The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Health and Human Services Appropriations Committee

BILL:	CS for SB 1854
INTRODUCER:	Committee on Health and Human Services Appropriations and Senator Peaden
SUBJECT:	Medicaid Program
DATE:	April 2, 2008 REVISED:

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

Please see Section VIII. for Additional Information:

A. COMMITTEE SUBSTITUTE.....	X	Statement of Substantial Changes
B. AMENDMENTS.....		Technical amendments were recommended
		Amendments were recommended
		Significant amendments were recommended

I. Summary:

The Committee Substitute provides for the following:

- Allows the Agency for Health Care Administration to transfer funds collected from nursing home lease bonds to the Grants and Donations Trust fund for nursing home reimbursement;
- Eliminates the MEDS AD optional Medicaid eligibility group effective November 1, 2008;
- Limits the Medically Needy optional Medicaid eligibility group to children and pregnant women effective November, 1, 2008;
- Terminates Medicaid dental services for adults on September 30, 2008;
- Eliminates the payment for Medicaid hearing services for adults effective October 1, 2008;
- Retains Medicaid payment of coinsurances and deductibles for portable x-ray Medicare Part B services provided in a nursing home;
- Eliminates the exemption for children in Hillsborough County with open cases in the HomeSafeNet system that did not allow them to participate in the state wide specialty prepaid behavioral health plan;
- Lowers the Average Wholesale Price (AWP) component in the pharmacy reimbursement methodology from AWP minus 15.4 percent to AWP minus 16.4 percent;

- Lowers the Wholesale Acquisition Cost (WAC) pricing component in the pharmacy reimbursement methodology from WAC plus 5.75 percent to WAC plus 4.75 percent;
- Requires increases in reimbursement for inpatient hospital, outpatient hospitals, nursing homes, county health departments, community intermediate care facilities for the developmentally disabled and prepaid health plans to be subject to a specific appropriation in the general appropriations act;
- Updates provisions related to the criteria used in the distribution of funds through the Medicaid Disproportionate Share program to implement the disproportionate share funding decisions in the Senate Health and Human Services budget;
- Requires Medipass recipients in counties with two or more managed care plans to be enrolled into a managed care plan if they fail to make a choice of plans during their choice period;
- Eliminates the agency's authority to adjust a hospital's inpatient per diem rate if the hospital meets the specific criteria; and
- Repeals the Sunshine for Seniors program.

This bill substantially amends, the following sections of the Florida Statutes: 400.179, 409.904, 409.906, 409.908, 409.911, 409.9112, 409.9113, 409.9117, 409.912, and 409.9122.

This bill repeals section 430.83 and subsection 409.905(5)(c) of the Florida Statutes.

II. Present Situation:

Nursing Home Lease Bonds
Since 1993, section 400.179, F.S., has required a performance bond as a condition of licensure for leased nursing homes to ensure that providers operating leased facilities satisfy their Medicaid overpayment liabilities. The statute requires a bond equal to three months Medicaid payments to the facility. Currently bond premiums cost approximately 1.27% of the coverage amount. As an alternative to the bond, the statute allows a leasehold licensee to meet the bond requirements by paying a non-refundable fee to the agency in the amount of 1 percent of the total of 3 months' Medicaid payments computed on the basis of the previous 12-month average of Medicaid payments. The fee is deposited into the Health Care Trust Fund and accounted for separately as a Medicaid nursing home overpayment account. These fees are used at the sole discretion of the Agency to repay nursing home Medicaid overpayments. Payment of this fee does not release the operator from any liability for any Medicaid overpayments nor does it bar the Agency from seeking to recoup overpayments from the operator and any other liable party. The money remains in the fund to protect the state's interest in recovering overpayments. This, in essence, creates a self-insurance pool for Medicaid overpayment liabilities.

Medicaid Aged and Disabled Program (MEDS AD)
The Medicaid Aged and Disabled Program (MEDS AD) eligibility category is an optional Medicaid eligibility group under s. 409.904(1), F.S. The program provides Medicaid coverage to individuals who are elderly or disabled, whose incomes are under 88 percent of the federal poverty level. Payments for services to individuals in optional eligibility 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. According to the February 2008 Social Services Estimating Conference for Medicaid caseloads, the estimated average monthly caseload for the MEDS AD program in fiscal year 2007-08 is 23,794 individuals.

Medically Needy Program

The Medically Needy eligibility category is an optional eligibility group authorized under Section 409.904, F.S. Title XIX of the Social Security Act specifies categories of individuals that the federal government gives state Medicaid programs the choice of covering (optional coverage groups). The Medically Needy program 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 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. According to the February 2008 Social Services Estimating Conference for Medicaid caseloads, the estimated average monthly caseload for the Medically Needy program for fiscal year 2007-08 is 18,247 individuals.

Dental Services

Medicaid adult dental services are optional services authorized in section 409.906, F.S.
The Florida Medicaid program reimburses for adult dental services when rendered by a dentist enrolled in Medicaid. Services provided include:

- Complete removable partial dentures;
- Comprehensive oral evaluation;
- Denture-related procedures;
- Incision and drainage of an abscess;
- Necessary radiographs to make a diagnosis;
- Problem-focused oral evaluation; and
- Extractions and surgical procedures essential to the preparation of the mouth for dentures.

Evaluations for adults are limited to determining the need for dentures or for acute emergency services. Emergency services are limited to an emergency problem-focused evaluation, necessary x-rays to make a diagnosis, extraction, and incision and drainage of an abscess.

Adult Medicaid recipients are responsible for paying a 5 percent coinsurance charge for all procedures related to denture services, unless otherwise exempt. Collection of the 5 percent coinsurance is the responsibility of the provider and is based upon 5 percent of the Medicaid fee or the provider's charge, whichever is less. Medicaid will automatically deduct the 5 percent from the provider's payment. In Fiscal Year 2006-2007, 41,547 individuals utilized Medicaid adult dental services.

Hearing Services
Medicaid hearing services for adults are optional services authorized in section 409.906, F.S. The Florida Medicaid program reimburses for hearing services rendered by licensed, Medicaid participating otolaryngologists, otologists, audiologists, and hearing aid specialists. Medicaid reimbursable hearing services include:

- Cochlear implant services;
- Diagnostic testing;
- Hearing aids;
- Hearing aid evaluations;
- Hearing aid fitting and dispensing;
- Hearing aid repairs and accessories; and

In Fiscal Year 2006-2007, 6,669 individuals utilized Medicaid adult hearing services.

Disproportionate Share
There are currently five separate Medicaid disproportionate share hospital programs that are operational in Florida. They are: the Regular program established in s. 409.911, F.S.; the Teaching Hospitals program established in s. 409.9113, 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 three 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 Primary Care program established in s. 409.9117, F.S.; and the Specialty Hospitals for Children program established in s. 409.9119, F.S.

Medicaid Prepaid Behavioral Health Plans
In March 1996, the AHCA implemented a Prepaid Mental Health Plan (PMHP) demonstration, under the authority of a 1915b waiver from the Federal Health Care Financing Administration (now known as the Centers for Medicare and Medicaid Services). The program was piloted for many years in two areas of the state before being expanded statewide in 2004. A prepaid behavioral health plan is a managed care organization that contracts with the AHCA to provide comprehensive mental health services to its members though a capitated payment system. The AHCA pays a per member, per month (PMPM) fee to the plan based on the age and eligibility category of each member. Services provided by these plans must include:

- Inpatient Psychiatric Hospital Services,
    - 45 days for adult recipients,

    - 365 days for children
- Outpatient Psychiatric Hospital Services,
- Psychiatric Physician Services,
- Community Mental Health Services, and
- Mental Health Targeted Case Management.

Any Medicaid recipient who elects to enroll in MediPass for the provision of their physical health care services is assigned to a prepaid behavioral health plan for the provision of their mental health services, unless they are ineligible. Ineligible persons include:

- Recipients who have both Medicaid and Medicare (dual eligibles),
- Persons living in an institutional setting, such as a nursing home, state mental health treatment facility, or prison,
- Medicaid-eligible recipients receiving services through hospice,
- Recipients in the Medically Needy Program,
- Newly enrolled recipients who have not yet chosen a health plan,
- SOBRA-eligible pregnant women and presumptively eligible pregnant women,
- Individuals with private major medical coverage,
- Members of a Medicaid HMO,
- Recipients receiving FACT services, and
- Children enrolled in the HomeSafeNet database.

Because of their unique situation, children in the HomeSafeNet database are excluded from participating in the prepaid behavioral health plan. A separate prepaid plan was developed for these children to provide services (including behavioral health services) operated by community-based lead agencies as of July 1, 2005.

Prescribed Drugs

Florida provides prescription drug coverage as part of its Medicaid program. For outpatient services, Medicaid pays for most prescription drugs and selected over-the-counter medicines.

Florida's Medicaid program pays pharmacies the lower of two costs: (1) what it estimates pharmacies pay for drugs (referred to as acquisition costs) plus a $4.23 dispensing fee, or (2) the pharmacy's usual and customary price for the drug. AHCA's prescription drug pricing algorithm first selects the lowest estimated acquisition cost and adds the dispensing fee. The algorithm then compares this price to the pharmacy's usual and customary price and pays the lower of these prices. AHCA estimates acquisition costs using two nationally published prices, the Average Wholesale Price (AWP) and the Wholesale Acquisition Cost (WAC); and two maximum prices, the federal upper limit (FUL) and the state maximum allowable cost (SMAC).

The AWP resembles a list price, or sticker price, and does not reflect what pharmacies are actually paying the wholesalers for the drug after volume discounts or rebates. Therefore, Florida, as do other states, tries to arrive at the pharmacy's EAC by applying a fixed discount percentage to the published AWP's (currently AWP minus 15.4 percent). To further provide the most accurate estimate of the pharmacy's acquisition cost, Florida, as do many other states, utilizes published WAC pricing plus a fixed percentage to reflect the wholesaler's mark-up to the pharmacy (currently WAC plus 5.75 percent).

Medicaid Managed Care Programs

The state of Florida operates a Medicaid managed care program through a federal 1915(b) waiver obtained from the Centers for Medicare and Medicaid Services in 1991. The managed care waiver provides the state with the authority to mandatorily assign eligible beneficiaries[1] and, within specific areas of the state, limit choice to approved managed care providers. The federal waiver requires Florida Medicaid recipients to be given a choice of managed care providers. The Medicaid managed care program is broken into two major categories of providers: MediPass and managed care plans. However, section 409.91211, F.S., codifies the Medicaid reform managed care pilot program in Baker, Broward, Clay, Duval, and Nassau Counties. Eligible Medicaid recipients in these counties must enroll in a managed care plan and do not have the ability to choose the MediPass program.

The Medicaid Provider Access System (MediPass) is a primary care case management program for Medicaid recipients developed and administered by Florida Medicaid. MediPass was established in 1991 to assure adequate access to coordinated primary care while decreasing the inappropriate utilization of medical services. In MediPass, each participating Medicaid recipient selects, or is assigned, a health care provider who furnishes primary care services, 24-hour access to care, and referral and authorization for specialty services and hospital care. The primary care providers are expected to monitor appropriateness of health care provided to their patients. MediPass providers receive a $3 monthly case management fee for each of their enrolled patients, as well as the customary reimbursement according to the Medicaid Provider Handbook for all services rendered.

The second major category of provider in the Medicaid managed care program is the managed care plan. Section 409.9122, F.S., defines managed care plans as health maintenance organizations (HMOs), exclusive provider organizations (EPOs), provider service networks (PSNs), minority physician networks, the Children's Medical Services Network, and pediatric emergency department diversion programs. These plans tend to be reimbursed through a capitated payment where the plan receives a set amount per member per month and is responsible for providing all necessary Medicaid services within that capitation rate.

Depending on where an individual lives in the state and their eligibility status, Medicaid recipients are given a choice of either MediPass or a managed care plan when they enroll in the Medicaid program. Under s. 409.9122, F.S., the AHCA is required to assign all Medicaid recipients eligible for mandatory assignment into either MediPass or a managed care plan if they do not make a choice within 30 days of being determined eligible. There are 23 counties with MediPass as the only managed care choice, ten counties have one managed care plan and MediPass, and 29 counties have at least two managed care plans in addition to MediPass. As of January 2008, there were 2,107,427 individuals enrolled in the Florida Medicaid Program. Of these Medicaid recipients, 195,230 are enrolled in the Medicaid reform pilot and 1,912,197 are enrolled in the non-reform component of the program. Of those individuals not in the reform

[1] Certain persons are ineligible for mandatory managed care enrollment. The major population groups excluded from enrolling in managed care altogether include the Medically Needy, recipients who reside in an institution, those in family planning waivers, and those who are eligible for Medicaid through the breast and cervical cancer program. Dual eligibles (persons who have both Medicaid and Medicare coverage) are excluded from enrollment in MediPass, yet the dual eligibles and others (SOBRA pregnant women and children in foster care) may voluntarily enroll in any other type of managed care plan.

counties, 1,265,562 are eligible for mandatory managed care. Of the individuals eligible for mandatory managed care enrollment, they are enrolled in the following types of plans in these numbers: 362,505 are enrolled in MediPass; 586,361 are enrolled in HMOs; 117,523 are enrolled in minority physician networks; 24,274 are enrolled in the Children's Medical Services Network; 7,521 are enrolled in PSNs; and 6,258 are enrolled in pediatric emergency room diversion plans.

Hospital Inpatient Services Reimbursement
Medicaid reimburses for inpatient hospital services prospectively based on cost-reported, per diem rates that are subject to caps. Teaching, specialty, and community health education hospitals and other qualifying hospitals are exempted from the caps contingent upon counties contributing to the state's share of the cost of the exemption.

To calculate the reimbursement rate, the agency requires each provider to submit an annual report of its prior year Medicaid costs ("a cost report"). Utilizing this information, the agency then calculates the providers average daily cost of services provided to Medicaid recipients for the reported year. The costs are inflated using a nationally published medical inflation factor to adjust the providers historical average cost into an amount that can be used to reimburse the provider for the upcoming period subject to certain limitations that are built into the methodology. This per-diem rate is used to reimburse the provider for services delivered to Medicaid recipients for the rate semester period (July 1st to December 31st; and January 1st to June 30th). The agency repeats this process every six months utilizing the most recent cost report information submitted by the provider and the most recent inflation trends in order to provide the most accurate estimate of the providers current average daily cost of providing services to Medicaid recipients. Further details of the reimbursement plan are explained in the Florida Medicaid (Title XIX) Inpatient Hospital Reimbursement Plan. The plan is available on the Agency for Health Care Administration website at http://ahca.myflorida.com/Medicaid.

Hospital Outpatient Services Reimbursement
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Nursing Homes
Medicaid nursing facility reimbursement is made in accordance with the Florida Medicaid (Title XIX) Long-Term Care Reimbursement Plan. A summary of the reimbursement methodology is included in the following paragraph. A detailed explanation is available in the Medicaid Title XIX Long-Term Care Reimbursement Plan on the agency website at: http://ahca.myflorida.com/Medicaid.

Each nursing home provider is required to submit an annual report of its prior year Medicaid costs ("a cost report") to the agency each year no later than five months after the end of the provider's fiscal year. Utilizing this information, the agency then calculates the provider's average cost of services for the following five cost components: Operating, Direct Patient Care, Indirect Patient Care, Property, and Return on Equity. The costs are inflated using a nationally published medical inflation factor to adjust the providers historical average cost into an amount that can be used to reimburse the provider for the upcoming period subject to certain limitations that are built into the methodology. The agency combines the five cost components into one facility specific per-diem reimbursement rate. The rate is used to reimburse the provider for services delivered to Medicaid recipients for each rate semester period (July 1st to December 31st; and January 1st to June 30th). The agency repeats this process every six months utilizing the most recent cost report information submitted by the provider and the most recent inflation trends in order to provide the most accurate estimate of the providers current average cost of providing services to Medicaid recipients. Since the methodology is based on average cost, there is no difference in reimbursement rates for recipients with skilled or intermediate levels of care. Rural swing-bed providers receive the average statewide nursing-facility rate. Hospital-based skilled nursing units receive the average nursing-facility rate for the county in which the hospital is located. Supplemental reimbursement is available for approved recipients who have AIDS or are medically-fragile children 20 years of age or younger. Prior authorization is required for a supplemental reimbursement.

Community Intermediate Care Facilities for the Developmentally Disabled
Community Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) facilities are reimbursed by Medicaid using a cost based reimbursement methodology that results in a per diem (daily) rate for each ICF/DD for each level care provided. The ICF/DD reimbursement levels are categorized in two groups: 1) a reimbursement rate for a Level of need 7 client base; and 2) a reimbursement rate for a Level of need 8 and 9 client base. A detailed explanation is available in the Medicaid Title XIX Intermediate Care Facility for the Mentally Retarded and Developmentally Disabled, Not Publicly Owned, Not Publicly Operated Reimbursement Plan on the agency website at: http://ahca.myflorida.com/Medicaid.

County Health Departments
County Health Departments (CHD)'s are reimbursed by Medicaid using a cost based reimbursement methodology that creates a facility specific encounter rate. Each CHD is required to submit detail costs for its entire reporting year, making appropriate adjustments as required by the County Health Department reimbursement plan. Details of the reimbursement plan can be found on the agency's website at: http://ahca.myflorida.com/Medicaid.

The following services are reimbursed through the facility specific encounter reimbursement rate:

- Adult health screening services
- Child Health Check-Up
- Dental services
- Family planning services
- Medical primary care
- Registered nurse services

Prepaid Health Plan Reimbursement

Prepaid Health Plans or Health Maintenance Organizations (HMO)'s managed care providers are reimbursed based on capitation payments calculated for the applicable contract year. Currently, the Agency for Health Care Administration as the administrating agency, is responsible for calculating the capitation payment rates for reimbursement to the HMO managed care plans. The agency's methodology is established through the administrative rule process (Rule 59G-8.100; F.A.C). The methodology can be summarized as follows:

- The capitation payment is the fixed amount paid monthly by the agency to an HMO for each enrolled HMO member to provide covered services needed by each member during the month as specified in each contract.
- The agency uses two years of certain historical expenditure data (excluding some fees and payments as described in the rule) from the Medicaid fee-for-service program for the same services the HMO is responsible for delivering.
- These data are then categorized into "rate cells" by age, gender, eligibility group, geographic region and are forecasted to the applicable year using inflation factors adopted by the legislature in the Social Services Estimating Conference. Once forecasted to the applicable year, these expenditure data are adjusted to reflect policy changes adopted by the legislature. It is important to note that Federal rules do not allow Medicaid managed care payments to exceed what would have been paid to providers under Medicaid fee-for-service. Therefore any policy changes that may affect fee-for-service expenditures in the applicable year must be accounted for in the capitation rates (i.e. reduction in fee-for-service Hospital Inpatient reimbursement rates. Hospital inpatient expenditures are a major component of HMO capitation rates).
- After the adjustment for policy issues, the agency applies a discount factor and a trend adjustment to each rate cell. The discount factor ranges from 0% to 8% and varies by rate cell depending on the geographic region and eligibility category.
- Upon completion, the rates are reviewed and certified by an independent actuarial firm. Upon actuarial certification, and confirmation by CMS, the agency will begin reimbursing HMOs the monthly capitation payment for each recipient enrolled in the plan.
- In the Medicaid Reform counties, a similar methodology is used as listed above, with the added criteria of risk adjustment based on recipient health status.

Sunshine For Seniors

Section 430.83, Florida Statutes, creates Sunshine for Seniors, a one-stop prescription assistance counseling program designed to help eligible seniors age 60 and older and disabled persons in

obtaining free and low-cost prescription drugs from manufacturer pharmaceutical-assistance and other discount programs.

Sunshine for Seniors is administered through the Department of Elder Affairs', Serving Health Insurance Needs of Elders (SHINE) program, and is sponsored locally by area agencies on aging. This program provides free and unbiased prescription-assistance counseling services through the SHINE network of volunteer counselors who uphold consumer confidentiality. Sunshine for Seniors counselors inform elder and disabled consumers of program eligibility criteria established by pharmaceutical companies and the drugs covered by those programs.

III. Effect of Proposed Changes:

Section 1 amend s. 400.179, F.S., to allow the Agency for Health Care Administration to transfer funds collected from nursing home lease bonds to the Grants and Donations Trust fund for nursing home reimbursement.

Section 2 amends s. 409.904, F.S., to eliminate the Medicaid Aged and Disabled eligibility group on October 31, 2008; and limits the Medicaid Medically Needy eligibility group to services for children and pregnant women effective November 1, 2008.

Section 3 amends s. 409.906, F.S. to eliminate Medicaid adult dental and hearing services effective October 1, 2008.

Section 4 amends s. 409.908, F.S., requiring Medicaid to pay all deductibles and coinsurance for portable x-ray Medicare Part B services provided in a nursing home; reduces the Average Wholesale Price (AWP) component of pharmacy pricing from AWP minus 15.4 percent to AWP minus 16.4 percent; reduces the Wholesale Acquisition Cost (WAC) component of pharmacy pricing from WAC plus 5.75 percent to WAC plus 4.75 percent; and requires the agency to reduce provider reimbursement rates on a recurring basis as prescribed in the general appropriations act for inpatient and outpatient hospitals, nursing homes, county health departments, community intermediate care facilities for the developmentally disabled, and prepaid health plans.

Section 5 amends s. 409.911, F.S., to update the years of audited data used in determining Medicaid and charity care days for each hospital in the Disproportionate Share program from 2000, 2001 and 2002 to 2002, 2003, and 2004; and to change the fiscal year that funds are distributed under the Disproportionate Share program from Fiscal Year 2006-2007 to Fiscal Year 2008-2009.

Section 6 amends s. 409.9112, F.S., to update dates from Fiscal Year 2005-2006 to Fiscal Year 2008-2009, continuing the prohibition on distributing funds through the Regional Perinatal Intensive Care Disproportionate Share program.

Section 7 amends s. 409.9113, F.S., to update the state fiscal year dates from Fiscal Year 2006-2007 to Fiscal Year 2008-2009, to allow for disproportionate share payments to teaching hospitals as provided in the General Appropriations Act.

Section 8 amends s. 409.9117, F.S., to update dates from Fiscal Year 2006-2007 to Fiscal Year 2008-2009, continuing the prohibition on distributing funds through the Primary Care Disproportionate Share program.

Section 9 amends s. 409.912, F.S., eliminating the exemption for children with open cases in the HomeSafeNet system in Hillsborough County that did not allow them to participate in the state wide specialty prepaid behavioral health plan; reduces the Average Wholesale Price (AWP) component of pharmacy pricing from AWP minus 15.4 percent to AWP minus 16.4 percent; and reduces the Wholesale Acquisition Cost (WAC) component of pharmacy pricing from WAC plus 5.75 percent to WAC plus 4.75 percent.

Section 10 amends s. 409.9122, F.S., requiring recipients already enrolled in a managed care plan that fail to make a choice of plans during the choice period, to remain in their managed care plan; and requiring recipients in the MediPass program who fail to make a choice during the annual choice period to be assigned to a managed care plan.

Section 11 repeals section 409.905(5)(c), F.S. eliminating the agency's authority to adjust a hospital's inpatient per diem rate if the hospital meets specific criteria; and repeals section 430.83 F.S., eliminating the Sunshine for Seniors Program.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Health care providers may see an increase in uncompensated care due to the elimination of Medicaid coverage for the MEDS AD, adult coverage under that Medically Needy program and dental and hearing services. Medicaid participating pharmacies will

experience lower reimbursements than anticipated due to the changes in the AWP and WAC pricing methodologies outlined in the bill.

Hospital, nursing home, county health departments, intermediate care facilities for the developmentally disabled, and prepaid health plans will experience changes in reimbursement do to the provisions requiring the agency to reduce reimbursement rates as prescribed in the general appropriations act.

The following five hospitals will experience lower Medicaid hospital inpatient reimbursement rates due to the elimination of the special ceiling exemption qualifications in section 409.905(5)(c), Florida Statutes: Health Central Hospital, Lake Wales Hospital, Winter Haven Hospital, New Port Richey Hospital, and Larkin Community Hospital.

C. Government Sector Impact:

The table below provides a summary of the fiscal impact of the bill. The bill makes the changes to Medically Needy and MEDS AD effective November 1, 2008, and the elimination of Adult dental and hearing services effective October 1, 2008. The column in the table below labeled "Restore Non-Recurring" provides the necessary funding for the time period prior to when the changes go into effect (includes $105.4 million in funds from the Lawton Chiles Endowment Fund). All reductions listed in the table below are included in PCB 7084, Fiscal Year 2008-09 appropriations.

	12-month Total			Annualization
Issue:	**General Revenue**	**Trust Funds**	**Total Funds**	**Restore Non-Recurring**
Elimination of the MEDS AD eligibility group, November 1, 2008	($152.7)	($202.9)	($355.6)	$118.5
Limit the Medically Needy program to children and pregnant women only, November 1, 2008	($148.1)	($201.4)	($349.5)	$116.5
Elimination of hearing services for adults, October 1, 2008	($1.5)	($1.8)	($3.3)	$0.8
Elimination of dental services for adults, October 1, 2008	($9.5)	($12.0)	($21.5)	$5.4
Inpact on reimbursement rates subject to GAA provisions:				
County Health Departments	($13.5)	($16.8)	($30.3)	
Hospital Inpatient	($52.6)	($65.5)	($118.1)	
Hospital Outpatient	($13.3)	($16.6)	($29.9)	
Intermediate Care Facilities for the Developmentally Disabled	($2.7)	($8.9)	($6.2)	
Nursing Homes	($72.9)	($90.7)	($163.6)	
Prepaid Health Plans*	($68.5)	($86.1)	($154.6)	
Reduce pharamcy reimbursement AWP and WAC pricing, July 1, 2008	($4.3)	($5.4)	($9.7)	
Removal of special reimbursement exemptions in s. 409.905(5)(c)	($5.3)	($6.7)	($12.0)	
Managed care enrollment	($2.6)	($3.1)	($5.7)	
Sunshine for Seniors	($0.2)		($0.2)	
Total impact of the bill	($547.7)	($717.9)	($1,260.0)	$241.2

* Includes impacts from other service changes

Funding reflected in Millions

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Committee on Health and Human Services Appropriations on April 2, 2008:

Senate Bill 1854 was originally filed as a shell bill expressing legislative intent to revise laws relating to health care. The Health and Human Services Appropriations Committee adopted the committee substitute as described in this bill analysis.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.