HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCB HCAS 11-06 Medicaid Services
SPONSOR(S): Health Care Appropriations Subcommittee, Hudson
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Health Care Appropriations Subcommittee	10 Y, 5 N	Hicks	Pridgeon

SUMMARY ANALYSIS

This bill conforms statutes to the funding decisions included in the proposed General Appropriations Act (GAA) for Fiscal Year 2011-2012. The bill:

- Repeals the sunset of the Medically Needy for adults and the Medicaid Aged and Disabled (MEDS-AD) waiver, which will sunset June 30, 2011.
- Eliminates optional Medicaid coverage of chiropractic and hearing services for adult recipients.
- Modifies the formula used for calculating reimbursements to providers of prescribed drugs.
- Repeals the sunset date for the freeze on Medicaid institutional unit cost; and deletes obsolete workgroups and reporting requirements.
- Provides for the allowed aggregated amount of assessments for all nursing home facilities to increase to conform to federal regulations.
- Revises the years of audited data used in determining Medicaid and charity care days for hospitals in the Disproportionate Share Hospital (DSH) Program; and changes the distribution criteria for Medicaid DSH payments to implement funding decisions for the DSH program.
- Eliminates the requirement to implement a wireless handheld clinical pharmacology drug information database for practitioners; and allowing electronic access to certain pharmacology drug information.
- Authorizes the implementation of a home delivery of pharmacy products program; establishes the requirements for the procurement and the program; and eliminates the requirement for the expansion of the mail-order-pharmacy diabetes-supply program.
- Eliminates certain specific components of the prescription drug management system program.
- Authorizes an additional Program of All-inclusive Care for the Elderly (PACE) site in Palm Beach County and approves up to 150 initial enrollees, subject to a specific appropriation.

The House Proposed GAA appropriates:

- $1,161.95 million to restore the Medically Needy program with recurring funds;
- $889.3 million to restore the MEDS-AD waiver program with recurring funds; and
- $246.6 million to implement the changes in DSH program funding.

The House Proposed GAA includes the following reductions:

- $393.9 million due to the continuation of the institutional providers unit cost freeze;
- $6.7 million due to an adjustment in the reimbursement formula for prescribed drugs;
- $3.7 million for the elimination of chiropractic and hearing coverage for adults; and
- $3.4 million due to elimination of certain contractual arrangements.

This bill has an effective date of July 1, 2011.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Optional Medicaid Eligibility and Coverage

Current law allows Medicaid reimbursement for medical assistance and related services for beneficiaries deemed eligible subject to income, assets, and categorical eligibility tests set forth in federal and state law. Payment on behalf of these Medicaid eligible beneficiaries is subject to the availability of moneys and any limitations established by the GAA or chapter 216, F.S.

- **The Medicaid Aged and Disabled Program (MEDS-AD)** eligibility category is an optional Medicaid eligibility group. The program provides Medicaid coverage to individuals who are age 65 or older or totally and permanently disabled, have incomes less than 88 percent of the federal poverty level, not eligible for Medicare and meet asset limits. The 2005 Legislature through chapter 2005-60, L.O.F, directed the Agency for Health Care Administration (AHCA) to seek federal waiver authority to revise Medicaid eligibility coverage for the Medicaid MEDS-AD eligibility group beginning January 1, 2006. The AHCA received approval of the 1115 Research and Demonstration Waiver on November 22, 2005. The waiver was subsequently renewed on January 1, 2011. In accordance with the approved waiver, the revised program covers:

    - Individuals without Medicare residing in the community or receiving Medicaid-covered institutional care services, hospice services, or home and community based services (HCBS), and
    - Individuals eligible for Medicare and also eligible for and receiving Medicaid-covered institutional care services, hospice services, or home and community based waiver services.

  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 MEDS-AD program, those who are eligible for Medicare will continue to have Medicaid coverage for Medicare premiums, deductibles, and coinsurance. This program is expected to have an average monthly enrollment of approximately 42,115 individuals in Fiscal Year 2011-12.

- **The Medically Needy** eligibility category is an optional Medicaid eligibility group. Title XIX of the Social Security Act specifies categories of individuals that the federal government gives state Medicaid programs the option of covering through their state plan. The Medically Needy program covers persons who have experienced a catastrophic illness and either have no health insurance, or have exhausted their benefits. On a month by month basis, the individual's medical expenses are subtracted from his or her income. If the remainder falls below Medicaid's income limits, the individual may qualify for Medicaid for the full or partial month depending on the date the medical expenses were incurred. The amount of expenses that must be deducted from the individual's income to make him or her eligible for Medicaid is called "share of cost." A person eligible for the Medically Needy Program is eligible for all Medicaid services with the exception of skilled nursing facility, state mental hospital, intermediate care facility for the developmentally disabled, assistive care services, community-based waiver services, or the payment of Medicare premiums by Medicaid. This program is expected to serve an average monthly enrollment of approximately 46,096 individuals in Fiscal Year 2011-12.

Current law allows Medicaid reimbursement to providers for at least 27 optional services, including chiropractic and hearing services.

- **Chiropractic Services –** Medicaid reimburses chiropractic services rendered by a licensed, Medicaid participating chiropractic physician. Chiropractic services include manual manipulation of the spine, initial services and screening, and x-rays provided by a licensed chiropractic physician. For Fiscal Year 2011-2012, it is estimated that approximately 8,242 adult beneficiaries would be eligible for this Medicaid coverage.

- **Hearing Services –** Medicaid reimburses for hearing services rendered by licensed, Medicaid participating otolaryngologists, otologists, audiologists, and hearing aid specialists. Reimbursable hearing services include cochlear implant services, diagnostic audiological testing, hearing aids, hearing evaluations to determine hearing aid candidacy, hearing aid fitting and dispensing, hearing aid repairs and accessories, and mandatory newborn hearing screening. For Fiscal Year 2011-2012, it is estimated that approximately 880,184 adult beneficiaries would be eligible for this Medicaid coverage.

The bill repeals the June 30, 2011 sunset date for the MEDS-AD and Medically Needy programs, restoring Medicaid coverage to eligible individuals with recurring funds. The bill also eliminates Medicaid reimbursement for optional Medicaid chiropractic and hearing services for adult recipients effective September 30, 2011.

Reimbursement Rates for Medicaid Providers

Currently, Medicaid reimburses Medicaid providers in one of the following ways:

Capitated Rate Setting - Capitated reimbursement is provided for in ss. 409.9124, and 409.91211. F.S, and is a methodology used for managed care providers.

- Fee-For-Service Method -
  Capitated rates are set annually based upon two years of fee-for-service claims and financial data for all recipients eligible for enrollment in a health maintenance organization (HMO) plan, and must be actuarially sound for comparable recipients. Thus, current rates are based upon data from State Fiscal Years 2007-2008 and 2008-2009, and are based upon 25 different service categories, such as hospital inpatient, laboratory, x-ray, etc. Actuarially sound rates are established for recipient categories, such as TANF, SSI without Medicare, SSI with Medicare Parts A and B, and SSI with Medicare Part B only; in all 11 AHCA areas for age/gender bands (birth to 2 months; 3-11 months, 1-5 years, 6-13 years, 14-20 years female; 14-20 years male; 21-54 years female; 21-54 years male; and 55+). Age and gender bands are only utilized in non-reform rate setting. Reform has composite rates.

- Financial/Encounter Data Method -
  In addition to the Fee-for-Service data, plan financial data for Calendar Years 2008 and 2009 for non-pharmacy services was used. The non-pharmacy encounter data was used as a source for validation of the plan specific financial reporting. The Financial Data Method receives 24 percent weight for Non-Reform rates and 50 percent for Reform rates for non-pharmacy services in rate calculation for the TANF and SSI without Medicare categories for Fiscal Year 2010-2011.

- Pharmacy Encounter Data Method –
  Pharmacy encounter data was used from State Fiscal Year 2008-2009. The pharmacy encounter data was submitted by the HMOs to develop the pharmacy component of the capitation rates. The Pharmacy Encounter Data Method received 100% weight for pharmacy services in the rate calculation for the TANF and SSI without Medicare categories.

- Risk Adjustment –
  The Reform Area final rates are risk adjusted for age, gender, medical conditions and diagnosis.

Fee-For-Service - Fee-for-service reimbursement is accomplished through the assignment of an established fee for each service provided by specific Medicaid provider types, which is established by Medicaid based upon funding provided in the GAA. The types of services typically reimbursed through a fee for service payment are physician, nursing care, dental services, pharmaceuticals, laboratory services, durable medical equipment and supplies, home health agency services, dialysis center services, and emergency transportation services. Reimbursement rates for physicians are set for periodic adjustment pursuant to federal directive, which is based upon updates to the Resource Based Relative Value Scale that requires budget neutrality as part of adjustments.

Cost-based Reimbursement - Cost-based reimbursement is accomplished through periodically establishing fees for each provider type based upon the provider type's historic cost of providing services, which, for institutional providers, is generally indexed to pre-determined health care inflation indices (price level increases). AHCA collects the cost data from individual providers to use in calculating and setting cost-based reimbursement rates. Nursing homes, hospitals, intermediate care facilities for the developmentally disabled, rural health clinics, county health departments, hospices, and federally qualified health centers are the types of providers that are reimbursed using cost-based methodologies, and provider types may be subject to specified reimbursement ceilings and targets.

Section 5, chapter 2008-143, L.O.F., directed AHCA to establish provider rates for hospitals, nursing homes, community intermediate care facilities for the developmentally disabled and county health departments in a manner that would result in the elimination of automatic cost-based rate increases for a period of two fiscal years. The unit cost rate freeze is set to expire July 1, 2011.

The bill repeals the sunset date for unit cost rate freeze on Medicaid provider rates for hospitals, nursing homes, community intermediate care facilities for the developmentally disabled and county health departments. The bill also repeals an obsolete provision to establish workgroups to evaluate alternate reimbursement and payment methods for hospitals, nursing facilities, and managed care plans and the reporting requirement on its evaluation.

Medicaid Reimbursement for Prescribed Drugs Services

Reimbursement for prescribed drug claims is made in accordance with the provisions of 42 CFR 447.512-516; and ss. 409.906(20), 409.908, 409.912(39) (a), F.S. The current reimbursement for covered drugs dispensed by a licensed pharmacy, approved as a Medicaid provider, or an enrolled dispensing physician filling his own prescriptions, is the lesser of:

- Average Wholesale Price (AWP) minus 16.4%, plus a dispensing fee of $3.73 or
- Wholesaler Acquisition Cost (WAC) plus 4.75%, plus a dispensing fee of $3.73 or
- The Federal Upper Limit (FUL) established by the CMS, plus a dispensing fee of $3.73 or
- The State Maximum Allowable Cost (SMAC), plus a dispensing fee of $3.73 or
- The provider's Usual and Customary (UAC) charge, inclusive of dispensing fee.

AWP and WAC are published by First Data Bank (FDB) as reference prices for pharmaceuticals. AWP is a "list price" and is higher than the cost wholesalers actually pay. WAC is slightly more representative of costs actually paid by wholesalers, and is more accurate with respect to branded pharmaceuticals than generics. Third party payors and State Medicaid Programs use these published prices (AWP and WAC) in their retail pharmacy reimbursement calculations.

On March 30, 2009, the U.S. District Court for the District of Massachusetts entered a Final Order and Judgment approving a class action settlement that involved two major publishers of drug pricing information, FDB and Medi-Span. The Plaintiffs in this case alleged that FDB's and Medi-Span's policies and practices caused them to pay inflated prices for certain pharmaceutical products.

The settlement requires FDB and Medi-Span to reduce the AWP mark-up factor to a standard ceiling of 120 percent of WAC on all National Drug Codes (NDCs). This change took effect on September 26, 2009, and will affect all prescriptions where the reimbursement calculation was based on AWP. With

respect to Florida Medicaid, 25.39 percent of prescriptions are reimbursed based on AWP. These are primarily branded pharmaceuticals still under patent. Both FDB and Medi-Span have independently announced plans to discontinue publishing AWP by September, 2011.

This bill modifies the reimbursement formula for prescribed drugs by adjusting the WAC-based formula to WAC plus 3.75 percent. Upon the loss of the AWP-based formula, WAC plus 3.75 percent will be the reimbursement rate used to reimburse Medicaid pharmacy providers.

Disproportionate Share Program (DSH)

Each year the Low-Income Pool Council (formerly Disproportionate Share Council) makes recommendations to the Legislature on the Medicaid Disproportionate Share Hospital Program funding distributions to hospitals that provide a disproportionate share of the Medicaid or charity care services to uninsured individuals. However, the legislature delineates how the funds will be distributed to each eligible facility.

The bill amends several provisions of chapter 409, F.S., to update for the most recent years of audited data used to implement the changes in DSH program funding for Fiscal Year 2011-2012. The bill:

- Revises the method for calculating disproportionate share payments to hospitals for Fiscal Year 2011-2012 by changing the years of averaged audited data from 2003, 2004, and 2005 to 2004, 2005, and 2006;
- Revises the time period from Fiscal Year 2010-2011 to 2011-2012 during which the AHCA is prohibited from distributing funds under the Disproportionate Share Program for regional perinatal intensive care centers;
- Requires that funds for statutorily defined teaching hospitals in Fiscal Year 2011-2012 be distributed in the same proportion as funds were distributed under the Disproportionate Share Program for teaching hospitals in Fiscal Year 2003-2004, or as otherwise provided in the GAA; and
- Revises the time period from Fiscal Year 2010-2011 to Fiscal Year 2011-2012 during which the AHCA is prohibited from distributing funds under the primary care disproportionate share program.

Program of All-Inclusive Care for the Elderly (PACE)

PACE is a capitated benefit model authorized by the federal Balanced Budget Act of 1997 that features a comprehensive service delivery system and integrated federal Medicare and state Medicaid financing. The model was tested through CMS demonstration projects that began in the mid-1980s.[1] The PACE model was developed to address the needs of long-term care clients, providers, and payors.

For most participants, the comprehensive service package permits them to continue living at home while receiving services rather than receiving services in other more costly long term care settings. Capitated financing allows providers to deliver all the services that participants need rather than being limited to those services reimbursable under the Medicare and Medicaid fee-for-service systems. [2]

The Balanced Budget Act of 1997 established the PACE model of care as a permanent entity within the Medicare program and enabled states to provide the PACE services to Medicaid beneficiaries as a state option without a Medicaid waiver. The state plan must include PACE as an optional Medicaid benefit before the State and the Secretary of the Department of Health and Human Services can enter into program agreements with PACE providers.[3]

[1] Centers for Medicare and Medicaid Services website: http://www.cms.hhs.gov/PACE/ (last visited on March 17, 2011).

[2] *Id.*

[3] *Id.*

A PACE organization is a not-for-profit private or public entity that is primarily engaged in providing the PACE services and must:[4]

- Have a governing board that includes community representation;
- Be able to provide the complete service package regardless of frequency or duration of services;
- Have a physical site to provide adult day services;
- Have a defined service area;
- Have safeguards against conflicts of interest;
- Have demonstrated fiscal soundness; and
- Have a formal participant bill of rights.

The PACE project is a unique federal/state partnership. The federal government establishes the PACE organization requirements and application process. The state Medicaid agency or other state agency is responsible for oversight of the entire application process, which includes reviewing the initial application and providing an on-sight readiness review before a PACE organization can be authorized to serve patients. An approved PACE organization must sign a contract with the CMS and the state Medicaid agency.[5]

Florida PACE Project

The Florida PACE project is one project among many that provide alternative, long-term care options for elders who qualify for Medicare and the state Medicaid program. The PACE project was initially authorized in chapter 98-327, Laws of Florida, and is codified in s. 430.707(2), F.S. The PACE model targets individuals who would otherwise qualify for Medicaid nursing home placement and provides them with a comprehensive array of home and community based services at a cost less than the cost of nursing home care. The PACE project is administered by DOEA in consultation with AHCA.

Section 3, chapter 2006-25, L.O.F., included proviso language in the 2006-2007 GAA to authorize 150 additional clients for the existing PACE project in Miami-Dade County and funding for the development of PACE projects to serve 200 clients in Martin and St. Lucie counties, and 200 clients in Lee County.

Section 3, chapter 2008-152, L.O.F., included proviso language in the 2008-09 GAA to reallocate 150 unused PACE slots to Miami-Dade, Lee and Pinellas Counties. Each site received 50 slots.

Section 20, chapter 2009-55, L.O.F., directed the AHCA, upon federal approval of an application to be a site for PACE, to contract with one private, not-for-profit hospice organization located in Hillsborough County, which provides comprehensive services, including hospice care for frail and elderly persons. This section also authorized the AHCA, in consultation with DOEA and subject to an appropriation, to approve up to 100 slots for the program.

Section 14, chapter 2010-156, L.O.F., directed the AHCA to contract with a private health care organization to provide comprehensive services to frail and elderly persons residing in Polk, Highlands, Hardee, and Hillsborough Counties. This section also authorized 150 initial slots for the program.

Section 15, chapter 2010-156, L.O.F., directed AHCA to contract for a new PACE site in Southwest Miami-Dade County and approved 50 initial slots for the program.

In addition to receiving the necessary legislative authority, the development of a new PACE organization or the expansion of an existing program is a lengthy process that includes: identifying a service area, acquiring and renovating a PACE facility and processing the PACE application through the state and the federal review system.

[4] PACE Fact Sheet, available at http://www.cms.hhs.gov/PACE/Downloads/PACEFactSheet.pdf.

[5] *Id*.

The bill authorizes, subject to an appropriation, up to 150 initial enrollee slots for a new PACE project in Palm Beach County.

Modifications in Contractual Arrangements

- **Wireless Handheld Devices –** Pursuant to s. 409.912 (16)(b), F.S., the AHCA was directed to contract with an entity in the state to implement a wireless handheld clinical pharmacology drug information database for practitioners. The device was envisioned to provide continuous updates of clinical pharmacology information, reference to the Medicaid Preferred Drug List (PDL), specific patient medication history, and ongoing education and support. Initially, the vendor provided a pilot group of 1,000 high volume practitioners with the wireless handheld device. The objective with this pilot group was to prevent duplicate prescribing and improve clinical outcomes. The device gave the practitioners a specific patient drug profile and access to clinical drug information at the point of care. The 2004 Legislature expanded the program to 3,000 devices. In 2005, e-prescribing capability was added giving practitioners access to continuous updates of clinical pharmacology information, reference to the Medicaid PDL and specific patient medication history at the point of care. Prescriptions could also be submitted electronically to the patient's pharmacy of choice. However, utilization remained at less than capacity. In 2009, the number of handheld devices was reduced to 1,000 due to low utilization by practitioners. Currently, the vendor provides 555 handheld devices to high volume practitioners to support e-prescribing.

  The bill removes the requirement for the AHCA to implement a wireless handheld program and grants the AHCA authority to provide electronic access to pharmacology drug information to Medicaid providers to ensure adequate access to e-prescribing in the most cost effective manner.

- **Therapy Management Contract (Prescribed Drugs) -** The 2005 Legislature directed the AHCA to implement a prescription drug management system with various components to reduce costs, waste, and fraud, while improving recipient safety. The drug management system implemented must rely on cooperation between physician and pharmacist to determine appropriate practice patterns and clinical guidelines to improve prescribing, dispensing, and medication usage for recipients in the Medicaid program. The AHCA entered into a contractual arrangement to reduce clinical risk, lower prescribed drug costs and the rate of inappropriate spending for certain Medicaid prescription drugs.

  There are over 4,000 pharmacy providers in Florida. There are 841 pharmacies enrolled in the program and 200 of those pharmacies are actively participating in the program.

  This bill eliminates specific components of the prescription drug management system, but continues general authority that allows the AHCA to implement a drug management system.

- **Home Delivery of Pharmacy Products -** During Special Session 2001C Session, the Legislature expanded the home delivery of pharmacy products. The AHCA was directed to expand the current mail-order-pharmacy diabetes supply program to include all generic and brand name drugs used by Medicaid patients with diabetes. The program was established as voluntary participation for Medicaid recipients with diabetes. Pharmacies were prohibited from charging higher reimbursement rate for this expansion in service. The initiative was limited to the geographic area covered by the current contract.

  In 2010, the Legislature directed the AHCA, through specific proviso language, to issue an invitation to negotiate with a pharmacy or pharmacies to provide mail order delivery services at no cost to the patients who elect to receive their drugs by mail order delivery services for patients with chronic disease states. Participation was limited to 20,000 patients statewide.

  This bill grants statutory authority to the AHCA to implement a mail order home delivery pharmacy program with a focus on serving recipients with chronic diseases. The bill also eliminates the requirement to expand the current mail-order-pharmacy diabetes-supply program.

Nursing Home Facility Providers Quality Assessment Program

Section 409.9082, F.S., establishes a quality assessment program for nursing home facility providers. The program had an effective date of April 1, 2009. Current federal regulations provide that assessment revenues cannot exceed 5.5 percent of the total aggregate net patient service revenue of the assessed facilities. The AHCA was authorized to calculate the assessment annually on a per-resident-day basis, exclusive of those days funded by the Medicare program. Certain nursing home facilities are exempt from the imposition of the quality assessment. The purpose of the nursing home quality assessment is to ensure continued quality of care and that the collected assessments are used to obtain federal financial participation through the Medicaid program in order to make Medicaid payments for nursing home facility services up to the amount of nursing home facility Medicaid rates as calculated in accordance with the approved state Medicaid plan in effect on December 31, 2007.

Effective October 1, 2011, federal regulations will allow the total aggregate amount of assessment for all nursing home facilities to increase to 6.0 percent. This bill modifies statutory authority to conform to federal regulations.

B. SECTION DIRECTORY:

Section 1: Amends s. 409.904, F.S., repealing the sunset of provisions authorizing the Medically Aged and Disabled waiver and Medically Needy programs; and eliminating the limit to services placed on the Medically Needy program.

Section 2: Amends s. 409.906, F.S., eliminating adult Medicaid coverage for chiropractic and hearing services.

Section 3: Amends s. 409.908, F.S., updating the formula used for calculating reimbursements to providers for prescribed drugs; continuing the institutional providers reimbursement rate freeze; deleting an obsolete requirement; and eliminating the repeal date of the institutional providers reimbursement rate freeze.

Section 4: Amends s. 409.9082, F.S., revising the allowed aggregated amount of assessment for all nursing home facilities to conform to federal law.

Section 5: Amends s. 409.911, F.S., updating the share data used to calculate disproportionate share payments to hospitals.

Section 6: Amends s. 409.9112, F.S., prohibiting the distribution of disproportionate share payments to regional perinatal intensive care centers for Fiscal Year 2010-2011.

Section 7: Amends s. 409.9113, F.S., requiring the AHCA to distribute moneys provided in the GAA to statutorily defined teaching hospitals and family practice teaching hospitals under the teaching hospitals disproportionate share program for Fiscal Year 2010-2011.

Section 8: Amends s. 409.9117, F.S., prohibiting the distribution of moneys under the primary care disproportionate share program for Fiscal Year 2010-2011.

Section 9: Amends s. 409.912, F.S., allowing for the continuation of electronic access to certain pharmacology drug information; eliminating the requirement to implement a wireless handheld clinical pharmacology drug information database; updating the formula used for calculating reimbursements to providers of prescribed drugs; authorizing the implementation of a pharmacy products home delivery program; eliminating the requirement for the expansion of the mail order pharmacy diabetes supply program; and eliminating certain provisions of the Medicaid prescription drug management program.

Section 10: Amends s. 430.707, F.S., providing for an additional PACE site.

Section 11: Provides an effective date of July 1, 2011.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   $138,178,151 million in federal Medicaid funds will be generated through the implementation of the DSH programs.

2. Expenditures:

	FY 2011-12
OPTIONAL MEDICAID ELIGIBILITY AND COVERAGE	
MEDS-AD Program	
General Revenue	$ 199,733,536
Grants and Donations Trust Fund	$ 40,548,529
Public Medical Assistance Trust Fund	$ 182,000,000
Medical Care Trust Fund	$ 467,043,395
Total	**$ 889,325,460**
Medically Needy Program	
General Revenue	$ 487,238,897
Grants and Donations Trust Fund	$ 80,315,819
Medical Care Trust Fund	$ 594,402,255
Total	**$1,161,956,971**
Chiropractic Services	
General Revenue	($ 438,965)
Medical Care Trust Fund	($ 557,097)
Refugee Assistance Trust Fund	($ 3,392)
Total	**($ 999,454)**
Hearing Services	
General Revenue	($ 1,187,273)
Medical Care Trust Fund	($ 1,507,400)
Total	**($ 2,694,673)**
INSTITUTIONAL PROVIDERS UNIT COST FREEZE	
General Revenue	($ 137,016,867)
Grants and Donations Trust Fund	($ 35,718,646)
Medical Care Trust Fund	($ 219,925,441)
Refugee Assistance Trust Fund	($ 1,226,741)
Total	**($ 393,887,695)**
PHARMACY PROGRAM REDUCTION	
General Revenue	($ 2,961,900)
Medical Care Trust Fund	($ 3,760,524)
Refugee Assistance Trust Fund	($ 14,823)
Total	**($ 6,737,247)**

DISPROPORTIONATE SHARE PROGRAM

General Revenue	$ 750,000
Grants and Donations Trust Fund	$ 107,642,426
Medical Care Trust Fund	$ 138,178,151
Total	**$ 246,570,577**

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

General Revenue	$ 325,191
Operations & Maintenance Trust Fund	$ 412,872
Total	**$ 738,063**

MODIFICATIONS IN CONTRACTUAL SERVICES

Wireless Handheld Devices

General Revenue	($ 610,672)
Grants and Donations Trust Fund	($ 551,530)
Medical Care Trust Fund	($ 1,162,206)
Total	**($ 2,324,408)**

Therapy Management (Prescribed Drugs)

General Revenue	($ 520,000)
Medical Care Trust Fund	($ 520,000)
Total	**($ 1,040,000)**

BUDGETARY INCREASES

General Revenue	**$ 687,722,433**
Grants and Donations Trust Fund	**$ 228,506,774**
Public Medical Assistance Trust Fund	**$ 182,000,000**
Medical Care Trust Fund	**$1,199,623,801**
Grand Total – Increases	**$2,297,853,008**

BUDGETARY DECREASES

General Revenue	**($ 142,735,677)**
Grants and Donations Trust Fund	**($ 36,270,176)**
Medical Care Trust Fund	**($ 227,432,668)**
Refugee Assistance Trust Fund	**($ 1,244,956)**
Grand Total – Decreases	**($ 407,683,477)**

TOTAL BUDGETARY IMPACT

General Revenue	**$ 544,986,756**
Grants and Donations Trust Fund	**$ 192,236,598**
Public Medical Assistance Trust Fund	**$ 182,000,000**
Medical Care Trust Fund	**$ 972,191,133**
Refugee Assistance Trust Fund	**($ 1,244,956)**
Grand Total – All	**$ 1,890,169,531**

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

Local governments and other local political subdivisions may provide $107,642,426 million in contributions for the DSH programs.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Hospitals providing a disproportionate share of Medicaid or charity care services will receive additional reimbursements towards the cost of providing care to uninsured individuals.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The AHCA has sufficient rulemaking authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COUNCIL OR COMMITTEE SUBSTITUTE CHANGES