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.)

Prepared By: Ways and Means Committee

BILL:	CS/CS/SB 404
SPONSOR:	Ways and Means Committee, Health and Human Services Appropriations Committee and Senator Saunders
SUBJECT:	Health Care
DATE:	March 31, 2005 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Dull	Peters	HA	**Fav/CS**
2.	Dull	Coburn	WM	**Fav/CS**
3.				
4.				
5.				
6.				

I. Summary:

The bill makes the following changes to the Medicaid program which are necessary to implement the Medicaid funding decisions included in Committee Bill SPB 7078.

- Restores funding for Medicaid covered services for pregnant women with incomes between 150% and 185% of the federal poverty level, effective July 1, 2005.
- Revises Medicaid covered services for Medicare eligible, non-institutionalized individuals in the Medicaid Elderly and Disabled program (MEDS AD), effective January 1, 2006.
- Restores funding for all Medicaid covered services for individuals receiving benefits through the Medically Needy program, effective July 1, 2005.
- Restores Medicaid coverage for dentures, effective July 1, 2005.
- Delays the implementation of the nursing home staffing increase to 2.9 hours of direct care per resident from a certified nursing assistant until July 1, 2006.
- Eliminates the Silver Saver prescription drug program, effective January 1, 2006, as a result of the implementation of the Medicare Part D program.
- Modifies the reimbursement methodology for Medicaid nursing home payments.
- Removes the prior authorization exemption for mental health and antiretroviral drugs and subjects the drugs to the preferred drug list, allowing the agency to collect supplemental rebates.

- Extends the requirement for the Pharmaceutical and Therapeutics Committee review of newly approved drugs from the next scheduled meeting after FDA approval to the next scheduled meeting after the drug has been in distribution for twelve months.
- Replaces the four brand-name drug limit prior authorization requirement with an eight drug limit prior authorization requirement.
- Implements prescription drug safety requirements by authorizing the Pharmaceutical and Therapeutics Committee to review and/or place certain drugs on prior authorization if the drug has been removed from distribution to the public by the manufacturer or the United States Food and Drug Administration or has been required to carry a black box warning label by the United States Food and Drug Administration.
- Revises the Medicaid preferred drug list to include of a list of cost effective therapeutic options with at least two products in each therapeutic class.
- Authorizes one-hundred day supplies of maintenance medications.
- Removes the ability of a pharmacist in an institutional pharmacy to receive prior authorization.
- Authorizes the Agency, in conjunction with the Pharmaceutical and Therapeutics Committee, to place certain age related recipient prior authorization requirements for prescriptions written for recipients that do not meet the age requirements listed by the manufacturer or the United States Food and Drug Administration on a prior authorization process.
- Authorizes the Agency to implement a step therapy prior authorization process for prescriptions that are not included on the preferred drug list.
- Authorizes the Agency to implement the program of all-inclusive care for children to provide in-home hospice-like support services to children diagnosed with life-threatening illness and enrolled in the Children's Medical Services network.
- Requires equal assignment of recipients to Medipass or a managed care plan in service areas 1 and 6 and requires assignment of 40 percent Medipass and 60 percent managed care in all other areas of the state for recipients who fail to choose a plan at the time of enrollment.
- Requires the agency to include policy reductions that have been accurately estimated and verified into health maintenance organization capitation rates.

This bill substantially amends the following sections of the Florida Statutes: 400.23, 409.903, 409.904, 409.906, 409.908, 409.9112, 409.9113, 409.9117, 409.91195, 409.912, 409.9122 and 409.9124.

This bill repeals section 409.9065, of the Florida Statutes.

II. Present Situation:

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 utilized 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 hours, effective January 1, 2002, 2.6 hours, effective January 1, 2003, and 2.9 hours, 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 2003 Legislature delayed the effective date of the increase to 2.9 hours to May 1, 2004[1] and subsequently, the 2004 Legislature further delayed the increase to 2.9 hours to July 1, 2005.[2]

Medicaid Coverage for Pregnant Women
Florida has extended Medicaid coverage to pregnant women who have incomes at or below 185 percent of federal poverty level. The prenatal care provided to the pregnant women under this program helps in reducing excess medical expenses associated with complicated and traumatic births. Upon birth the newborn qualifies for Medicaid, and any medical costs for treating the newborn are paid by Medicaid. Beginning July 1, 2005, section 409.903, F.S., limits Medicaid coverage to pregnant women with incomes below 150 percent of the federal poverty level.

Medicaid Aged and Disabled Program (MEDS AD)
Individuals who are elderly or disabled, whose incomes are under 88 percent of the federal poverty level, are an optional coverage group eligible for Medicaid under s. 409.904(1), F.S. Payments for services to individuals in the optional categories are subject to the availability of monies and any limitations established by the General Appropriations Act or chapter 216, F.S. Medicaid is required to provide Medicare "buy-in" coverage for aged and disabled individuals who are Medicare beneficiaries. Therefore, if Medicaid coverage is eliminated for persons eligible under the criteria for the Elderly and Disabled (MEDS AD) program, those who are eligible for Medicare will continue to have Medicaid coverage for Medicare premiums, deductibles, and coinsurance.

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

[1] Chapter 2003-405, Laws of Florida.
[2] Chapter 2004-270, Laws of Florida.

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, an intermediate care facility for the developmentally disabled, or 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 per 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. Beginning July 1, 2005, section 409.904, F.S., limits Medically Needy program benefits to prescribed drugs only.

Adult Dentures:
Medicaid currently provides coverage for emergency adult dental services rendered by licensed, Medicaid participating dentists. Medicaid reimbursable acute emergency adult dental services are provided to recipients age 21 and older to alleviate pain or infection. The 2004 Legislature restored coverage for adult denture services beginning January 1, 2005 through June 30, 2005. The program provides for complete dentures, services required to seat dentures, the repair and realignment of dentures, the extraction of necessary teeth, and other surgical procedures essential to prepare the mouth for dentures to Medicaid recipients age 21 and older. This provision is repealed July 1, 2005.

Ron Silver Senior Drug Program (Silver Saver Rx)
In the recognition of the need for prescription drug coverage for the elderly, the 2002 Legislature created section 409.9065, F.S., creating the Silver Saver Prescription drug program. Silver Saver uses the Medicaid program's ability to utilize federal matching funds to expand Medicaid eligibility for prescription drugs to recipients who qualify for the program. To qualify for the program, recipients must be age 65 or older, eligible for Medicare, and have incomes between 88-120% of the federal poverty level. Qualified recipients receive $160 per month in assistance for purchasing prescription drugs. There are currently over 55,000 individuals enrolled in the program.

The 2004 Congress passed the Medicare Modernization Act which includes prescription drug benefits for all Medicare recipients, beginning January 1, 2006 (Medicare Part D). This benefit will provide full coverage of prescription drugs for all Medicare recipients. The program includes a sliding scale of premiums and co-payments for recipients in the program. Although the Medicare Part D benefit is available to all Medicare recipients, the focus related to Medicaid will be on those Medicare recipients with incomes below 135% of the federal poverty level. Medicare recipients with incomes below 135% of the federal poverty level will not be required to pay the premiums or co-payments for prescriptions purchased through the Medicare Part D program. Therefore, all recipients eligible for the Silver Saver prescription drug program will be eligible for the Medicare Part D program.

Medicaid Reimbursement to Nursing Homes
Nursing facility services are governed by Title 42, Code of Federal Regulations (C.F.R.) Parts 405, 442, 456, and 483. State authority for participation in the Title XIX Medicaid Program is governed by Chapter 409.919, F.S. The state authority for the licensing of nursing facilities is located in chapter 400, Part II and chapter 395, Part I, F.S. Reimbursement requirements are contained in chapter 409.908, F.S., and chapter 59G, Florida Administrative Code.

Methods and standards in which Medicaid nursing home reimbursement rates are established are detailed in the Florida Title XIX Long-Term Care Reimbursement Plan (Plan). Under the Plan, each provider is paid a cost-based, prospective rate, which is subject to certain limitations.

Reimbursement rates for nursing homes participating in the Medicaid program are set every January and July. Every nursing home is required to submit a cost report each year. The reimbursement rate is set using the costs and census data contained within the cost report submitted to the agency by the nursing home. The costs are converted to per diem amounts and inflated forward to the current rate semester using a nationally recognized inflation index. The per diem is then adjusted in accordance with the Plan in determining the prospective reimbursement per diems. The total per diem for each nursing home consists of four main cost components:

- Operating costs
- Patient Care costs (including both direct and indirect care costs)
- Property
- Return on Equity

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 for Health Care Administration (AHCA) 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.

Section 409.912, 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 in addition to those required by Title XIX of the Social Security Act. Such rebates must be no less than 10 percent of the average manufacturer price as defined in 42 U.S.C. § 1936 on the last day of a quarter unless the federal or supplemental rebate, or both, equals or exceeds 29 percent.

Program for All Inclusive Care for Children
In 2000, Congress appropriated funding to Children' s Hospice International to administer funds to support demonstrations of the Program For All Inclusive Care for Children (PACC) model in five states. The five states identified in proviso were New York, Virginia, Kentucky, Utah, and Florida. Florida received three years of funding to support planning and development of a state PACC model. The Florida model is Partners In Care-Together for Kids (PIC). The Florida

model is a solid and supportive partnership between the Agency for Health Care Administration (Medicaid and Child Health Insurance Programs), the Department of Health's Children's Medical Services Network (CMSN) for children with special health care needs, and Florida Hospices and Palliative Care, Inc. (a formal organization for the state's forty hospice programs). The Agency for Health Care Administration is the administrator of the PACC/PIC program.

The mission of the PIC program is to enable children with potentially life-limiting conditions and their families to access a support system that is continuous, compassionate, comprehensive, culturally sensitive, and family centered. The goal of the PIC program is to demonstrate that its mission is achievable and cost effective through reduced hospital and emergency room visits. PIC support services include pain and symptom management, counseling, expressive therapies for young children, respite, and specialized nursing and personal care.

Managed Care Enrollment
Medicaid recipients are provided care through fee-for-service (Medipass) or managed care systems. The Medipass program utilizes the fee for service system but incorporates a primary care case management approach through a primary care physician, who in exchange for a three dollar monthly fee, is responsible for managing the recipients care. Alternatively, Medicaid managed care programs are responsible for the full risk of managing a patient in return for a monthly capitated payment.

At the time of enrollment, eligible Medicaid recipients are given thirty days to choose to have their care provided through Medipass or a managed care provider. If a recipient fails to choose a plan, the agency will assign them to a plan. Section 409.9122, F.S., requires the agency to assign recipients who fail to make a choice to managed care plans until a ratio for the total eligible Medicaid population reaches sixty percent managed care and forty percent Medipass. However, in areas of the state that provide prepaid behavioral health plans, the agency is required to assign recipients equally to Medipass and managed care plans. There are currently over 740,000 recipients enrolled in Medipass and over 900,000 recipients enrolled in managed care plans.

Managed Care Reimbursement
Section 409.9124, F.S., requires the agency to develop and adopt a methodology for reimbursing managed care plans. By September 1of each year, the agency is required to set rates that are actuarially sound based on the utilization of fee-for-service expenditures for comparable groups of Medicaid recipients. Once the capitation rates are developed and certified, the agency provides each managed care plan a monthly payment for each recipient enrolled in the plan.

III. Effect of Proposed Changes:

Section 1. Amends s. 400.23, F.S., delaying the scheduled increase in the minimum staffing standards for nursing homes from 2.6 hours to 2.9 hours of direct care per patient per day until July 1, 2006.

Section 2. Amends s. 409.903, F.S., removing the July 1, 2005 expiration of Medicaid covered services to pregnant women with incomes between 150 to 185 percent of the federal poverty level.

Section 3. Amends s. 409.904, F.S., regarding eligibility for the Medicaid Aged and Disabled program (MEDS AD). Effective January 1, 2006, eligibility for the MEDS AD program will be limited to persons who are age 65 or older or are determined to be disabled, whose income is at or below 88 percent of the federal poverty level, who are not eligible for Medicare or if eligible for Medicare are also eligible and receiving Medicaid-covered institutionalized care services, hospice services, or home and community-based services. The section also eliminates the July 1, 2005 expiration date of limiting Medically Needy recipients to prescription drug services only.

Section 4. Amends s. 409.906, F.S., restoring Medicaid coverage for adult denture services and eliminating the July 1, 2005 repeal.

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

Section 6. Amends s. 409.908, F.S., eliminating outdated language to reduce hospital inpatient rates by 6 percent between July 1, 2001 and April 1, 2002, and revising guidelines for limiting the direct care per-diem subcomponent for nursing home reimbursement.

Section 7. Amends s. 409.9112, F.S., eliminating outdated language relating to the RPICC disproportionate share program.

Section 8. Amends s. 409.9113, F.S., eliminating outdated language relating to the teaching hospital disproportionate share program.

Section 9. Amends s. 409.9117, F.S., eliminating outdated language relating to the primary care disproportionate share program.

Section 10. Amends s. 409.91195, F.S.:

- Eliminating the exemption of the prior authorization requirements for mental health, antiretroviral drugs, and drugs for nursing home recipients and other institutionalized individuals. The drugs will now be subject to the PDL and prior authorization requirements.
- Requiring the Agency to publish the preferred drug list on the Internet.
- Extending the requirement for the Pharmaceutical and Therapeutics Committee review of newly approved drugs from the next scheduled meeting after FDA approval to the next scheduled meeting after the drug has been in distribution for twelve months.
- Removing outdated language allowing the Agency to adopt a voluntary preferred drug list.
- Implementing prescription drug safety requirements by authorizing the Pharmaceutical and Therapeutics Committee to review and place certain drugs on prior authorization if the drug has been removed from distribution to the public by the manufacturer or the United States Food and Drug Administration or has been required to carry a black box warning label by the United States Food and Drug Administration.

Section 11. Amends s. 409.912, F.S.:

- Establishing a Medicaid preferred drug list which includes a list of cost effective therapeutic options with at least two products in each therapeutic class.
- Requiring prior authorization of all drugs in excess of eight per recipient per month.
- Eliminating the four brand name drug limit and prior authorization requirements.
- Eliminating language that exempts children and medications to treat mental illness from prior authorization requirements.
- Authorizing the dispensing of one-hundred day maximum supplies of maintenance medications.
- Eliminating the exception which allows prior authorization requirements to be sought by the pharmacy rather than by the prescribing physician for nursing home residents and other institutionalized adults.
- Eliminating language which established an advisory committee for the purpose of studying the feasibility of using a restricted formulary for nursing home residents.
- Eliminating language which required the Agency for Health Care Administration to negotiate a contract for a behavioral health management program by September 1, 2004.
- Authorizing the agency, in conjunction with the Pharmaceutical and Therapeutics Committee, to place certain age related recipient prior authorization requirements for prescriptions written for recipients that do not meet the age requirements listed by the manufacturer or the United States Food and Drug Administration on a prior authorization process.
- Authorizing the Agency to implement a step therapy prior authorization process for prescriptions that are not included on the preferred drug list.
- Authorizing the Agency to implement the program of all-inclusive care for children to provide in-home hospice-like support services to children diagnosed with life-threatening illness and enrolled in the Children's Medical Services network.

Section 12. Amends s. 409.9122, F.S., requiring equal assignment of recipients to Medipass or a managed care plan in service areas 1 and 6 where the agency is contracting for prepaid behavioral health services and requiring the assignment of 40 percent Medipass and 60 percent managed care in all other areas of the state for recipients who fail to choose a plan at the time of enrollment.

Section 13. Amends s. 409.9124, F.S., requiring the agency to include policy reductions when establishing managed care rates and limit payment of managed care rates to the amounts allowed in the General Appropriations Act.

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 2005-06 includes the following fiscal changes that require statutory change.

SUMMARY OF FISCAL IMPACT

Recurring Expenditures	**FY 2005-06**	**FY 2006-07**
Section 1 **Delay Nursing Home Staffing Increase**		
General Revenue	(27,870,730)	0
Trust Fund	(39,924,770)	0
Total	(67,795,500)	0

Section 2		
Restore Funding For Pregnant Women		
General Revenue	24,590,495	24,590,495
Trust Fund	36,169,690	36,169,690
Total	60,760,185	60,760,185
Section 3		
Eliminate Medicare Eligible Non-institutionalized MEDS AD		
General Revenue	(64,368,718)	(128,737,436)
Trust Fund	(20,330,839)	(40,661,678)
Total	(84,699,557)	(169,399,114)
Restore Funding for Medically Needy		
General Revenue	161,434,236	161,434,236
Trust Fund	231,911,324	231,911,324
Total	393,345,560	393,345,560
Section 4		
Restores Coverage for Adult Dentures		
General Revenue	8,449,143	8,449,143
Trust Fund	12,248,267	12,248,267
Total	20,697,410	20,697,410
Section 11		
Prescribed Drug Controls		
Preferred Drug List		
General Revenue	(90,000,000)	(90,000,000)
Trust Fund	(201,970,803)	(201,970,803)
Total	(291,970,803)	(291,970,803)
Eight Drug Prior Authorization		
General Revenue	(20,000,000)	(20,000,000)
Trust Fund	(28,661,800)	(28,661,800)
Total	(48,661,800)	(48,661,800)

Recipient Age Related Prior Authorization		
General Revenue	(371,177)	(371,177)
Trust Fund	(866,080)	(866,080)
Total	(1,237,257)	(1,237,257)
TOTAL ALL		
General Revenue	(8,136,751)	(44,634,739)
Trust Fund	(11,425,011)	8,168,920
Total	(19,561,762)	(36,465,819)

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Summary of Amendments:

None.