HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB1893 PCB FC 05-05 Health Care
SPONSOR(S): Fiscal Council and Negron
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 404

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
Orig. Comm.: Fiscal Council	17 Y, 0 N	Speir	Kelly
1)			
2)			
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5)			

SUMMARY ANALYSIS

PCB FC 05-05 makes a number of changes to the Medicaid Program. These statutory changes are necessary to implement the Medicaid funding decisions included in the Fiscal Council's General Appropriations Act (PCB FC 05-01). Specifically, the bill does the following:

- Delays implementation of a nursing home staffing increase.
- Continues Medicaid coverage for pregnant women below 185 percent of the federal poverty level.
- Continues the Medically Needy Program.
- Revises services for Medicare eligible, non-institutionalized individuals.
- Continues adult denture benefits.
- Repeals the Ron Silver Senior Drug Program.
- Revises provisions relating to long-term care reimbursement.
- Changes the reimbursement paid to pharmacies for ingredient costs.
- Limits adult Medicaid recipients to six prescriptions per month.
- Authorizes implementation of a program of all-inclusive care for certain children.
- Removes the exception to the MediPass/Managed Care assignment ratio.
- Changes the managed care rate setting methodology for infants.
- Limits managed care reimbursement to the amount in the General Appropriations Act.

The bill allows the state to implement $15.9 billion in Medicaid funding, which is a 6.5 percent increase over the current year.

This bill has an effective date of July 1, 2005.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide Limited Government—The bill enables the Medicaid program to provide $15.9 billion in services to 2.3 million recipients.

Promote Personal Responsibility—This bill continues Medicaid services for more than 42,000 Medically Needy Floridians.

B. EFFECT OF PROPOSED CHANGES:

Nursing Home Staffing Increase

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. 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, Laws of Florida. 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 section 400.23, Florida Statutes, 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.

The 2003A Legislature delayed the effective date of the nursing assistant ratio to 2.9 hours until May 1, 2004. The 2004 Legislature delayed the effective date of the nursing assistant ratio to 2.9 hours until July 1, 2005 (chapter 2004-270, Laws of Florida). PCB FC 05-05 would delay the effective date of the increase until July 1, 2006.

Nonrecurring Items

The 2004 Legislature used nonrecurring funds to provide adult dentures to Medicaid recipients, as well as services to Medically Needy recipients and pregnant women with incomes between 150 percent and 185 percent of the federal poverty level. Sunset provisions were placed in statute by chapter 2004-270, Laws of Florida, to reflect the nonrecurring funding of these items.

The Office of Program Policy Analysis and Government Accountability (OPPAGA) was directed to perform a study to determine the cost/benefit to the state of providing these optional Medicaid items. OPPAGA concluded that continuing these items would increase costs, but would benefit recipients and Florida.

Pregnant Women

Pregnant women are an optional eligibility group under Medicaid. Section 409.903(5), Florida Statutes, was amended in chapter 2004-270, Laws of Florida, to eliminate Medicaid eligibility for pregnant women with incomes above 150 percent of the federal poverty level effective July 1, 2005. PCB FC 05-05 removes the repealing language.

Medically Needy

The Medically Needy is an optional eligibility group under Medicaid that primarily consists of individuals who have experienced a catastrophic illness and either have no health insurance, or have exhausted their benefits. The option provides Medicaid coverage for persons who qualify categorically for Medicaid except that their income or assets are greater than the level allowed under other Medicaid eligibility groups. There is no limit to the monthly income an individual can have. To be eligible for Medicaid payment, however, the individual must incur enough medical bills to offset his or her income to the income level that would qualify the individual for Medically Needy eligibility. 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.

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 to qualify for the program.

Section 409.904(2), Florida Statutes, was amended in chapter 2004-270, Laws of Florida, to provide only a prescription drug benefit to the Medically Needy effective July 1, 2005. PCB FC 05-05 repeals this provision.

Adult Dentures

Adult denture services include diagnostic examinations for denture services, radiographs necessary for dentures, extractions and other surgical procedures essential to the preparation of the mouth for dentures, and emergency extractions and abscess treatment to alleviate pain or infection. Chapter 2004-270, Laws of Florida, amended section 409.906(1), Florida Statutes, to provide adult denture services to Medicaid recipients. The amendment reflected the nonrecurring funding and sunset the services effective July 1, 2005. PCB FC 05-05 repeals the sunset language.

Medicaid Aged and Disabled (MEDS-AD)

Florida's Medicaid program provides services to optional recipients who qualify for Medicaid as MEDS-AD. These recipients are age 65 or older or determined to be disabled, have incomes at or below 88 percent of federal poverty level, and assets which do not exceed $5,000 for an individual and $6,000 for an eligible couple.

Approximately 77,000 non-institutionalized recipients in the MEDS-AD program are also eligible for Medicare. They are commonly referred to as "duals" because they are dually eligible for Medicare and Medicaid. Beginning January 1, 2006, duals will begin receiving a Medicare prescription drug benefit.

PCB FC 05-05 eliminates the dually eligible from the MEDS-AD program effective January 1, 2006. Duals will continue to receive payment of Medicare Part A and B premiums through the Qualified Medicare Beneficiary program, which provides physician services and hospitalization. Subject to the provisions of Medicare Part D, Medicare would be the primary healthcare provider for all non-institutionalized medical services and drugs.

Silver Saver

The Ron Silver Senior Drug Program, also known as Silver Saver, was established to provide a Medicaid prescription drug benefit to low income Medicare recipients who do not receive prescription drug benefits through Medicare. Silver Saver provides up to $160 of prescription drugs each month to Medicaid eligible Medicare recipients with incomes between 88 percent and 120 percent of the federal poverty level. Silver Saver members make a co-payment of $2 for generic drugs, $5 for brand-name drugs on the preferred drug list and $15 for brand-name drugs not on the state's preferred drug list.

Medicare recipients do not currently receive a Medicare prescription drug benefit. They will begin receiving a prescription drug benefit through Medicare effective January 1, 2006. As a result, the Silver Saver program is no longer necessary and this bill will repeal it effective January 1, 2006.

Long-Term Care Reimbursement

The total per diem for each nursing home consists of four components, including the patient care cost component. The patient care cost component is created by adding together the direct care subcomponent and the indirect care subcomponent. AHCA is required by section 409.908, Florida Statutes, to limit the direct care subcomponent by the cost-based class ceiling. The indirect care subcomponent is limited by the lower of the cost-based class ceiling, the target rate class ceiling, or the individual provider target. PCB FC 05-05 would allow AHCA to limit the direct care component by the same ceilings and targets as the indirect care subcomponent. This change is necessary to implement the long-term care reimbursement changes in the proposed budget.

Ingredient Cost Adjustment

Medicaid uses ingredient cost plus a dispensing fee to reimburse pharmacies for dispensing prescription drugs to Medicaid recipients. The Medicaid maximum allowable fee for ingredient cost is the lower of: average wholesale price (AWP) minus 15.4 percent, wholesaler acquisition cost (WAC) plus 5.75 percent, the federal upper limit (FUL), the state maximum allowable cost (SMAC), or the usual and customary (UAC) charge.

Pharmacies receive volume discounts from pharmaceutical wholesalers if they purchase large quantities of products. PCB FC 05-05 amends the maximum allowable fee for ingredient cost to the lower of average wholesale price (AWP) minus 17 percent, wholesaler acquisition cost (WAC) plus 3.75 percent, the federal upper limit (FUL), the state maximum allowable cost (SMAC), or the usual and customary (UAC) charge for pharmacies that have $75,000 or more in average aggregate monthly payments from Medicaid.

Six Prescription Limit

The Florida Medicaid program currently limits prescribed-drug coverage for brand-name drugs for adult Medicaid recipients to the dispensing of four brand-name drugs per month per recipient. Behavioral health drugs and antiretroviral agents are excluded from this limitation. The supply of generic drugs, contraceptive drugs and items, and diabetic supplies are not limited. AHCA may authorize exceptions to the brand-name-drug restriction based upon the treatment needs of the patients, only when such exceptions are based on prior consultation provided by AHCA or by an AHCA contractor.

PCB FC 05-05 amends section 409.912(39)(a), Florida Statutes, to limit adult Medicaid recipients to three brand-name drugs per month, including contraceptive drugs. Behavioral health drugs and antiretroviral agents are not excluded from this limitation. This bill also limits the supply of generic drugs and diabetic supplies to three per month. AHCA may not authorize exceptions to these drug restrictions based upon the treatment needs of the patients.

Program of All Inclusive Care for Children Waiver

A 1999 study reported that the needs of terminally ill children were not addressed according to half the hospice programs in Florida. At that time, only 18 hospice programs of the 36 surveyed provided a full hospice program for children.

In response to the study, AHCA formed a partnership with the Department of Health, and Florida Hospices and Palliative Care to address the healthcare needs of seriously ill children. The partnership obtained demonstration grant funding from the Centers for Medicare and Medicaid Services (CMS) and second year funding from Children's Hospice International. Children participating in the Program of All Inclusive Care for Children (PACC) must have a life-threatening condition and be at risk of death prior to reaching 21 years of age.

AHCA sought a Medicaid 1115 demonstration waiver to fund the program. Section 1115 demonstrations must not cost the federal government more than what would have been spent in the absence of the demonstration. During discussions with AHCA about the waiver request, CMS expressed problems with the waiver's budget neutrality and recommended that AHCA file a 1915 (b) managed care waiver or a 1915 (c) home and community-based services waiver. PCB FC 05-05 grants AHCA the authority to seek either waiver.

Managed Care Assignment

Section 409.9122, Florida Statutes, governs Medicaid enrollment procedures. Recipients are allowed to choose between a managed care plan and a MediPass provider at the time of enrollment. The term "managed care plan" includes exclusive provider organizations, provider service networks, Children's Medical Services Network, minority physician networks, and pediatric emergency department diversion programs.

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 (k) of section 409.9122, Florida Statutes, allows for the assignment of recipients who fail to choose a managed care plan or MediPass provider to managed care plans or MediPass with 40 percent being assigned to MediPass and 60 percent being assigned to managed care plans. There is an exception to this ratio for geographic areas where the agency is contracting for the provision of comprehensive behavioral health services through a capitated prepaid arrangement, recipients who fail to make a choice shall be assigned equally to MediPass or a managed care plan. This bill removes the exception.

Managed Care Reimbursement

Most neonatal intensive care charges and regional perinatal intensive care center charges are incurred during a child's first three months of life. These charges drive up fee-for-service cost, which is the base for HMO rate calculation. Presently, the higher rate is spread across a rate cell encompassing the entire first year of a child's life. Health maintenance organizations are receiving the current high rate for all members less than 1 year, even though their 4–12 month-old caseload is significantly more than their newborn caseload.

PCB FC 05-05 requires AHCA to develop rates for children 0–3 months and separate rates for children 4-12 months. Overall capitation payments for the under 1 year population will decrease because of the combination of a smaller enrollment at a higher rate for newborns and a larger enrollment at a lower rate for the 4–12 month-old population.

C. SECTION DIRECTORY:

Section 1: Amends s. 400.23, F.S., delaying until July 1, 2006, the requirement that nursing homes provide 2.9 hours of direct care per resident from a certified nursing assistant.

Section 2: Amends s. 409.903, F.S., continuing Medicaid services for pregnant women with incomes between 150 percent and 185 percent of the federal poverty level.

Section 3: Amends s. 409.904 (2), F.S., continuing Medicaid services for Medically Needy individuals.

Section 4. Amends s.409.906, F.S., continuing denture services to Medicaid recipients.

Section 5. Repeals s. 409.9065, F.S., eliminating the Silver Saver program effective January 1, 2006.

Section 6. Amends s. 409.908, F.S., changing long-term care reimbursement methodology and changing the ingredient cost reimbursement.

Section 7. Amends s. 409.912, F.S., limiting the Medicaid prescription drug benefit, changing the ingredient cost reimbursement, and authorizing AHCA to seek a federal waiver for children's hospice services.

Section 8. Amends s. 409.9122, F.S., removing the exception to the assignment ratio.

Section 9. Adds paragraphs to s. 409.9124 to requiring two infant groups for rating purposes and limiting capitated managed care reimbursement to the appropriation in the General Appropriations Act.

Section 10: Provides effective date.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

	FY 2005-06	FY 2006-2007
Recurring Expenditures		
Continue Pregnant Women below 185% of FPL		
General Revenue Fund	$24,590,495	$24,590,495
Medical Care Trust Fund	$35,603,220	$35,603,220
Grants & Donations Trust Fund	$ 566,470	$ 566,470
Total Funds	$60,760,185	$60,760,185
Continue Adult Dentures		
General Revenue Fund	$ 8,449,143	$ 8,449,143
Medical Care Trust Fund	$12,104,718	$12,104,718
Refugee Assistance Trust Fund	$ 143,549	$ 143,549
Total Funds	$20,697,410	$20,697,410
Continue Medically Needy		
General Revenue Fund	$161,434,236	$161,434,236
Medical Care Trust Fund	$231,269,802	$231,269,802
Grants & Donations Trust Fund	$ 641,522	$ 641,522

Total Funds	$393,345,560	$393,345,560

Ingredient Cost Adjustments

General Revenue Fund	($11,951,226)	($11,951,226)
Medical Care Trust Fund	($17,127,183)	($17,127,183)
Total Funds	($29,078,409)	($29,078,409)

Two Infant Rates

General Revenue Fund	($30,545,512)	($30,545,512)
Medical Care Trust Fund	($44,167,500)	($44,167,500)
Refugee Assistance Trust Fund	($ 286,988)	($ 286,988)
Total Funds	($75,000,000)	($75,000,000)

Modify Meds A/D

General Revenue Fund	($64,368,718)	($64,368,718)
Medical Care Trust Fund	($20,330,839)	($20,330,839)
Total Funds	($84,699,557)	($84,699,557)

Six Prescription Limit

General Revenue Fund	($ 86,924,631)	($ 86,924,631)
Medical Care Trust Fund	($124,570,882)	($124,570,882)
Grants & Donations Trust Fund	($ 70,498,484)	($ 70,498,484)
Total Funds	($281,993,938)	($281,993,938)

Nonrecurring Expenditures

Delay of nursing home staffing increase

General Revenue Fund	($27,870,730)
Medical Care Trust Fund	($39,924,770)
Total Funds	($67,795,500)

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill creates income for providers and benefits for recipients by continuing services for the Medically Needy, adult dentures and pregnant women. The bill also decreases income for managed care companies by changing the way rates are developed for infants. Finally, the bill decreases income for pharmacists and prescription drug companies by changing the ingredient cost reimbursement and limiting Medicaid recipients to six prescriptions per month.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not appear to require cities or counties to spend funds or take actions requiring the expenditure of funds; reduce the authority that cities or counties have to raise revenues in the aggregate; or reduce the percentage of a state tax shared with cities or counties.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The Agency for Health Care Administration already has rulemaking authority to administer the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES