HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 5007 PCB FC 06-04 Health Care
SPONSOR(S): Fiscal Council
TIED BILLS: **IDEN./SIM. BILLS:** SB 390

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
Orig. Comm.: Fiscal Council	21 Y, 0 N	Speir	Kelly
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SUMMARY ANALYSIS

House Bill 5007 makes a number of changes to the Medicaid Program. These statutory changes are necessary to implement the Medicaid funding decisions included in the House version of the General Appropriations Act. Specifically, the bill does the following:

- Repeals implementation of a nursing home staffing increase.
- Provides adult partial-denture benefits.
- Provides adult vision benefits.
- Increases the Managed Care/MediPass assignment ratio from 60/40 to 65/35.
- Amends the Disproportionate Share program.
- Removes a requirement that the hospitalist program replace existing utilization review.
- Changes the enrollment effective date for provider applications.
- Replaces emergency room co-payment for non-emergency visits with a co-insurance not to exceed $15.
- Allows managed care rates to be adjusted for health status.
- Requires the Florida Healthy Kids Corporation to refund unspent local match.

The bill allows the state to implement $16.3 billion in Medicaid funding.

This bill has an effective date of July 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide Limited Government— The bill enables the Medicaid program to provide $16.3 billion in services to 2.3 million recipients.

Promote Personal Responsibility— This bill provides adult Medicaid recipients with vision and partial denture services.

B. EFFECT OF PROPOSED CHANGES:

Repeal of 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 s. 400.23, F. S., specifying the nursing assistant ratio increases to 2.3 effective January 1, 2002; 2.6 effective January 1, 2003; and 2.9 effective January 1, 2004. Additional Medicaid funding for reimbursement of the increased staffing was authorized for each year. Staffing was also enhanced by increased training and documentation requirements in nursing homes.

The Legislature has delayed the effective date of the increase to 2.9 hours certified nursing assistant hours per resident per day during the last three regular sessions. Current law has July 1, 2006, as the effective date of the increase. This bill will repeal the increase.

Family Planning Waiver

The current family planning waiver began on December 1, 2003, and will expire on November 30, 2006. All women who lose Medicaid and have had a pregnancy related service during the two years prior to losing Medicaid are eligible as long as the family income is 185 percent or less of the federal poverty level. The women are eligible for up to two years. They must actively seek enrollment in the program through a county health department, as well as re-enrollment for the second year.

Because of changes in federal requirements, changes in the Florida Family Planning Waiver Program are required. The required change to Florida statutes would allow for a woman living in a family and who would otherwise be exiting Medicaid to be eligible to enroll in the family planning waiver for up to two years if their income remains under 185 percent of the federal poverty level. Previously, only those who had had a pregnancy-related service in the prior two years were eligible.

Adult Partial-Dentures

Medicaid provides full dentures for recipients, but not partial dentures. This policy requires the removal of all a recipient's teeth, which Medicaid reimburses, before a recipient may receive dentures. This bill would allow recipients to receive partial dentures.

Adult Vision Benefits

The Adult Dental, Visual and Hearing services program was eliminated, effective July 1, 2002, in the 2001 Special Session "C" (chapter 2001-377, Laws of Florida). The 2002E Legislature restored the hearing and vision services with non-recurring funds prior to the elimination of the services on July 1, 2002. The 2003 Legislature did not continue the funding for adult vision services, so they were eliminated effective July 1, 2003.

Florida's Medicaid Program currently provides, under optional Medicaid services, reimbursement for visual services rendered by licensed, Medicaid participating ophthalmologists, optometrists and opticians. Medicaid reimbursable services include visual examinations, refractions, eyeglasses and eyeglass repairs for children less than 21 years of age. Services for recipients age 21 and older are limited to prosthetic eyes and specialized contact lenses. There is a $2 recipient co-payment for optometric services per provider per day unless the recipient is exempt.

This bill amends s. 409.906, F. S., to provide adult vision services to approximately 675,000 adult Medicaid recipients. Services will include one pair of eyeglasses per recipient every two years, as well as necessary eyeglass repairs. Contact lenses are provided to recipients who have unilateral aphakia or bilateral aphakia.

Managed Care/MediPass Assignment Ratio

Section 409.9122, F.S., governs Medicaid enrollment procedures. Recipients are allowed to choose between a managed care plan and a MediPass provider at the time of enrollment, with certain exceptions. When a Medicaid recipient does not choose a managed care plan or MediPass provider, the agency assigns 60 percent of the Medicaid recipients to a managed care plan and 40 percent to a MediPass provider. This bill allows for the diversion of all undecided Medicaid recipients into managed care until a ratio of 65 percent managed care and 35 percent MediPass is achieved. AHCA estimates this ratio will not be reached during Fiscal Year 2006-2007.

The percentage is determined by dividing the number of individuals in managed care by the number of recipients that must choose a managed care plan or MediPass. The individuals that must choose managed care or MediPass are all Medicaid recipients, except those Medicaid recipients who are institutionalized, in Medically Needy or eligible for both Medicaid and Medicare.

However, some individuals exempt from choosing managed care or MediPass elect to have their services provided through managed care or MediPass. This results in individuals being included in the numerator that are not part of the denominator. This bill changes the statute to include in the denominator all recipients that are eligible to choose managed care, not just those in the numerator. This includes adoption subsidy children, foster children, SOBRA Pregnant Women, and all dual-eligibles.

According to an estimate from the agency this would increase the denominator by 434,895 individuals. This would reduce the current managed care enrollment percentage to 49 percent. This would result in years of placing all undecided mandatory choosers into managed care until the 65 percent threshold is reached.

Disproportionate Share Program

Each year the Medicaid Disproportionate Share Council makes recommendations to the Legislature on the funding of the Disproportionate Share Program, which provides special Medicaid payments to hospitals. This bill amends the Florida Statutes to implement the current recommendations of the Medicaid Disproportionate Share Council.

Section 409.911, F. S., is amended to delete obsolete provisions related to the data used in determining the charity care and Medicaid days for purposes of calculating disproportionate share payments. Section 409.9113, F. S., is amended to direct that the funds for statutory teaching hospitals 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.

Hospitalist Program Replacement of Existing Utilization Review

The 2004 Legislature created paragraph (d) of subsection (5) of s. 409.905, F. S., to implement a Medicaid hospitalist program. One of the policy decisions required the hospitalist program to replace existing hospital utilization review program. The federal government informed AHCA that this policy violates federal law (*See 42 U.S.C. 1396(a)(30)).* This bill amends the statute to comply with federal law by deleting the requirement.

Effective Date of Provider Applications

Section 409.907, F. S., states that the effective date of a provider's enrollment as a Medicaid provider is "no earlier than the effective date of the approval of the provider application." Exceptions are made for providers who were recently granted a change of ownership and those who primarily provide emergency medical services transportation or emergency services and care pursuant to s. 395.1041 or s. 401.45, F. S., or services provided by federally qualified health centers, and out-of-state providers. Their effective date is the date of their application. This bill would grant every applicant the earlier effective date contingent upon the state being able to perform certain audits.

Emergency Room Co-Insurance

Subsection (1) of s. 409.9081, F. S., requires Medicaid recipients to pay a $15 co-payment when they seek non-emergency care at an emergency room. Federal law limits co-payments to a nominal amount, which is not defined by federal law. This bill would amend the statute to make the recipient's share of cost a 5 percent co-insurance that would not exceed $15, which complies with 42 C.F.R. 447.54. Pregnant women and children are exempt from all share of cost requirements.

Adjustment of Managed Care Rates

Medicaid reform is predicated on the agency being able to adjust managed care rates based on a recipient's health status. This bill amends s. 409.9122, F. S., to allow the adjustment of managed care rates based on a recipient's health status.

Florida Healthy Kids Corporation Unspent Local Match

Florida Healthy Kids Corporation collects local match to help subsidize health coverage for legal aliens that do not qualify for the State Children's Health Insurance Program. The caseload for these children has dropped below estimates in the current fiscal year. As a result, Florida Healthy Kids Corporation collected more match than was necessary. There is no direction in statute, however, for refunding unspent local match. This bill directs that local match shall be returned based on a methodology developed by the Florida Healthy Kids Corporation.

Capitated Long-Term Care Reimbursement

Capitated payments to long-term care providers are based on fee-for-service experience. This bill amends ss. 409.912, and 430.705, F.S., to risk adjust the rates based on recipient's level of chronic illness, functional limitations and risk of institutional placement. The payments for Medicaid home and community based services shall be the greater of fee-for-service level or plan experience.

C. SECTION DIRECTORY:

Section 1. Amends s. 400.23, F.S., repealing the requirement of 2.9 hours of direct care.

Section 2. Amends s. 409.904(5), F.S., making the family planning waiver comply with federal law.

Section 3. Amends s. 409.905(5)(d), F.S., deleting the requirement that the hospitalist program replace existing hospital utilization review.

Section 4. Amends ss. 409.906(1) and (23), F.S., providing adult Medicaid recipients with partial denture and vision services.

Section 5. Amends s. 409.907(9), F.S., making the application date the enrollment effective date for Medicaid providers.

Section 6. Amends s. 409.9081(1), F.S., changing the share of cost for non-emergency use of emergency room services from a co-payment to a co-insurance, not to exceed $15.

Section 7. Amends s. 409.911(2), (3), and (4), F.S., implementing the Disproportionate Share Program changes for Fiscal Year 2006-2007.

Section 8. Amends s. 409.9113, F.S., implementing the Disproportionate Share Program changes for Fiscal Year 2006-2007.

Section 9. Amends s. 409.9117, F.S., implementing the Disproportionate Share Program changes for Fiscal Year 2006-2007.

Section 10. Amends s 409.912 (44) and creates subsection (53), F.S., allowing managed care rates to be adjusted for health status.

Section 11. Amends s. 409.9122 (2), F.S., changing the ratio of undecided individuals placed in managed care instead of MediPass from 60/40 to 65/35 and changing how that ratio is determined.

Section 12. Amends s. 624.91(5), F.S., requiring Florida Healthy Kids Corporation to refund unspent local match.

Section 13. Amends s. 430.705(4) to change the reimbursement for managed long-term care providers.

Section 14. Provides that the bill will take effect on July 1, 2006.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

	FY 2006-07	FY 2007-08
Repeal of Nursing Home Staffing Increase		
General Revenue Fund	($26,184,622)	($26,184,622)
Medical Care Trust Fund	($37,324,040)	($37,324,040)
Managed Care/MediPass Assignment Ratio		
General Revenue Fund	($1,583,952)	($1,583,952)
Medical Care Trust Fund	($2,257,794)	($2,257,794)
Adult Partial-Dentures		
General Revenue Fund	$2,868,173	$2,868,173
Medical Care Trust Fund	$4,137,955	$4,137,955
Adult Vision Benefits		
General Revenue Fund	$3,817,002	$3,817,002
Medical Care Trust Fund	$5,748,410	$5,748,410
Total		
General Revenue Fund	(21,083,399)	(21,083,399)
Medical Care Trust Fund	(29,695,469)	(29,695,469)

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The diversion of more recipients to managed care plans will result in more income for health maintenance organizations, exclusive provider organizations, provider service networks, minority physician networks, Children's Medical Services Network, and pediatric emergency department diversion programs.

The bill also provides new adult vision and partial denture benefits to Medicaid recipients.

D. FISCAL COMMENTS:

The payments for Medicaid home and community based services shall be the greater of fee-for-service level or plan experience. These changes will have a fiscal impact that has not yet been determined. Without the term managed long-term care programs defined, it is not clear which programs should have their rates adjusted.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to spend funds or take an action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

No additional rulemaking authority is required to implement the provisions of this bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

On March 30, 2006, the Fiscal Council adopted three amendments. The amendments did the following:

- Change the denominator used for the ratio used for determining the number of individuals assigned to managed care and MediPass.
- Mandate that capitation rates for long-term care programs be risk-adjusted.
- Require that payments for home and community based services be the greater of fee-for-service or plan experience.

This analysis is drafted to the amendments.