, Florida Statutes, is amended to require AHCA to assign all undecided Medicaid enrollees to a managed care plan.

Section 18. Subsections (8) and (28) of section 409.913, Florida Statutes, are amended to allow AHCA to outsource the Medicaid Program Integrity investigations.

Section 19. Subsections (7), (8), and (9) are added to section 430.502, Florida Statutes, to implement a Medicaid home and community-based waiver targeted to persons with Alzheimer's disease.

Section 20. Section 624.91, Florida Statutes, is amended to remove contracting for recipients health care services from the duties of the Florida Healthy Kids Corporation.

Section 21. Section 624.915, Florida Statutes, is amended to require Florida Healthy Kids Corporation to remit excess operating funds to AHCA.

Section 22. Section 57 of chapter 98-288, Laws of Florida, is repealed.

Section 23. Provides an effective date.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

Medically Needy	
General Revenue	$162,965,943
Medical Care Trust Fund	$285,828,921
Total	$448,794,864
Managed Care Diversion for Undecideds	
General Revenue	($ 3,983,667)
Medical Care Trust Fund	($ 7,706,858)
Total	($11,690,525)
Alzheimer's Disease Waiver	
General Revenue	$2,300,000
Operation & Maintenance Trust Fund	$3,300,195
Total	$5,600,195
KidCare Reorganization	
General Revenue	($19,228,215)
Tobacco Trust Fund	($ 4,831,431)
Medical Care Trust Fund	($49,714,883)
Total	($73,774,529)
Emergency Room Copayment	
General Revenue	($ 9,988,731)
Medical Care Trust Fund	($ 14,346,434)
Total	($ 24,335,165)
Prescription Drug Coinsurance	
General Revenue	($ 22,020,427)
Medical Care Trust Fund	($ 31,583,340)
Total	($ 53,603,767)
Increased Third Party Liability Recoveries	
General Revenue	($ 1,587,413)
Total	($ 1,587,413)
Dental 65+	
General Revenue	$ 3,393,723
Medical Care Trust Fund	$ 4,867,529
Total	$ 8,261,252

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

2. Expenditures:

$7 million in voluntary contributions from to pay for Non-Title XXI children in the Florida Healthy Kids Program.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

There are new fiscal consequences for the private sector. The savings achieved for some services will mean less money for some providers, while overall increased spending will mean increased money for providers.

The copayment and coinsurance requirements will result in out of pocket costs to beneficiaries. They may also result in lost payment for services to the emergency rooms.

D. FISCAL COMMENTS:

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

2. Other:

B. RULE-MAKING AUTHORITY:

C. DRAFTING ISSUES OR OTHER COMMENTS:

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES