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: CS/ SB 1276

SPONSOR: Appropriations Committee and Senator Peaden

SUBJECT: Health Care

DATE: March 25, 2004 REVISED: _____ _____ _____ _____

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			AHS	Withdrawn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

I. Summary:

The bill makes the following changes to health care programs that are required in order to implement the proposed General Appropriations Act for FY 2004-05.

- Provides that certain limitations on the number of authorized positions in the Department of Health do not apply to positions funded by the United States Trust Fund.
- Eliminates the scheduled increase in minimum staffing standards for nursing homes from 2.6 hours to 2.9 hours of direct care per resident per day, effective May 1, 2004.
- Clarifies that a child who has a preexisting condition that prevents coverage under another family member's group health benefit plan or under other employer health insurance coverage, who is otherwise eligible for the KidCare program, is eligible for KidCare coverage when enrollment is possible.
- Allows children with family incomes below 200 percent of the federal poverty level who are not eligible for premium assistance payments under the KidCare program to participate in the program by paying the full cost of the premium.
- Reduces Medicaid coverage of pregnant women from 185 percent to 150 percent of the federal poverty level, effective October 1, 2004.
- Limits the medically needy program for adults to a pharmacy services benefit only, effective January 1, 2005.

- Clarifies a recipient's responsibility for the cost of nursing home care and specifies allowable costs that are to be deducted from income in determining Medicaid eligibility.

- Allows implementation of a comprehensive utilization program that requires prior authorization of all private duty nursing services for children, effective November 1, 2004.

- Requires implementation of a hospitalist program in certain high-volume participating hospitals, effective September 1, 2004.

- Requires implementation of a comprehensive utilization management program for hospital neonatal intensive care stays in certain high-volume Medicaid participating hospitals, effective November 1, 2004.

- Requires that nonemergency transportation services may not be offered to nondisabled recipients if public transportation is generally available in the beneficiary's community, effective January 1, 2005.

- Authorizes implementation of utilization management programs and consolidation of Medicaid home and community-based services programs.

- Requires the community hospice income standard to be equal to 88 percent of the federal poverty level, effective October 1, 2004.

- Makes the LifeSaver Rx prescription drug program for seniors contingent on an appropriation and, in the absence of a state appropriation, authorizes operation of the Silver Saver program.

- Clarifies that licensed, certified, or otherwise qualified providers are not entitled to enrollment in the Medicaid provider network.

- Establishes the Medicaid Disproportionate Share Council for the purpose of studying and making recommendations on the formula for the regular disproportionate share program and alternative financing options, special Medicaid payments, and upper payment limit options.

- Provides for reimbursement to pharmacies at the average wholesale price less 14.25 percent or wholesale acquisition cost plus 5 percent, whichever is less.

- Revises the threshold for supplemental rebates from manufacturers to a minimum of 27 percent.

- Requires implementation of a return and reuse program for drugs dispensed by pharmacies to institutional recipients and includes payment of a $5 restocking fee for operation of the program.

- Requires implementation of a utilization management and prior authorization program for COX-II selective inhibitor products.

- Requires a limitation to one dose per month for any drug prescribed for the purpose of enhancing or enabling sexual performance.

- Allows for the specification of the preferred daily dosing form or strength of certain drugs.
- Allows prior authorization for the off-label use of Medicaid-covered prescribed drugs.
- Authorizes adoption of algorithm-driven treatment protocols for major psychiatric disorders.
- Requires implementation of a Medicaid behavioral health drug management program financed through value-added agreements with pharmaceutical manufacturers that provide guaranteed savings.
- Authorizes implementation of Medicaid fee-for-service provider network controls, including provider credentialing.
- Revises the Medicaid program enrollment goal for managed care to 61 percent managed care and 39 percent MediPass.
- Requires applicants required to enroll in managed care to chose or be assigned to a managed care plan so that enrollment begins on the same day as the eligibility start date, effective January 1, 2005.
- Requires the agency to include in its calculation of the hospital inpatient component of a Medicaid health maintenance organization's capitation rate any special payments, including the upper payment limit or disproportionate share hospital payments made to qualifying hospitals through the fee-for-service program.
- Requires the Department of Elder Affairs to fund, through each area agency on aging in each county defined in s.125.011(1), F.S., more than one community care service system.
- Requires the Department of Elder Affairs to fund, through each area agency on aging in each county as defined in s. 125.011(1), F.S., more than one community care service system that provides case management and other in-home and community services.
- Eliminates state-funded assistance for paying premiums for non-Title XXI eligibles in the Florida Healthy Kids program and requires purchases made by the Florida Healthy Kids Corporation to be made in a manner consistent with delivering accessible medical care.

The bill amends sections 216.341, 400.23, 409.814, 409.903, 409.904, 409.905, 409.906, 409.9065, 409.907, 409.911, 409.912, 409.9122, 430.204, 430.205, and 624.91, Florida Statutes.

II. Present Situation:

County Health Department Trust Funds

Chapter 216.341, F.S., provides that county health department trust funds may be expended by the Department of Health for the respective county health departments in accordance with

budgets and plans agreed upon by the county authorities of each county and the Department of Health. The limitations on appropriations provided in s. 216.262 (1), F.S., do not apply to county health department trust funds. In FY 2003-04, the Legislature adopted this same policy for the Office of Disability Determination but did not include specific statutory language to facilitate this change.

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. Subsequently, Chapter 2003-405, L.O.F., delayed the effective date of the increase to 2.9 hours to May 1, 2004.

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. With the exception of the Medicaid component, the Florida KidCare program is not an entitlement.

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 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.

The KidCare program was amended by the 2004 Legislature through CS for SB 2000 to provide an appropriation in FY 2003-04 to fund 90,280 children on the wait list through January 30, 2004 and to make various policy changes effective July 1, 2004 related to eligibility and access to other health insurance.

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 screenings.

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. Persons eligible must incur medical bills that, if deducted from their income, would reduce their income to $180 per month for an individual.

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.

Medicaid Peer Review Process/ Utilization Review

Certain Medicaid services are subject to utilization review by a Peer Review Organization (PRO) under contract with AHCA. The purpose of the utilization review program is to safeguard against unnecessary and inappropriate medical care rendered to Medicaid recipients. Medical services and records are reviewed for medical necessity, quality of care, appropriateness of place of service and length of stay (inpatient hospital). The following Medicaid services are subject to review by a PRO:

- Inpatient Hospital Services
- Home Health Services
- Community Mental Health Services
- Targeted Case Management
- Home and Community Based Waiver Services for the Developmentally Disabled

The Bureau of Medicaid Program Integrity (MPI) monitors this information on an ongoing basis in an effort to control fraud and abuse. If the staff suspect that there is a problem with a provider's records based on their initial review of the records, they are required to send the records to another physician to review.

Transportation

Medicaid reimburses for transportation services provided by Medicaid-participating ground and air ambulance companies, wheelchair stretcher van providers, taxicab companies, multi-passenger van and bus lines, and public and private organizations. To be reimbursed by Medicaid, transportation must be for the purpose of transporting the recipient to or from a Medicaid-covered service to receive medically-necessary care. Transportation services are available only to eligible recipients who cannot obtain transportation on their own through any available means such as family, friends, or community resources. All transportation must be the most cost-effective and most appropriate method of transportation available to each eligible Medicaid recipient.

Medicaid Waivers

Home and community-based service delivery programs have become a growing part of states' Medicaid long-term care coverage, serving as an alternative to care in institutional settings such as nursing homes. To provide these services, states obtain waivers from certain federal statutory requirements for Medicaid. States often operate multiple waiver programs serving different

population groups, such as the elderly, persons with mental retardation or developmental disabilities, persons with physical disabilities, and children with special care needs.

Hospice
Hospices are regulated under part VI of chapter 400, F.S. Hospices provide a continuum of palliative and supportive care for the terminally ill patient and his or her family. The care may be provided in the patient's home; in a hospice residential unit or other residential setting such as an assisted living facility, adult family care home, or nursing home; or in a freestanding hospice inpatient facility or other inpatient facility such as a hospital or nursing home. Hospices are licensed by the Agency for Health Care Administration and are also subject to certificate-of-need regulation, as a health care facility, under chapter 408, F.S.

LifeSaver Rx Program
The LifeSaver Rx Program was created in Chapter 2003-405, L.O.F., and expands Medicaid eligibility through a federal waiver to provide partial coverage of a prescription-drug-only benefit. This benefit is limited to: 1) residents of the state who are age 65 or older, 2) have net family incomes equal to or below 200 percent of the federal poverty level ($24,240 for a couple), (3) are eligible for Medicare, and (4) who have exhausted pharmacy benefits under Medicare, Medicaid, or any other insurance plan and (5) request to be enrolled in the program.

Eligible individuals with incomes equal to or less than 120 percent of the federal poverty level are to receive a discount of 100 percent for the first $160 worth of copayments that the agency requires on these benefits. For all other prescription drugs received each month, eligible individuals are to receive a discount of 50 percent.

Eligible individuals with incomes of more than 120 percent but not more than 150 percent of the federal poverty level are to receive a discount of 50 percent.

Eligible individuals with incomes of more than 150 percent but not more than 175 percent of the federal poverty level are to receive a discount of 41 percent.

Eligible individuals with incomes of more than 175 percent but not more than 200 percent of the federal poverty are to receive a discount of 37 percent.

The Agency for Health Care Administration submitted a federal waiver to the Centers for Medicare and Medicaid (CMS) in September 2003. CMS is currently reviewing Florida's waiver and determining its impact as a result of the recent passage of the Medicare Prescription Drug Improvement and Modernization Act.

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 40 percent in MediPass and 60 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(40), 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. 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.

Medicaid HMOs
Florida Medicaid contracts with HMOs to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients. Medicaid pays each HMO a monthly capitation fee for managing and providing care to each enrolled recipient. In accordance with certain contractual agreements with Medicaid, the HMO provides a specified, comprehensive package of medical services for this monthly Medicaid fee. Medicaid HMOs are also required to provide quality and benefit enhancements and can provide other expanded benefits. The services provided under contract with each HMO are negotiated with each HMO contractor. However, every HMO plan must include the basic services up to the limits required by fee-for-service Medicaid.

Medicaid Disease Management
In 1997, the Florida Legislature authorized disease management programs and directed AHCA to "select methods for implementing the program that included best practices, prevention strategies, clinical-practice improvement, clinical interventions and protocols, outcomes research, information technology, and other tools." The Florida disease-management initiative has been designed to promote and measure: health outcomes, improved care, reduced inpatient hospitalization, reduced emergency room visits, reduced costs, and better educated providers and patients. AHCA contracts with disease-management organizations to provide disease management services to Medicaid recipients enrolled in the Primary Care Case Management Program (MediPass) who have been diagnosed with diabetes, HIV/AIDS, asthma, hemophilia, congestive heart failure, end stage renal disease, mental illness, or hypertension.

Community Care for the Elderly Program
The Department of Elderly Affairs administers the Community Care for the Elderly (CCE) program under ss. 430.202-430.207, F.S. The purpose of these programs is to assist functionally impaired elderly persons in living dignified and reasonably independent lives in their own homes or in the homes of relatives or caregivers through the development, expansion, reorganization, and coordination of various community-based services. The department is required to fund through each area agency on aging, at least one community care service system the primary purpose of which is the prevention of unnecessary institutionalization of functionally impaired elderly persons through the provision of community-based core services. The department, through the area agency on aging, is also required to fund in each planning and service area at least one community care service system that provides case management and other in-home and community services as needed to help the older person maintain independence and prevent or delay more costly institutional care.

III. Effect of Proposed Changes:

Section 1. Amends s. 216.341, F.S., to provide that certain limitations on the number of authorized positions in the Department of Health do not apply to Office of Disability Determinations positions funded by the United States Trust Fund.

Section 2. Amends s. 400.23, F.S., effective May 1, 2004, to eliminate the scheduled increase in minimum staffing standards for nursing homes from 2.6 hours to 2.9 hours of direct care per resident per day.

Section 3. Amends s. 409.814, F.S., regarding KidCare eligibility, to clarify that a child who is otherwise eligible for KidCare and who has a preexisting condition that prevents coverage under another family member's group health benefit plan or under other employer health insurance coverage which would have disqualified the child for KidCare if the child were able to enroll in the plan, is eligible for KidCare coverage when enrollment is possible. Removes the income eligibility requirement of family income being above 200 percent of the federal poverty level for children that are not eligible for premium assistance payments under the KidCare program and enables them to participate in the program by paying the full cost of the premium.

Section 4. Amends s. 409.903, F.S., regarding mandatory Medicaid eligibility, to clarify that the family income level for mandatory eligibility for pregnant women is at or below 150 percent of the federal poverty level, effective October 1, 2004.

Section 5. Amends s. 409.904, F.S., regarding optional Medicaid eligibility, to provide that children and pregnant women eligible under the medically needy program are eligible to receive the same services as other Medicaid recipients. Effective January 1, 2005, parents or caretaker relatives of children and aged, blind, or disabled persons eligible under the medically needy program are limited to a pharmacy services benefit only. In determining a person's responsibility for the cost of care in a nursing facility, the following amounts must be deducted from their income: the monthly personal allowance for residents as set based on appropriations; the reasonable costs of medically necessary services and supplies that are not reimbursable by the Medicaid program; and the cost of premiums, copayments, coinsurance, and deductibles, for supplemental health insurance. Revises eligibility, effective January 1, 2005, for a child under 1

year of age living in a family with income from between 150 percent and 200 percent of the federal poverty level.

Section 6. Amends s. 409.905, F.S., regarding mandatory Medicaid services, to :

- Require, effective November 1, 2004, implementation of a comprehensive utilization program that requires prior authorization of all private duty nursing services for children. The agency may competitively bid a contract to select a qualified organization to provide services and is authorized to seek a federal waiver to implement this policy.
- Clarify payment of hospitalization services for mental health reasons, subject to federal Medicaid waiver approval.
- Require, effective September 1, 2004, implementation of a hospitalist program in certain high-volume participating hospitals, in select counties or statewide. A hospitalist is required to authorize and manage Medicaid recipients' hospital admissions and lengths of stay. Exempts dually eligible Medicare and Medicaid individuals from this requirement. Physicians and other practitioners with hospital admitting privileges must coordinate and review admissions of Medicaid beneficiaries with the hospitalist. The agency must competitively bid a contract for selection of a qualified organization to provide hospitalist services and may seek a federal waiver to implement this policy.
- Require, effective November 1, 2004, implementation of a comprehensive utilization management program for hospital neonatal intensive care stays in certain high-volume Medicaid participating hospitalist in select counties or statewide and is to replace existing hospital inpatient utilization management programs. Requires lengths of stay for children to be managed and the earliest medically appropriate discharge to the children's home or other less costly treatment settings. The agency may competitively bid a contract for selection of a qualified organization to provide neonatal intensive care utilization management services and may seek a federal waiver to implement this policy.
- Require, effective January 1, 2005, that nonemergency transportation services may not be offered to nondisabled recipients if public transportation is generally available in the beneficiary's community. Provides that Medicaid disability standards are to be adopted by rule. The agency may competitively bid and contract statewide with a vendor on a capitated basis for the provision of nonemergency transportation services and may seek a federal waiver to implement this policy.

Section 7. Amends s. 409.906, F.S., regarding optional Medicaid services, to:

- Authorize consolidation of home and community-based services offered by various Medicaid waiver programs. The agency may seek federal waivers to implement this policy.
- Authorize implementation of utilization management programs for home and community-based service plans, including quantity and duration of services, and ongoing monitoring of service use for participants in the program. The agency may competitively procure a qualified organization to provide utilization management services and may seek a federal waiver to implement this policy.
- Require, effective October 1, 2004, the community hospice income standard to be equal to 88 percent of the federal poverty level.

Section 8. Amends s. 409.9065, F.S., to authorize the agency, in the absence of a state appropriation for the expansion of the LifeSaver Rx program, to continue the pharmaceutical expense assistance program (Silver Saver) that limits eligibility and benefits to Medicaid beneficiaries age 65 and over, have incomes less than or equal to 120 percent of the federal poverty level, are eligible for Medicare, and request to be enrolled in the program. Benefits include Medicaid payment for up to $160 per month for prescription drugs, subject to benefit utilization controls and the following copayments: $2 per generic product, $5 for a product on the Medicaid Preferred Drug List, and $15 for a product that is not on the Preferred Drug List.

Section 9. Amends s. 409.907, F.S., related to Medicaid provider agreements, to clarify that licensed, certified, or otherwise qualified providers are not entitled to enrollment in the Medicaid provider network.

Section 10. Amends s. 409.911, F.S., related to the disproportionate share program, to require the agency to convene a Medicaid Disproportionate Share Council for the purpose of studying and making recommendations on the formula for the regular disproportionate share program and alternative financing options, special Medicaid payments, and the upper payment limit options. The council is to include representatives from the Executive Office of the Governor and the agency, representatives from teaching, public, private nonprofit, private for-profit and family practice teaching hospitals, and representative from other groups as needed. A report of findings and recommendations is to be submitted no later than February 1 of each year.

Section 11. Amends s. 409.912, F.S., related to cost-effective purchasing of health care, to:

- Revise reimbursement to pharmacies at the average wholesale price less 14.25 percent or wholesale acquisition cost plus 5 percent, whichever is less.
- Revise the supplemental rebates from manufacturers to no less that 12 percent of the average manufacturer price on the last day of a quarter unless the federal or supplemental rebate, or both, equals or exceeds 27 percent.
- Require implementation of a return and reuse program for drugs dispensed by pharmacies to institutional recipients, which includes a $5 restocking fee for operation of the program. The program is to be implemented electronically and in a manner that promotes efficiency. Pharmacies are allowed to exclude drugs from the program if they are not practical or cost-effective to be included and must provide for the return to inventory of drugs that cannot be credited or returned in a cost-effective manner. Removes obsolete language related to the establishment of an advisory committee for the purpose of studying a restricted drug formulary for nursing home residents and other institutionalized adults.
- Require implementation of a utilization management and prior authorization program for COX-II selective inhibitor products. Requires evidence-based therapy management guidelines to ensure medical necessity and appropriate prescribing. The agency may seek a federal waiver to implement this policy.
- Require a limitation to one dose per month for any drug prescribed for the purpose of enhancing or enabling sexual performance. The agency may seek a federal waiver to implement this policy.
- Authorize specification of the preferred daily dosing form or strength for the purpose of promoting best practices with regard to the prescribing of certain drugs and ensuring cost effective prescribing practices.

- Authorize prior authorization for the off-label use of Medicaid-covered prescribed drugs. The agency may preauthorize the use of a product for an indication not in the approved labeling. Prior authorization may require prescribing professional to provide information about the rationale and supporting medical evidence for the off-label use of a drug.
- Authorize adoption of algorithm-driven treatment protocols for major psychiatric disorders, including schizophrenia, major depressive disorders, and bipolar disorder for the purpose of improving the quality of care, achieving the best patient outcomes, and ensuring cost-effective management of the use of medications. The medication program is to use evidence-based, consensus medication treatment algorithms, clinical and technical support, patient and family education programs, and uniform documentation of care provided and patient outcomes achieved. The agency is to coordinate with the Department of Children and Families and may seek federal waivers to implement this program.
- Requires implementation of a Medicaid behavioral health drug management program financed through a value-added agreement with pharmaceutical manufacturers that provide financing for program startup and operation costs and guarantee savings. The agency must contract with certain vendors to implement this program in conjunction with the Department of Children and Families. Various criteria are specified that must be included in the behavioral health drug management program. If the agency is unable to negotiate a contract with one or more manufacturers to finance and guarantee savings by July 30, 2004, the four-brand drug limit and preferred drug list prior-authorization requirements are to apply to mental health related drugs.
- Authorize implementation of Medicaid fee-for-service provider network controls, including provider credentialing. Allows the agency to contract for the prescribed drug spending control program including the overall management of the drug program. Specifies a variety of considerations that must be included if a credentialing process is used to limit the network.

Section 12. Amends s. 409.9122, F.S., regarding mandatory Medicaid managed care enrollment, to 39 percent MediPass and 61 percent in managed care plans. Effective January 1, 2005, the agency and the Department of Children and Family Services must ensure that applicants for Medicaid for categories of assistance that require eligible applicants to enroll in managed care plans are to choose or be assigned to a managed care plan prior to an eligibility start date so that enrollment in a managed care plan begins on the same day as the eligibility start date. Medicaid recipients in counties with fewer than two managed care plans accepting enrollees are subject to mandatory assignment until an enrollment of 39 percent in MediPass and 61 percent in managed care is achieved. The agency is required to include in its calculation of the hospital inpatient component of a Medicaid health maintenance organization's capitation rate any special payments, including the upper payment limit or disproportionate share hospital payments made to qualifying hospitals through the fee-for-service program. The agency may seek federal waiver approval to implement this adjustment.

Section 13. Amends s. 430.204, F.S., to require the Department of Elder Affairs to fund, through each area agency on aging in each county defined in s. 125.011(1), F.S., more than one community care service system.

Section 14. Amends s. 430.205, F.S., to require the Department of Elder Affairs to fund, through each area agency on aging in each county as defined in s. 125.011(1), F.S., more than one

community care service system that provides case management and other in-home and community services.

Section 15. Amends s. 624.91, F.S., related to the Florida Healthy Kids Corporation, to eliminate eligibility for state-funded assistance in paying Florida Healthy Kids premiums for non-Title XXI eligibles. Requires purchases to be made in a manner consistent with delivering accessible medical care.

Section 16. Provides an effective date of July 1, 2004, except that this section and section 2 of this act shall take effect May 1, 2004 , or upon becoming a law, whichever occurs later, in which case section 2 of this act shall operate retroactive to May 1, 2004.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

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

B. Public Records/Open Meetings Issues:

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

C. Trust Funds Restrictions:

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

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Providers will be affected by reductions in Medicaid reimbursement, changes in services and eligibility, and other cost containment initiatives.

C. Government Sector Impact:

The proposed Senate Budget for FY 2004-05 includes the following fiscal changes that require statutory change.

Summary of Fiscal Impact

	FY 2004-05	FY 2005-06
Recurring Expenditures		
Section 2		
Eliminate Nursing Home Staffing Increase		
General Revenue	($25,711,338)	($25,711,338)
Trust Fund	($36,846,662)	($36,846,662)
Total	($62,558,000)	($62,558,000)
Section 4		
Reduce Coverage for Pregnant Women from 185% to 150% (10/1/2004)		
General Revenue	($12,789,415)	($17,052,553)
Trust Fund	($18,328,383)	($24,437,844)
Total	($31,117,798)	($41,490,397)
Section 5		
Medically Needy Pharmacy Program Benefit Only (1/1/2005)		
General Revenue	($60,045,734)	($120,091,468)
Trust Fund	($86,050,943)	($172,101,886)
Total	($146,096,677)	($292,193,354)
Uncovered Medical Expenses for Nursing Home Recipients		
General Revenue	$14,430,848	$14,430,848
Trust Fund	$20,706,352	$20,706,352
Total	$35,137,200	$35,137,200
Section 6		
Utilization Management of Private Duty Nursing Services (11/1/2004)		
General Revenue	($3,370,215)	($5,130,322)
Trust Fund	($4,894,785)	($7,417,178)
Total	($8,265,000)	($12,547,500)

	FY 2004-05	FY 2005-06
Establish Hospitalist Program (9/1/2004)		
General Revenue	($1,288,424)	($3,217,899)
Trust Fund	($3,795,332)	($6,560,443)
Total	($5,083,756)	($9,778,342)
Utilization Review of Neonatal Intensive Care Unit (NICU) Services (11/1/2004)		
General Revenue	($500,598)	($975,897)
Trust Fund	($782,366)	($1,248,549)
Total	($1,282,964)	($2,224,446)
Eliminate Non-Emergency Transportation Services for Non-Disabled Beneficiaries (1/1/2005)		
General Revenue	($3,602,311)	($7,204,622)
Trust Fund	($5,166,689)	($10,333,378)
Total	($8,769,000)	($17,538,000)
Section 7		
Consolidate Home and Community Based Waiver Services		
General Revenue	($721,287)	($721,287)
Trust Fund	($6,136,681)	($6,136,681)
Total	($6,857,968)	($6,857,968)
Utilization Review of Home and Community Based Waiver Services		
General Revenue	($721,287)	($721,287)
Trust Fund	($6,490,732)	($6,490,732)
Total	($7,212,019)	($7,212,019)
Eliminate Hospice for Individuals Not Otherwise Eligible (10/1/2004)		
General Revenue	($1,051,749)	($1,402,332)
Trust Fund	($1,507,251)	($2,009,668)
Total	($2,559,000)	($3,412,000)

	FY 2004-05	FY 2005-06
Section 8		
Eliminate LifeSaver Rx Program		
General Revenue	($4,852,265)	($4,852,265)
Trust Fund	($24,553,845)	($24,553,845)
Total	($29,406,110)	($29,406,110)
Section 11		
Pharmacy Ingredient Cost Adjustment		
General Revenue	($17,574,360)	($17,574,360)
Trust Fund	($25,185,640)	($25,185,640)
Total	($42,760,000)	($42,760,000)
Expand Supplemental Drug Rebate Threshold to a Minimum of 27%		
General Revenue	($4,378,336)	($4,378,336)
Trust Fund	$4,378,336	$4,378,336
Total	$0	$0
Pharmacy - COX II Prescribing Algorithm		
General Revenue	($2,215,208)	($2,215,208)
Trust Fund	($4,694,792)	($4,694,792)
Total	($6,910,000)	($6,910,000)
Limit Sexual Enhancing Drugs to One Dose per Month		
General Revenue	($1,604,544)	($1,604,544)
Trust Fund	($2,299,456)	($2,299,456)
Total	($3,904,000)	($3,904,000)
Pharmacy - Decrease Selected Drugs to One Dose per Day		
General Revenue	($2,466,000)	($2,466,000)
Trust Fund	($3,534,000)	($3,534,000)
Total	($6,000,000)	($6,000,000)

	FY 2004-05	FY 2005-06
Prior Authorize Off Label Use of Prescribed Drugs		
General Revenue	($2,877,016)	($2,877,016)
Trust Fund	($4,146,334)	($4,146,334)
Total	($7,023,350)	($7,023,350)
Adopt Best Practice Algorithms for Selected Prescribed Drugs		
General Revenue	($1,605,793)	($1,605,793)
Trust Fund	($2,324,557)	($2,324,557)
Total	($3,930,350)	($3,930,350)
Behavioral Health Drug Management		
General Revenue	($9,504,235)	($9,504,235)
Trust Fund	($20,142,765)	($20,142,765)
Total	($29,647,000)	($29,647,000)
Provider Network Management (1/1/05)		
General Revenue	($5,000,000)	($10,000,000)
Trust Fund	($7,165,450)	($14,330,900)
Total	($12,165,450)	($24,330,900)
Section 12		
Increase Managed Care Enrollment (61% HMO)		
General Revenue	($818,959)	($818,959)
Trust Fund	($1,434,914)	($1,434,914)
Total	($2,253,873)	($2,253,873)
Mandatory Managed Care Enrollment Effective on Date of Medicaid Enrollment (1/1/2005)		
General Revenue	($1,102,919)	($2,205,838)
Trust Fund	($1,580,582)	($3,161,164)
Total	($2,683,501)	($5,367,002)

	FY 2004-05	FY 2005-06
Eliminate Exclusion of Special Hospital Payments from HMO Rate Setting		
General Revenue	$23,155,763	$23,155,763
Trust Fund	$33,184,292	$33,184,292
Total	$56,340,055	$56,340,055
TOTAL ALL		
General Revenue	($126,215,382)	($204,744,948)
Trust Fund	($208,793,179)	($321,122,408)
Total	($335,008,561)	($525,867,356)

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Amendments:

None.