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/SB 390
INTRODUCER:	Health and Human Services Appropriations Committee and Senator Saunders
SUBJECT:	Health Care
DATE:	March 27, 2006 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Dull	Peters	HA	**Fav/CS**
2.			HE	**Withdrawn**
3.			GO	**Withdrawn**
4.	Dull	Coburn	WM	**Favorable**
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 the Health and Human Services budget for Fiscal Year 2006-2007.

- Provides Medicaid coverage for partial dentures, effective July 1, 2006.
- Restores Medicaid coverage of adult vision services, effective July 1, 2006.
- Restores Medicaid coverage of adult hearing services, effective July 1, 2006.
- Increases Medicaid managed care enrollment for individuals who do not choose a plan to sixty-five percent managed care and thirty-five percent MediPass.
- Implements provisions for the Disproportionate Share Program as recommended by the Disproportionate Share Council.
- Deletes provisions requiring the Florida Healthy Kids Corporation to establish a local match policy each year and the minimum local match requirements.
- Requires the Office of Program Policy Analysis and Government Accountability (OPPAGA) to review functions of the CARES program and report its findings to the President of the Senate and Speaker of the House by February 1, 2007.

II. Present Situation:

Adult Denture Services

Medicaid currently reimburses for emergency dental procedures to alleviate pain or infection, full dentures and denture-related procedures for recipients age 21 and older. The services

currently include complete dentures and services required to seat dentures, the repair and reline of dentures, and the extraction of necessary teeth and other surgical procedures essential to prepare the mouth for dentures. Adult recipients are responsible for paying a 5 percent coinsurance charge for all procedures related to dental services, unless otherwise exempt from the charge.

Adult Vision Services
Medicaid currently covers limited visual services for adult recipients which include, eye exams and other treatment for diseases of the eye, prior authorized contact lenses for specialized situations, e.g. post surgery and prosthetic eyes. Medicaid does not currently cover exams for visual acuity, eyeglasses or eyeglass repairs, as these programs were eliminated July 1, 2002 (Chapter 2001-377, LOF).

Adult Hearing Services
Medicaid currently covers limited diagnostic services for medical diagnosis when not related to hearing aid candidacy for recipients age 21 and older. Services must be rendered by licensed, Medicaid participating otolaryngologists, otologists, and audiologists. Medicaid does not currently provide coverage for hearing screenings, hearing ads (including evaluation, fitting and dispensing), hearing aid repair services, or cochlear implant services as the coverage was eliminated July 1, 2002 (Chapter 2001-377, LOF).

Managed Care Enrollment
MediPass and managed care plans are currently the two primary healthcare delivery systems in the Medicaid program. MediPass is a primary care case management system that requires a recipient to utilize a primary physician who coordinates all of the recipients care for a three dollar per month payment from Medicaid. Medicaid managed care plans consist of Health Maintenance Organizations, Provider Service Networks and Minority Physician Networks.

Current law provides Medicaid recipients up to thirty days to make a choice to enroll in a managed care plan or MediPass, and upon enrollment into the selected plan, the recipient is given an additional ninety days to opt out. The agency is required to provide information about the plans to Medicaid recipients for purposes of giving them the opportunity to make an informed choice between a managed care plan or MediPass. However, even with the information provided, many recipients fail to choose a plan. Section 409.9122(2)(f), F.S., requires the agency to assign recipients who fail to choose a plan into a managed care plan or MediPass until the enrollment percentage reaches forty percent MediPass and sixty percent managed care.

Disproportionate Share
There are currently four separate Medicaid disproportionate share hospital programs that are operational in Florida. They are: the Regular program established in s. 409.911, F.S.; the Mental Health Hospital program established in s. 409.9115, F.S.; the Rural Hospital/Financial Assistance program established in s. 409.9116, F.S.; and the Specialty Hospital program established in s. 409.9118, F.S.

Additionally, there are four separate Medicaid disproportionate share hospital programs that are listed in law but are not operational at this time. They are: the Regional Perinatal Intensive Care

Center (RPICC) program established in s. 409.9112, F.S.; the Teaching Hospital Graduate Medical Education (GME) program established in s. 409.9113, F.S.; the Primary Care program established in s. 409.9117, F.S.; and the Specialty Hospitals for Children established in s. 409.9119, F.S.

Florida KidCare

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. The KidCare Coordinating Council, located in the Department of Health, is charged with responsibility for making recommendations concerning the implementation and operation of the program.

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., and serves children ages 6 to 19 with incomes below 200 percent of the federal poverty level. Florida's Healthy Kids program existed prior to the implementation of the federal Title XXI State Child Health Insurance Program. Florida was one of three states to have the benefit package of an existing child health insurance program grandfathered as part of the Balanced Budget Act of 1997, which created the federal State Child Health Insurance Program.

The MediKids program component of KidCare, established in s. 409.8132, F.S., is administered by the Agency for Health Care Administration, in conjunction with the Florida Healthy Kids Corporation which is responsible for processing applications for the program. The MediKids program serves children ages 1 to 5 with incomes below 200% of the federal poverty level and utilizes the Medicaid infrastructure, offering the same provider choices and package of benefits.

The Children's Medical Services program component of KidCare, established in s. 391, F.S., provides services to children with special health care needs who are eligible for the Florida KidCare program. The program provides children with special health care needs a family-centered, comprehensive, and coordinated statewide managed system of care that links community-based health care with multidisciplinary, regional, and tertiary pediatric specialty care. The program provides essential preventive, evaluative, and early intervention services for children at risk for or having special health care needs, in order to prevent or reduce long-term disabilities.

The Florida Healthy Kids Corporation contracts with a fiscal agent to perform initial eligibility screening for the KidCare 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.

Comprehensive Assessment Review and Evaluation Services (CARES)
The Department of Elderly Affairs, Comprehensive Assessment Review and Evaluation Services (CARES) program, performs the federally-mandated medical/functional assessment component of determining eligibility for Medicaid nursing home and other long-term care waiver programs. Persons applying for Medicaid nursing home care are assessed by either a CARES nurse or social worker, with medical review by a physician prior to approval.

The primary goal of the program is to ensure that Medicaid payment for nursing facility care is made only for individuals whose conditions require such care and to ensure that long-term care services are provided in the setting most appropriate to the needs of the person and in the most economical manner possible. In addition, the program also refers Medicaid recipients to community-based programs if the individual could be safely served at a lower cost and the recipient chooses to participate in such program.

III. Effect of Proposed Changes:

Section 1. Amends s. 409.906, F.S., providing Medicaid coverage for full and partial dentures and restores Medicaid coverage for adult hearing and vision services.

Section 2. Amends s. 409.9122, F.S., increasing the Medicaid managed care assignment percentages for individuals who do not chose a plan during the choice period to sixty-five percent managed care and thirty-five percent MediPass.

Section 3. Amends s. 409.911, F.S., deleting obsolete provisions related to the data used in determining the charity care and Medicaid days for purposes of calculating disproportionate share payments.

Section 4. Amends s. 409.9113, F.S., providing for the funds defined for statutory teaching hospitals to be distributed in the same proportion as funds were distributed under the teaching hospital disproportionate share program during the 2003-04 fiscal year and requiring the funds for family practice teaching hospitals to be distributed equally.

Section 5. Amends s.624.91, F.S., deleting provisions requiring the Florida Healthy Kids Corporation to establish a local match policy each year and the minimum local match requirements.

Section 6. Requires the Office of Program Policy Analysis and Government Accountability (OPPAGA) to review functions of the CARES program and report its findings to the President of the Senate and Speaker of the House by February 1, 2007.

Section 7. Implements the provisions of the bill on July 1, 2006.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Medicaid dental, vision and hearing service providers may experience an increase in clients after the services and reimbursements are restored from this bill. Medicaid managed care providers may experience an increase in enrollment as a result of this bill.

C. Government Sector Impact:

The proposed Senate Budget for FY 2006-07 includes the following fiscal changes that require statutory change.

SUMMARY OF FISCAL IMPACT

Recurring Expenditures	**FY 2006-07**	**FY 2007-08**
Partial Dentures		
General Revenue	2,868,173	2,868,173
Trust Fund	4,137,955	4,137,955
Total	7,006,128	7,006,128
Restore Funding Adult Hearing Services		
General Revenue	899,196	899,196
Trust Fund	1,320,073	1,320,073
Total	2,219,269	2,219,269

Restore Adult Vision		
General Revenue	3,806,471	3,806,471
Trust Fund	5,733,272	5,733,272
Total	9,539,743	9,539,743
Increase Managed Care Enrollment		
General Revenue	(1,583,952)	(1,583,952)
Trust Fund	(2,257,794)	(2,257,794)
Total	(3,841,746)	(3,841,746)
Total Fiscal Impact		
General Revenue	5,989,888	5,989,888
Trust Fund	8,933,506	8,933,506
Total	14,923,394	14,923,394

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Summary of Amendments:

None.