HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1873 PCB HCG 05-01 Medicaid Reform
SPONSOR(S): Health Care General Committee and Harrell
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
Orig. Comm.: Health Care General Committee	7 Y, 3 N	Brown-Barrios	Brown-Barrios
1)			
2)			
3)			
4)			
5)			

SUMMARY ANALYSIS

Under a complex framework of federal and state laws and regulations, Medicaid funds health care services to people who meet certain categorical and income eligibility criteria. These populations are primarily low-income children, certain low-income families, certain disabled persons, and certain low-income elderly.

The Medicaid program funds health care benefits to approximately 2.15 million Floridians annually through a diverse network of approximately 80,000 providers. In the 1990s, Medicaid expenditures represented about 15% of the total state budget. At over $14 billion in FY 2004-05, Medicaid now represents approximately 25% of the state budget. If the current rate of growth continues (approximately 13.5 percent a year), future expenditures in Florida's Medicaid program are projected to exceed $52 billion in ten years. This rate of growth has been characterized as unsustainable. The potential cost and complexities of administering the program has led many, including Florida's Governor, to call for reform.

PCB HCG 05-01 proposes a framework to temper the rate of growth in Medicaid, reduce the complexities of the program, provide greater choices for the recipient, promote a competitive health care market and promote personal responsibility for health care. The bill:

- Provides authority for the Agency for Health Care Administration to seek a waiver to reform Florida's Medicaid program.
- Requires managed care plans to provide wellness or disease management programs for recipients with certain conditions or diseases.
- Requires managed care plans to provide pharmacy benefits.
- Establishes a framework to reward recipients that comply with wellness or disease management plans by depositing funds in Flexible Spending Accounts and Individual Development Accounts to allow recipients to purchase enhanced health benefits.
- Establishes a framework to allow recipients to opt-out of Medicaid and purchase health care coverage through the private insurance market.
- Requires the agency to implement existing provisions of law related to Medicaid fraud and abuse to ensure the integrity of the waiver and provides the agency authority to promulgate rules.

The bill provides a sunset provision that takes effect July 1, 2010 and also requires the agency to seek approval from the Legislative Budget Commission before submitting the waiver application and authority from the Legislature before the agency can implement the waiver.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Promote personal responsibility - The bill establishes a framework for Medicaid recipients to take more responsibility for their wellness and to better manage any disease state they have by providing a reward mechanism for compliance with wellness or disease management plans. The bill also provides greater choices for the recipient in the health care market.

B. EFFECT OF PROPOSED CHANGES:

PCB HCG 05-01 proposes a framework for a Medicaid Reform waiver that allows the Agency for Health Care Administration (agency) to temper the rate of growth in Medicaid, reduce the complexities of the program, provide greater choices for the recipient, promote a competitive health market and promote personal responsibility for health care.

The bill proposes to reduce the rate of growth in Medicaid by establishing an actuarially based risk - adjusted capitation reimbursement method to pay managed care plans for pharmacy benefits at a more predictable rate of growth.

The bill also requires managed care plans to implement wellness or disease management programs. Disease management seeks to improve patient care and health outcomes and to reduce health care costs by concentrating services on chronically ill patients who often receive fragmented care, do not follow treatment and medication regimens, experience a high rate of preventable complications, and have high use of costly services.

The bill establishes a framework for Medicaid recipients to take more responsibility for their wellness and to better manage any disease state they have by providing a reward mechanism for compliance with wellness or disease management plans. It establishes Flexible Spending Accounts and Individual Development Accounts where funds can be deposited and used by recipients for the purchase of enhanced benefits when the recipient complies with the objectives of a wellness or disease management plan.

It allows recipients to choose private market alternatives for health care benefits. Recipients may purchase health benefit coverage through the private insurance market in lieu of a Medicaid plan. It also allows recipients to opt-out of Medicaid and establish health savings accounts.

The bill reduces the agency's burden of administering the complexities of the Medicaid's fee for service system for mandatory and optional services by transferring the operational administration of service delivery to managed care plans.

BACKGROUND

Background

Federal Medicaid Framework

Medicaid was enacted in 1965, in the same legislation that created the Medicare program, under amendments to the Social Security Act (P.L. 89-97). The act created Title XIX of the Social Security Act of 1965. The creation of Medicaid and Medicare replaced two earlier programs of federal grants to States that provided medical care to welfare recipients and the aged.

Medicaid is a means-tested entitlement program. It is jointly financed by federal and state funds. Federal contributions to each state are based on a state's willingness to finance covered medical services and a matching formula. Each state designs and administers its own program under broad

federal rules. The Centers for Medicare and Medicaid Services (CMS), within the U.S. Department of Health and Human Services (HHS), is responsible for Federal oversight of the program.

Federal and State Laws and Regulations

The Medicaid program operates under a very complex and detailed regulatory framework. This frame work includes:

- Title XIX of the Social Security Act
- Code of Federal Regulations 42 CFR 430 - 42 CFR 455
- State Plan – The state plan acts as a contract between the State and the Federal government and contains policies regarding the administration, eligibility, coverage and reimbursement structure of the Medicaid program.
- State Medicaid Directors Letter
- Sections 409.905 - 409.9201, F.S.
- Laws of Florida
- Florida Administrative Code Chapters 59G-1 - Chapters 59G-13
- Medicaid Handbooks
- Policy Transmittals

Florida Medicaid

Florida implemented its Medicaid program on January 1, 1970, to fund medical services for indigent people. Over the years, the Florida Legislature has authorized Medicaid reimbursement for additional services. A major expansion occurred in 1989, when the United States Congress mandated that states provide all Medicaid services allowable under the Social Security Act to children under the age of 21.

The Agency for Health Care Administration

Federal law requires that a state's Medicaid program must be administered by a "single state agency." The Florida Legislature created the Agency for Health Care Administration as part of the Health Care Reform Act of 1992 (Ch. 92-33, Laws of Florida) to reduce administrative costs and improve the state's efficiency in addressing health care issues. The Governor nominates and the Senate confirms the Secretary of the agency.

The Medicaid program is administered primarily by the Florida Agency for Health Care Administration under Chapter 409, Florida Statutes. However, other state agencies have certain responsibilities. For example, the Department of Children and Families determines eligibility; the Department of Legal Affairs, Medicaid Fraud Control Unit prosecutes Medicaid fraud; the Department of Health contracts with and monitors medical providers; and the Department of Elder Affairs (DOEA) has responsibility for determining eligibility for nursing home care and other long-term care programs through its CARES (Comprehensive, Assessment, Review and Evaluation Services) program. DOEA also has responsibility for implementing several home and community based waiver programs designed to keep Medicaid recipients at home in the community instead of more costly nursing homes.

Medicaid Eligibility

Medicaid is a program that is targeted at individuals with low-income, but not all of the poor are eligible, and not all those covered are poor. Medicaid is a means-tested program. To qualify, applicants' income and resources must be within certain limits. The specific income and resource limitations that apply to each eligibility group are set through a combination of Federal parameters and State definitions.

Florida's Medicaid program covers all individuals required by federal law and has expanded eligibility to certain populations deemed particularly vulnerable. The average monthly caseload for FY 2004-05 is estimated to be over 2.15 million persons. The following categorical groups that meet financial eligibility requirements are served by Florida Medicaid:

- Elderly or disabled individuals of low-income who are determined eligible for supplemental security income (SSI) as determined by the Social Security Administration.

- Individuals in single-parent low-income families who meet the AFDC (Aid to Families with Dependent Children) eligibility standards effective in September 1996 or meet Temporary Assistance to Needy Families (TANF) eligibility guidelines.
- Unemployed parents and children under 18, children under 21 in intact families, or children born after 9/83 living with non-relatives, where family income meets AFDC standards.
- Individuals who meet SSI or TANF eligibility after expenses for medical care are deducted. This category is 100% federally funded and covers the first eight months in the U.S. for individuals who generally meet the TANF and SSI eligibility requirements.
- Elderly and disabled individuals with income above the criteria for supplemental security income, but less than 90% of the Federal Poverty Level.
- Elderly and disabled individuals between 90-120% of the Federal Poverty Level, Medicaid covers certain Medicare-related expenses.
- Pregnant women under 100% of the Federal Poverty Level and children age 6 and older in families under 100% of the Federal Poverty Level.
- Children age 1 to 6 under 133% of the Federal Poverty Level; pregnant women and infants less than one year old with incomes less than 185% of the Federal Poverty Level.
- Children born after 10/93 who have not reached age 19 and are under 100% of the Federal Poverty Level.

2005 Poverty Guidelines

Persons in Family Unit	48 Contiguous States and D.C.	Alaska	Hawaii
1	$ 9,570	$11,950	$11,010
2	12,830	16,030	14,760
3	16,090	20,110	18,510
4	19,350	24,190	22,260

Mandatory Services

Title XIX of the Social Security Act allows considerable flexibility within the states' Medicaid plans; however, a state's Medicaid program must offer certain mandatory medical benefits to most categorically needy populations if federal matching funds are to be received. Medicaid is also unable to disqualify eligibles based on pre-existing medical conditions. Mandatory Medicaid benefits include the following:

- Inpatient hospital services.
- Outpatient hospital services.
- Prenatal care.
- Vaccines for children.
- Physician services.
- Nursing facility services for persons aged 21 or older.
- Family planning services and supplies.
- Rural health clinic services.
- Home health care for persons eligible for skilled-nursing services.
- Laboratory and x-ray services.
- Pediatric and family nurse practitioner services.
- Nurse-midwife services.
- Federally qualified health-center (FQHC) services, and ambulatory services of an FQHC that would be available in other settings.

- Early and periodic screening, diagnostic, and treatment (EPSDT) services for children under age 21.

Optional Services

Florida's Medicaid program provides all of the mandatory medical benefits under its state plan but it may also receive federal matching funds to provide certain optional services. The following optional benefits are provided under Florida's Medicaid program:

- Adult Health Screening
- Ambulatory Surgical Centers
- Assistive Care
- Birth Center Services
- Children's Dental Services
- Children's Hearing Services
- Children's Vision Services
- Chiropractic Services
- Community Mental Health
- County Health Department
- Clinic Services
- Dialysis Facility Services
- Durable Medical Equipment
- Early Intervention Services
- Emergency Dental for Adults
- Healthy Start Services
- Home & Community-Based Services
- Hospice Care
- Intermediate Care Facilities/ Developmentally Disabled
- Intermediate Nursing Home Care
- Occupational Therapy
- Optometric Services
- Orthodontia for Children
- Personal Care Services
- Physical Therapy
- Physician Assistant Services
- Podiatry Services
- Prescribed Drugs
- Primary Care Case Management –(MediPass)
- Private Duty Nursing
- Registered Nurse First
- Assistant Services
- Respiratory Therapy
- School-Based Services
- Speech Therapy
- State Mental Hospital Services
- Subacute Inpatient Psychiatric Program for Children
- Targeted Case Management

Disease Management

The Florida Legislature in 1997 directed the Agency for Health Care Administration to implement a disease management initiative for Medicaid clients diagnosed with asthma, diabetes, HIV/AIDS, and hemophilia. The Legislature reduced Medicaid appropriations based on anticipated savings that were to be achieved through this initiative. In Fiscal Years 1998-99 and 2000-01, the Legislature directed the agency to expand the initiative and develop programs for hypertension, cancer, congestive heart failure, end-stage renal disease, and sickle cell anemia. The Legislature made further Medicaid budget reductions based on the additional expected savings.

Florida's disease management initiative delivers services to Medicaid clients enrolled in MediPass using disease management organizations (DMOs), which are private companies that specialize in disease management. These companies provide a range of services to both MediPass clients and providers. DMOs concentrate these services through a care manager who coordinates all aspects of patient care by developing individual care plans, monitoring patient compliance of treatment protocols, and informing physicians of patient progress. DMOs also provide services and educational materials to physicians by sharing best practice guidelines and offering to conduct educational conferences. In addition, DMOs sometimes engage in community outreach by participating in or sponsoring health fairs.

Disease management seeks to improve patient care and health outcomes and to reduce health care costs by concentrating services on chronically ill patients who often receive fragmented care, do not follow treatment and medication regimens, experience a high rate of preventable complications, and have high use of costly services. Disease management offers an integrated approach to treating chronic disease by providing support to patients and physicians. For example, by using a care manager, disease management helps patients follow appropriate treatments, use less expensive outpatient

interventions, and learn how to self-monitor their conditions. Disease management encourages doctors to use best practice guidelines for optimal treatment and enhances communication between patients and caregivers to prevent duplication or gaps in treatment.

Pharmacy Benefits

Florida's Medicaid program provides prescription drug coverage for its fee-for-service beneficiaries. Medicaid reimburses licensed, Medicaid-participating pharmacies. Medicaid covers prescription drugs as well as some over-the-counter medicines on an outpatient basis. In Fiscal Year 2004-05, prescription drug expenditures are expected to exceed $2.5 billion, comprising 18% of total Medicaid spending. Medicaid Pharmacy Services is responsible for managing the drug program for the Medicaid. Over the past three years there have been many new initiatives implemented to reduce the growth in drug expenditures.

Medicaid reimburses for most legend drugs (drugs requiring prescriptions) used in outpatient settings, including injectable drugs, and specific non-legend drugs. Brand name prescriptions are limited to four per month with some exceptions. Generic drugs, insulin and diabetic supplies, contraceptives, mental health drugs, and antiviral drugs used to treat HIV are exempt from these limits. Based on the treatment needs of the Medicaid recipient, the agency may authorize exceptions to the four-brand-name drug restriction. There is no limitation on the number of prescriptions for recipients under the age of 21.

The 2001 Legislature authorized the Agency for Health Care Administration to establish a mandatory preferred drug list and to negotiate supplemental rebates in addition to those required by federal law. In the Medicaid program, preferred drug lists (PDL) indicate which drugs providers are permitted to prescribe without seeking prior authorization (PA). The Florida Medicaid Preferred Drug List (PDL) is a listing of prescription products selected by the Pharmaceutical and Therapeutics Committee as efficacious, safe, and cost effective choices for prescribing to Medicaid patients. For drugs not included on the PDL, providers must obtain approval from the state Medicaid agency (or its contractors) before a particular drug can be dispensed. Decisions about which drugs to include on a PDL are usually based on the Medicaid program's assessment of relative clinical benefit within a therapeutic class and judgment about the value to the state based on total cost, including all manufacturers' rebates. Mental health drugs and anti-retrovirals for HIV are exempt from PDL restrictions.

According to the Agency for Health Care Administration[1]:

- Since FY 96-97, growth in pharmacy services has outpaced spending in other areas.
- Since FY 2001, pharmacy claims have increased by an average of 12% annually.
- Total expenditures for pharmacy services have grown annually by an average of approximately 16%.
- $1.77 billion spent on pharmacy benefits for mandatory populations in FY 2003.
- $529 million spent on pharmacy benefits for optional populations in FY 2003.
- Account for approximately 28% of the pharmacy budget.

On January 1, 2006, all dual eligibles (eligible for Medicare and Medicaid) will transition from Medicaid pharmacy benefits into Medicare. Medicaid matching funds will no longer be available if a dual eligible could enroll in Medicare Part D benefits. The state will continue to pay a portion of the cost for duals through the "clawback" provision. Clawback is a mechanism through which the states will help finance the new Medicare Part D drug benefit. The clawback is a monthly payment made by each state to the federal Medicare program beginning in January 2006. The amount of each state's payment reflects the expenditures of its own funds that the state would make if it continued to pay for outpatient prescription drugs through Medicaid on behalf of dual eligibles.

Service Delivery System for Medicaid Services

[1] Presentation to the Senate Health and Human Services Appropriations Committee, December 15, 2004 by Thomas W. Arnold, Deputy Secretary for Medicaid.

Florida law requires that, to the extent possible, Medicaid recipients enroll in a managed care delivery system. Depending on geographic availability, recipients have several managed care arrangements from which to choose. As of January 2004, over 1.4 million (or 67%) of the state's Medicaid recipients were enrolled in one of these managed care options, including 697,694 recipients enrolled in MediPass, 697,453 in Medicaid health maintenance organizations (HMOs), and 18,144 in provider service networks (PSNs). All other recipients are considered fee-for-service. This group includes dual eligibles (individuals who receive both Medicare and Medicaid), institutionalized and hospice recipients, new recipients, recipients for whom Medicaid is supplemental insurance, and the Medically Needy.

- Medicaid Provider Access System (MediPass). The MediPass system is available statewide and is a primary care case management program. MediPass recipients select or are assigned a primary care physician (PCP) who is responsible for providing primary care and referring patients for specialized services. The state pays PCPs a $3 monthly case management fee for each recipient in addition to fee-for-service reimbursement for each service they provide to recipients. The MediPass program also is currently implementing two pilot projects, Children's Provider Networks (also known as the Pediatric ER Diversion Program) and Minority Physician Networks. These pilot projects target specific utilization and cost concerns related to children and minorities and have the flexibility to develop their own networks and to outsource many administrative functions.

- Medicaid Health Maintenance Organizations (HMOs). Medicaid HMOs, available in 41 of the state's 67 counties, provide medical services to Medicaid recipients on a prepaid basis. For each enrolled recipient, the state pays HMOs a monthly fee that is set at 92% of the expected cost to provide services to equivalent groups of fee-for-service recipients. Besides the approved Medicaid services, HMOs are required to provide additional services, including smoking cessation, pregnancy prevention, and domestic violence intervention services.

- Provider Service Networks (PSNs). PSNs are currently available in only two counties, Broward and Miami-Dade. PSNs provide medical services through an integrated health care delivery system owned and operated by Florida hospitals and physician groups.

Waivers

Waivers are instruments under which the federal Centers for Medicare and Medicaid Services (CMS) allows states to try innovative programs that are cost neutral to the federal government. States may request waivers of certain federal regulations. In general, federal regulations require services to be provided on a statewide basis, comparable across the state, and must be sufficient in amount, duration, and scope to reasonably achieve its purpose. In addition, the recipient must have freedom of choice.

Waivers allow the reform of Medicaid services for certain populations and benefits. For example, Medicaid's home and community–based services waiver program affords states the flexibility to develop and implement creative alternatives to institutionalizing Medicaid-eligible individuals. This waiver program recognizes that many individuals at risk of institutionalization can be cared for in their homes and communities, preserving their independence and ties to family and friends, at a cost no higher than that of institutional care.

Medicaid waivers fall into one of four major categories: 1115, 1915 (b), 1915 (b/c), 1915 (c). Under Florida law [s.409.912 (11), F.S.], the Agency for Health Care Administration may apply for any federal waiver believed necessary to more efficiently or effectively manage the state's Medicaid program; however, the same law specifically requires the Legislature approve the waiver before it can be implemented by the agency.

States may apply to CMS for a section 1915(b) Freedom of Choice waiver, which allows a state to provide services in only specific areas of the state, allows states to provide a subset of services that may not be in the state plan, and allows states to waive freedom of choice requirements. By waiving freedom of choice, this means that individuals are constrained to receive waiver services from select

providers rather than choosing their own provider. The 1915(b) waivers are limited in that they apply to existing Medicaid-eligible beneficiaries; authority under this waiver cannot be used for eligibility expansions to individuals not covered under the traditional Medicaid program.

States may also apply to CMS for a section 1915(c) waiver to provide home and community-based services as an alternative to institutional care in a hospital, nursing home, or intermediate care facility for the mentally retarded. If approved, the waivers allow states to limit the availability of services geographically, to target services to specific populations or medical/disease conditions, or to limit the number of persons served; actions not allowed under Medicaid state plan services. Under a 1915(c) waiver, states determine the types of long-term care services they wish to offer and any provider who is interested and meets application requirements can provide services. Waivers may offer a variety of skilled services to only a few individuals with a particular condition, such as persons with traumatic brain injury, or they may offer only a few unskilled services to a large number of people, such as the aged or disabled.

Section 1115 of the Social Security Act allows states to pursue "an experimental, pilot or demonstration project which, in the judgment of the Secretary of Health and Human Services, is likely to assist in promoting the objectives" of Title XIX. The objectives of the Act are set forth in section 1901, and provide in part that funds are appropriated by the federal government:

> *For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care.*

While 1115 waivers allow states some flexibility regarding coverage eligibility, provider choice, provider reimbursement, managed care and other provisions, states must adhere to certain requirements. For example, any waiver initiative must be budget neutral to the federal government, must contain adequate evaluation components, and must maintain service to specific categories of beneficiaries. Section 1115 waivers are initially approved for 5 years and can be extended for 3 years.

Florida has numerous waivers.

1115	*1915(b)*	*1915(c)*
❖ *Cash and Counseling (Consumer Directed Care)*	*(1) – (4) Managed Care*	❖ *MR/DD (Developmental Disabilities)*
❖ *Pharmacy Plus*	❖ *MSPSI under 21 (Statewide Inpatient Psychiatric Program SIPP)*	❖ *MR/CLSA (Family & Supported Living)*
❖ *Family Planning*	*(4) Non-emergent Transportation*	❖ *Aged and Disabled*
		❖ *Channeling*
		❖ *Nursing Home Diversion*
		❖ *Assisted Living (Assisted Living for the Elderly)*
		❖ *AIDS/ARC (Project Aids Care)*
		❖ *TBI (Traumatic Brain/Spinal Cord Injury)*
		❖ *Spinocerebellar (Model or Katie Beckett*
		❖ *Adult Cystic Fibrosis*

Disproportionate Share Hospital (DSH) Payments

States may make additional payments to qualified hospitals that provide inpatient services to a disproportionate number of Medicaid beneficiaries and/or to other low-income or uninsured persons under what is known as the "disproportionate share hospital" (DSH) adjustment. These funds account for a significant proportion of Medicaid funding in many of Florida's "safety-net" facilities.

Upper Payment Level (UPL) Payments

This supplemental payment mechanism is a complex funding arrangement between the state and the federal government where states are allowed to make special Medicaid payments to compensate certain hospitals and providers to make up the difference between Medicaid and Medicare fees and their usual and customary charges for certain services.

Funding and Cost

For program administration costs, the federal government contributes 50 percent for each state. For medical services, the federal government contributes at a variable rate called the Federal Medical Assistance Percentage (FMAP). A state's FMAP is determined annually by a formula that compares the state's average per capita income level with the national income average. States with a higher per capita income level are reimbursed a smaller share of their costs. By law, the FMAP cannot be lower than 50 percent or higher than 83 percent.

Florida's FMAP is 59 percent, which means that the federal government pays 59 cents of every dollar spent in Florida's Medicaid program. These matching rates provide significant assistance to states in their efforts to provide medical care to low-income individuals; however, if downturns in the economy occur over a long period of time, states may find it difficult to balance their budgets even with this assistance.

Florida's Medicaid expenditures have grown in several distinct surges since its inception in 1970, with the most significant increases over the last 20 years. Florida Medicaid expenditures increased from $795 million in FY 1983-84 to over $12.5 billion in FY 2003-04. Since 1999, Medicaid expenditures have doubled, growing by over 112 percent. Future expenditures in Florida's program are projected to exceed $52 billion in ten years if the current rate of growth continues (approximately 13.5 percent a year).

Why has Medicaid cost increased so much? The factors that have been identified as contributing to the rapid growth of Medicaid are numerous[2]. The more frequently cited factors in the increased cost of Medicaid include:

- Increase in Florida's population. According to the 2000 U.S. Census, Florida's population increased from 12,937,926 in 1990 to 15,982,378 in 2000, a 23.53% increase.
- Increase in the population of very low-income seniors that usually need more prescription drugs and costly long-term care. This area of the Medicaid budget has been growing rapidly as people are living longer and will continue to do so as the "baby-boomer" generation ages, in part because dual-eligibles (eligible for Medicaid and Medicare) tend to be sicker and have higher health care costs than other Medicare recipients.
- Medical inflation has surpassed the yearly growth in state revenues.
- Economic downturns result in more people on Medicaid. When people lose their jobs and employers cut benefits, more people go on Medicaid, which increases state and federal spending on the program.

[2] "Florida's Medicaid Budget: Why are Costs Going Up?", Policy Brief, Winter Park Health Foundation., July, 2004 and the Centers for Disease Control and Prevention http://www.cdc.gov/nccdphp/dnpa/obesity/

- Cost of drugs – Prescription drug costs in Medicaid have increased dramatically and there are more and better medications. In 1995, prescription drug cost represented 10% of the Medicaid budget. In 2005, it represents approximately, 18% of the Medicaid budget.
- Advance in medical technology - Better technology but more cost associated with using the technology.
- Obesity – The Centers for Disease Control and Prevention (CDC) conducted a study that shows that deaths due to poor diet and physical inactivity rose by 33 percent over the last decade. About 2 out of 3 U.S. adults are overweight or obese, according to the CDC. Obesity has serious, long-term consequences. The incidence of type II diabetes has increased in U.S. children in parallel with the rising prevalence of obesity. Hypertension, hypercholesterolemia, heart disease, asthma, mental health concerns (e.g., depression and low self-esteem), and orthopedic disorders have all been linked to obesity. Minorities, individuals with low income, and low levels of education attainment are disproportionately affected by obesity.

Within Medicaid, certain categories of services are growing more rapidly than others. The categories of services that constitute the greatest amount of expenditures can be grouped into four distinct areas. Hospital inpatient services and nursing home care have traditionally been the largest expenditure categories, however this changed just in the last couple of years with prescription drugs expenditures increasing more rapidly than either and actually surpassing both as the single largest expenditure category.

For FY 2004-05, the largest projected expenditures by service category include prescription drugs ($2.6 billion or 17.98% of all expenditures), nursing home care ($2.3 billion or 15.73% of expenditures), hospital inpatient services ($1.76 billion or 11.98% of expenditures), and prepaid health plans/HMOs . ($1.6 billion or 11.03% of expenditures).

Estimated Medicaid Spending by Major Service Category, FY 2004-05

Service	Estimated Annual Spending	Percentage of Medicaid Budget
Prescribed Medicine/Drugs	$2,644,054,895	17.98%
Nursing Home Care	2,314,153,880	15.73%
Hospital Inpatient Services	1,762,289,358	11.98%
Prepaid Health Plans/HMOs	1,622,434,059	11.03%
Home & Community-Based Services	769,697,270	5.23%
Physician Services	754,478,058	5.13%
Special Payments to Hospitals	577,333,410	3.92%
Supplemental Medical Insurance	539,444,228	3.67%
Hospital Outpatient Services	533,443,612	3.63%
Disproportionate Share Hospital Payments	310,917,998	2.11%
Hospice Services	219,702,401	1.49%
Intermediate Care Facility/DD	194,819,297	1.32%
Home Health Services	162,861,286	1.11%
Therapeutic Services for Children	159,329,606	1.08%
Other	2,144,318,352	14.58%
TOTAL	**$14,709,277,810**	**100%**

Source: General Appropriations Act of 2004 and Agency for Health Care Administration.

C. SECTION DIRECTORY:

Section 1. Medicaid Reform

Subsection 1. Waiver Authority – Provides authority for the Agency for Health Care Administration (agency) to seek an experimental pilot or demonstration waiver, pursuant to Section 1115 of the Social Security Act to reform Florida's Medicaid program in urban and rural demonstration sites contingent on federal approval to preserve the upper-payment-limit funding method and the disproportionate share program pursuant to chapter 409, F.S.

Subsection 2. Definitions --Provides definitions.

Subsection 3. Managed Care Plans -- Requires managed care plans to provide disease management programs.

Subsection 4. Pharmacy Benefits -- Requires managed care plans to provide pharmacy benefits.

Subsection 5. Enhanced Benefit Coverage -- Establishes a framework to reward recipients that comply with wellness or disease management plans by depositing funds in Flexible Spending Accounts and Individual Development Accounts to allow recipients to purchase enhanced health benefits.

Subsection 6. Medicaid Opt-Out Option -- Authorizes the agency to provide an opt-out option to recipients in consultation with the Office of Insurance Regulation to allow recipients to purchase insurance from the private insurance market or an employer-sponsored insurer instead of through a Medicaid-certified plan on a voluntary basis with certain conditions.

Subsection 7. Fraud and Abuse – Requires the agency to apply and enforce statutory provisions related to fraud and abuse and to have certification, licensure and credentials, financial solvency, and other protections for Medicaid recipients.
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Subsection 8. Applicability -- Requires the agency to apply and enforce any provision of statutes not in conflict with the provisions of this act and not referenced in this act to ensure the safety, quality, and integrity of the waiver.

Subsection 9. Rulemaking Authority -- Provides authority to the agency to promulgate rules.

Subsection 10. Waiver Application -- Requires the agency to submit the waiver application to the Legislative Budget Commission for approval prior to submitting the waiver application to the Centers for Medicare and Medicaid Services.

Subsection 11. Implementation -- Requires the agency to seek authority from the Legislature to implement the waiver.

Subsection 12. Review and Repeal – Provides a sunset provision for the act that takes effect July 1, 2010.

Section 2. Provides an effective date.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

2. Expenditures:

   Not yet analyzed.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

2. Expenditures:

Not yet analyzed.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The opt-out option as delineated in Section 10 could provide a stimulus for the insurance market.

D. FISCAL COMMENTS:

A section 1115 waiver initiative must be budget neutral to the federal government. As a result, the waiver's cost must be comparable to or less than current Medicaid expenditures in the waiver demonstration sites.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not yet analyzed

2. Other:

B. RULE-MAKING AUTHORITY:

The bill provides authority to the agency to promulgate rules.

C. DRAFTING ISSUES OR OTHER COMMENTS:

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES