



The Florida Senate

Interim Project Report 98-29

September 1998

Senate Committee on Health Care

STATE-SPONSORED ADULT HEART TRANSPLANT PROGRAM

SUMMARY

This report is required by section 3 of chapter 98-192, Laws of Florida, which directed four committees of the Florida House of Representatives and Senate to analyze the short- and long-term public policy and cost implications of implementing a state-sponsored adult heart transplant program. In summary, the report finds the following.

Short- and Long-Term Public Policy Implications

- ◆ Florida is one of only seven states that does not cover adult heart transplants under its Medicaid program.
 - ◆ A heart transplant is no longer considered to be an experimental procedure and is the only alternative to death for certain patients. Approximately 83 percent of adult heart transplant patients will survive the first year; and approximately 67 percent will survive at least five years. Although heart transplant patients generally lead productive lives, they must continue extensive follow-up care and take immunosuppressant drugs for the remainder of their lives.
 - ◆ Some Floridians in need of a heart transplant are dying for lack of insurance coverage, since Floridians lacking insurance coverage are generally not considered as candidates for heart transplants by Florida transplant centers. The lack of consideration of uninsured patients for heart transplants is related to the insufficient supply of donated hearts. If the state covers heart transplants for the poor and uninsured at competitive rates, these persons will compete with privately insured patients for the limited supply of available organs. Waiting lists will get longer and ultimately, the same number of people will die unless more donated hearts remain in Florida or more donated hearts are brought into Florida. If Florida waiting lists are longer, however, Florida
- may access a slightly larger share of available organs nationwide.
 - ◆ If the Legislature funds adult heart transplants, it is likely that some migration from private insurance coverage to state-sponsored coverage could occur.
 - ◆ Funding an adult heart transplant program through Medicaid has the advantage of access to federal matching dollars and the use of the existing administrative structure (eligibility determination, provider network, reimbursement mechanisms, etc.). However, since Medicaid is an entitlement program, no limit may be placed on the number of procedures funded for eligible persons. Funding adult heart transplants in a non-Medicaid program provides the state flexibility in the number of procedures it will fund and how it will pay providers, but the state will be required to pay 100 percent of the program costs and will have to develop the necessary administrative mechanisms.
 - ◆ The fact that Medicaid covers adult liver transplants and not adult heart transplants is a function of past litigation history and not public policy considerations. Costs and outcomes for these two procedures are similar. However, since few transplant centers will accept current state funding for liver transplants, it is likely that a decision to fund adult heart transplants will result in increased pressure to revise funding formulas for liver transplants and perhaps other organ transplants, and to fund organ transplants that are not currently covered by Medicaid. Public policy issues related to coverage of kidney and cornea transplants differ from hearts and livers since transplant coverage for kidneys and corneas is a cost effective alternative to more expensive medical and social services interventions (kidney dialysis and care of the blind).

- ◆ It is not anticipated that there will be any major medical advances or large increases in heart donations that would suggest a potentially large growth in the number of heart transplants being done in future years. It appears that the number of heart transplants being done over the next 10 years will remain fairly stable.

Direct and Ancillary Cost Implications

Heart transplants are expensive medical procedures. Not only are pre-transplant and initial transplant costs high, but extensive follow-up care and immunosuppressant drugs are required for the duration of the patient's life.

A determination of actual costs was not feasible, so low and high range cost estimates are provided for a five-year time period. It is estimated that the program would provide evaluations to 60 patients the first year, and that one-third of these patients, or 20, would actually receive a transplant. By the end of the fifth year, it is estimated the program would evaluate 65 patients annually and that 22 would progress to transplant. Based on these numbers of patients to be served, the following cost estimates are provided:

- ◆ Per patient costs for pre-transplant evaluation are \$9,000 (inpatient) or \$6,000 (outpatient).
- ◆ Total first year transplant costs, including evaluation, transplant, follow-up, and immunosuppressant drugs, range from \$126,600 to \$222,000 per patient.
- ◆ Follow-up costs range from \$5,300 to \$10,600 per patient per year, and immunosuppressant drugs cost \$12,000 annually.
- ◆ Total program first year costs range from \$3.6 to \$5.5 million. By the end of the fifth year, total annual costs range from \$5.7 to \$8.6 million.
- ◆ Total costs for the first 5 years of the program range from \$23.4 to \$35.2 million.
- ◆ Some of these program costs will be offset by existing Medicaid expenditures for pre-transplant and post-transplant related services.
- ◆ If funded under Medicaid, 55 percent of all costs would be paid by the federal government.

Regardless of whether the Legislature decides to fund adult heart transplants, approximately the same number of Floridians will receive a heart transplant and the same number will die from failure to receive a heart transplant each year, unless more donated hearts become available for use in Florida. State funding for adult heart transplants will yield two results: allocation of donated hearts will be distributed more evenly based on medical necessity rather than ability to pay; and public resources could partially supplant private resources over time in funding organ transplants unless more donated hearts become available for Floridians.

BACKGROUND

Prior to July 1, 1997, Florida was one of only 7 states which did not include coverage for adult heart transplants as part of its Medicaid program. Since coverage of adult heart transplants is an optional service under federal Medicaid policy, states may choose whether to include, or not include, coverage of this service.

During the 1997 session, the Florida Legislature authorized Medicaid to pay for adult heart transplants effective July 1, 1997. As specified in Specific Appropriation 217B of the 1997-98 General Appropriations Act, total Medicaid expenditures for adult heart transplants for fiscal year 1997-98 were not to exceed \$1,604,535. This level of funding was determined sufficient to cover an estimated 30 adult heart transplants at \$53,000 per transplant, and was based on cost figures provided by the Agency for Health Care Administration (agency or AHCA).

In October of 1997, the agency informed the Legislature it could find no qualified hospital willing to provide an adult heart transplant for \$53,000. Instead, the agency informed the Legislature that the agency had negotiated with certain qualified hospitals a comprehensive global payment of \$177,000 per transplant procedure. This payment included reimbursement for evaluation, transplantation, and physician/professional fees.

Based upon this new, higher cost per adult for a heart transplant procedure, the 1998 Legislature did not include funding for Medicaid adult heart transplants in the 1998-99 General Appropriations Act. In addition, the 1998 Legislature enacted ch. 98-192, Laws of Florida, which, in section 3, directed the Senate Committee on Ways and Means, the Senate Health Care

Committee, the House of Representatives Health Care Services Committee, and the House of Representatives Fiscal Responsibility Council to: analyze the short- and long-term public policy and cost implications of implementing a state-sponsored adult heart transplant program; consider all direct and ancillary costs associated with providing comprehensive care associated with an adult heart transplant; and include the alternatives of implementing this program through the Medicaid program and on a non-Medicaid basis. The report is to be presented to the Social Services Estimating Conference, which is required to review and certify the cost estimates. Thereafter, the report and the findings of the Social Services Estimating Conference are to be presented to the President of the Senate and the Speaker of the House of Representatives by September 1, 1998.

The report, including the Social Services Estimating Conference findings, was submitted to the President of the Senate and the Speaker of the House of Representative on September 1, 1998. For additional detail, especially additional background information regarding the organ procurement and distribution system, the Medicaid program, the Certificate-of-Need program as it relates to transplant activities, and Medicare and insurance coverage of transplants, as well as additional general background and supportive detail, the reader should see the complete report on this interim project entitled, "State-Sponsored Adult Heart Transplant Program, Public Policy and Cost Implications."

In addition, ch. 98-192, Laws of Florida, authorizes the agency to submit a budget amendment in accordance with the provisions of ch. 216, F.S., for the purpose of implementing an adult heart transplant program in fiscal year 1998-99.

METHODOLOGY

The purpose of this section is to describe the methodology used by staff in addressing the public policy issues relating to, and the direct and ancillary costs associated with, a state-sponsored adult heart transplant program. Legislative staff identified a number of questions that served as the policy development framework for the analysis. Answers to these questions were derived from legislative staff research, from AHCA staff, and from information provided by Florida hospitals with adult heart transplant programs. Legislative staff used a standard set of questions to interview transplant surgeons and financial administrators and executives at in-state adult heart transplant centers.

It was beyond the resources and time frame of this project to determine actual adult heart transplant costs. As an alternative, staff developed low range and high range cost estimates. To determine the payment level required for transplant centers to accept state-sponsored adult heart transplant patients, the legislative staff surveyed all in-state adult heart transplant centers and selected centers in other Southern states. The hospitals surveyed included: University Medical Center, Jacksonville, Florida; Shands at the University of Florida, Gainesville, Florida; Tampa General Hospital, Tampa, Florida; Tallahassee Memorial HealthCare, Tallahassee, Florida; Jackson Memorial Hospital, Miami, Florida; The University of Alabama Hospital, Birmingham, Alabama; Duke University Medical Center, Durham, North Carolina; and Emory University Hospital, Atlanta, Georgia. Each hospital was asked to provide the payment rate it would require in order to perform an adult heart transplant for a state-sponsored patient. Each request was accompanied by a survey form for the hospital to use in determining its payment level, which divided the total costs of the transplants into five components: hospital evaluations, which includes all service/testing required to complete an evaluation; physician evaluation, which includes all professional services required to complete an evaluation; hospital transplant episode, which includes the time period beginning with admission for the procedure to discharge; physician transplant, which includes all surgeon fees from the time period beginning with admission for the procedure to 90 days post-transplant; and organ procurement, which includes proposed payment, if any, for the procurement and transport of an organ. After making a number of assumptions regarding various aspects of the cost data, these data were used in a calculation matrix, and the result formed the high range cost estimates for the provision of state-sponsored adult heart transplants.

Data to establish a low range cost figure were derived from a different source - national charge data from an actuarial study by Milliman and Robertson, Inc., the state's actuary for the State Group Health Insurance Program. These national charge data were converted to cost data using the cost-to-charge ratio reported by AHCA for Florida hospitals.

Additional detail regarding these calculations and the assumptions that are part of them are presented in subsequent portions of this report. Complete detail on the calculations are contained in the full project report.

FINDINGS

Policy and cost concerns were grouped under the following broad questions.

1. What is the impact on heart transplant candidates of not allocating (or allocating) state resources to pay for heart transplants for needy Floridians?
2. How should adult heart transplant services be ranked against other health care services that receive state funding?
3. What are the costs to the state to implement an adult heart transplant program?

Under each of these questions were numerous additional related questions that are discussed below.

PUBLIC POLICY IMPLICATIONS

Impact on Heart Transplant Candidates

Are Floridians who do not have insurance coverage or the financial means to pay for adult heart transplant services being denied evaluation to determine if they are heart transplant candidates and are Floridians dying because the state does not pay for heart transplant services?

Most transplant center representatives believe that individuals are determined ineligible for adult heart transplants even before they reach the point of the extensive medical evaluation, due to their lack of funding. Since there are a limited number of donor hearts available for transplant, paying patients are more likely to proceed to a full evaluation to become an adult heart transplant candidate. Because most patients who lack funding are not referred to the transplant centers for evaluation, the centers cannot know exactly how many Floridians may be dying per year. Rough estimates from some of the transplant centers contacted ranged from 10 to 25 Floridians who died per year as a result of being denied evaluations due to lack of financial means to pay for the transplant.

Even if the state provided funding to pay for heart transplants for the poor and uninsured Floridians who are determined to be heart transplant candidates, some of these individuals would die on the waiting list while waiting for a suitable donated heart, since the availability of donor hearts is severely limited. Until more donated hearts are available, the issue is whether the poor and uninsured are given an equal chance, based on clinical

criteria, to be recipients of one of the limited number of donated hearts. Equity will be affected by the amount the state is willing to pay for a heart transplant, when compared to what private insurers will pay.

If state-sponsored adult heart transplant candidates use available donated hearts, would that mean that other insured patients will die on the waiting list due to an insufficient supply of donated hearts?

All of the transplant centers stressed that there is a limited number of hearts and this shortage, more than any other factor, such as criteria for selection, is what controls the heart transplant process. Because there is a limited number of donated hearts for which everyone on the waiting list is in competition, it seems likely that, if the supply of hearts does not increase and more patients are put on the waiting lists, more insured patients will die on the waiting list. This will only be true, however, if the state reimburses transplant centers at a competitive rate when compared to private insurers.

What would be the expected average added years of life and quality of life for state-sponsored adult heart transplant recipients?

Generally, the quality of life after a heart transplant is good and most patients lead full and active lives. A patient's productivity after transplant depends mostly on the patient's productivity prior to transplant. There must be, however, a major long-term commitment to post-transplant treatment regimens, which includes biopsies, arteriograms, anti-rejection drugs, etc.

The transplant centers agreed that approximately 85 percent of the transplant recipients have 1-year survival rates; approximately 70 percent have 5-year survival rates; and approximately 50 percent have 10-year survival rates. In order to get on the waiting list for a heart transplant, the patient must have a 50 percent chance of survival for 1 year. Transplant centers that do more transplants report having higher survival rates than the rates mentioned above.

The general consensus among the transplant centers is that the quality of life and survival rates for state-sponsored adult heart transplant recipients should be the same as for adult heart transplant recipients who are not sponsored by the state. There was some concern expressed, however, about state-sponsored patients' potential lack of compliance with post-transplant treatment regimens, which would affect survival rates.

Ranking of Heart Transplant Services for Allocation of State Resources

Should the life-saving nature of adult heart transplant services give such services a higher ranking than other services currently receiving state funding?

Heart transplants result in added years of life, at an acceptable level of quality of life, for most transplant recipients. However, heart transplants are expensive procedures that are provided to very few people. How should heart transplant services be ranked against other services which may not save a life, but which may prevent illness or deterioration of a person's health? Could the funding that would pay for heart transplants be more effectively used to provide services that prevent illness in large numbers of people? Perhaps a more timely question is whether resources should be used for life saving treatments as opposed to treatments that do not save lives, but improve a person's quality of life.

In the late 1980's and early 1990's, the State of Oregon underwent an extensive public debate about prioritizing illness conditions and medical treatments for purposes of deciding what services should be covered under the state's Medicaid program. In deciding how conditions and treatments ranked relative to one another, the Oregon Health Services Commission considered three principle factors: (1) how much a treatment costs; (2) what improvement in a person's quality of life it is likely to produce; and (3) how many years that improvement will probably last. In addition, they grouped health services into categories, such as preventive care for children, maternity care, lifesaving treatments for sudden injuries or illnesses, and others. The Oregon Health Services Commission has ranked over 700 conditions/treatments. The rankings have been updated several times since the initial list was finished in 1991, with the latest update being May 1, 1998. Currently, cardiac transplant as a treatment for several heart conditions is ranked 155 out of 743 conditions/treatments that are ranked. The Oregon Medicaid program currently funds the top 574 conditions/treatments out of the 743 ranked conditions/treatments.

Should the state fund Medicaid coverage of certain organ and tissue transplants (liver, kidney, cornea, and bone marrow transplants), but not other organ and tissue transplants, such as adult heart transplants?

According to the United Network for Organ Sharing (UNOS), kidney and bone marrow transplants are covered in almost every state Medicaid program.

Forty-three state Medicaid programs cover adult liver transplants.

The Oregon Health Services Commission has ranked the following organ and tissue transplants in addition to heart transplants as described above: liver, kidney, bone marrow, heart-lung and lung, and pancreas/kidney. Each is ranked for specific illness conditions, so each transplant may receive multiple rankings. Liver transplants are ranked 103, 106, 177, and 617, depending on what condition is being treated. Kidney transplants are ranked 105 when used to treat end stage renal disease. Pancreas/kidney transplants are ranked 532 when used to treat diabetes mellitus with end stage renal disease. Bone marrow transplants are ranked 114, 116, 117, 119, 121, 122, 180, 197, 210, 225, 476, and 533, depending on what condition is being treated. Heart-lung and lung transplants are ranked 445 and 446, depending on the condition being treated. Of all the organ and tissue transplants that have been ranked, only liver transplants for cancer of the liver and intrahepatic bile ducts are not currently covered by the Oregon Medicaid program.

The decisions to cover each of the types of organ transplants currently included under the Florida Medicaid program were made on a case-by-case basis apart from any overall policy regarding organ transplants. In some cases, political and legal factors influenced the Legislature's decision to provide Medicaid reimbursement. In other cases, it was clearly more cost-effective to provide Medicaid reimbursement for the organ transplant than to reimburse for other treatments or services that would have been covered by Medicaid. In the absence of a prioritization system such as Oregon has adopted, Florida is again in the posture of deciding whether to cover another specific type of organ transplant.

Are adult heart transplant services covered by other states' Medicaid programs and by other insurers?

According to UNOS, forty-three state Medicaid programs cover adult heart transplants. The Health Care Financing Administration established national coverage of heart transplantation under the Medicare program in 1987. In most cases, the costs of an adult heart transplant are paid by private insurance companies.

COST IMPLICATIONS

What is the estimated total cost of state sponsorship of adult heart transplants, for current Medicaid eligibles,

for fiscal year 1999-2000 through fiscal year 2003-2004?

It is estimated that a state-sponsored adult heart transplant program would cost between \$3.6 - \$5.5 million for the first year, \$4.1- \$6.2 million the second year, \$4.6 - \$7.0 million the third year, \$5.2 - \$7.8 the fourth year, and \$5.7 - \$8.6 the fifth year, for a cumulative total of between \$23.4 - \$35.2 million. The state share of that cost will depend on whether the program is done through Medicaid or through a state program without federal matching funds. Actual costs will depend on how much the state pays for each transplant and how many transplants are actually done, but actual costs should fall somewhere within the specified range.

How does the projected cost of a state-sponsored adult heart transplant program compare to other transplant services covered by Medicaid, as well as other categories of Medicaid-covered services for adults?

According to AHCA, costs paid by the state each year for other adult organ transplants include: \$4,043,284 for adult liver transplants; \$1,085,362 for adult bone marrow transplants; and \$1,653,171 for adult renal transplants. For comparison purposes, the Florida Medicaid program projects spending \$3 million for coverage of the prescription drug Viagra during calendar year 1999. For coverage of anti-retro viral drugs, the Florida Medicaid program expects to spend \$70 million during calendar year 1999.

How predictable and stable would the costs be for a state-sponsored adult heart transplant program?

If the state provides funding for heart transplants for certain adults, would the presence of state funding encourage growth in the number of heart transplants being performed and could the state experience unpredictable, large increases in state appropriations for adult heart transplants in future years? Several factors could potentially affect the number of heart transplants being done and the costs of such procedures in Florida in future years: increased number of donated hearts; additional hospitals establishing heart transplant centers (thus potentially performing more transplants); medical advances that would reduce rejection of transplanted organs, increase the "shelf-life" of donated hearts, diminish (or increase) the need for heart transplants, or reduce or eliminate the need for human heart donors (pigs hearts or mechanical hearts); federal policies regarding the allocation of harvested organs; and private insurers dropping coverage of adult heart transplants.

All of the Florida adult heart transplant centers stressed that there is a limited number of donated hearts and this shortage, more than any other factor, is what controls the number of heart transplants that are done in Florida. Florida currently has one of the best organ procurement systems in the country and exports many donated organs which cannot be used in the state. The national average for harvested donor hearts is 20 hearts per million people and the Florida average is 36-38 hearts per million people. Although recent changes in Florida's laws relating to organ procurement and donor education are expected to increase the number of organs being donated, there probably will not be a large increase in the number of hearts donated since Florida is already far above the national average with respect to rates of harvesting donor hearts. In addition, if new federal allocation policies are instituted, there is the possibility that more hearts from Florida donors may go to patients outside of Florida.

Because of the limited number of donor hearts, it is unlikely that additional adult heart transplant centers would be established by Florida hospitals. None of the current adult heart transplant centers are performing transplants at capacity level. The transplant centers stressed the importance of volume of procedures performed at each center because the more heart transplants that are performed the greater the competency of the staff and the better the outcome of the transplants performed. The centers also noted that finding the personnel to create a transplant center is extremely difficult.

With regard to medical advances, the adult heart transplant center representatives agree that medical advances and increased technology have actually increased the population in need of heart transplants. Due to bridging technology, such as temporary artificial hearts and advanced drugs, patients are living longer and remain healthier while waiting for transplants. There have already been major advances with anti-rejection drugs, which have increased the longevity of transplant patients and decreased the need for second transplants. Transplant center representatives do not anticipate any new medical advances within the next ten years in the area of anti-rejection drugs, mechanical hearts, animal hearts for human transplant, and increasing the "shelf-life" of donated hearts that would significantly affect the number of heart transplants performed or the costs of such procedures. There is promising research that indicates that laboratory-produced organs, including hearts, may be possible in the next 10 years.

Most of the adult heart transplant center representatives strongly oppose the new organ allocation policy being proposed by the Department of Health and Human Services. They believe that the policy will increase the number of organs exported out of Florida and decrease the number of hearts available to Florida residents. One doctor noted that, due to the short “shelf-life” of donated hearts, the proposed policy may have more of a regional impact on heart transplants, while the impact on organs with longer “shelf-lives” will be greater. A representative of one center said that heart transplants in Florida will be least affected by the proposed new policy since Florida has so many of the sickest patients. It is possible that the distribution within Florida might change, but that more donated hearts would not likely go out of Florida. At the current time it is unclear what the effect of the proposed policy will be on Florida.

Finally, would private insurers drop coverage of heart transplants, if the state covers this service under Medicaid or a non-Medicaid program? There is no evidence to suggest that private insurers would drop coverage of organ transplants. However, if a state-sponsored program were available, and if that state program offered competitive levels of reimbursement, it is likely that migration from private coverage to state coverage could occur to some degree.

Virtually anyone sick enough to need a heart transplant would meet the medical criteria necessary to qualify for disability under Supplemental Security Income. Thus, depending on income and assets, a heart transplant patient could qualify for Medicaid immediately, or might qualify after meeting spend-down criteria under the Medicaid Medically Needy program. Although federal policy limits the ability of a person to transfer assets in order to qualify for Medicaid benefits in an institutional setting, there is no federal prohibition on transferring assets in order to qualify for a community program like Medicaid Medically Needy.

In the case of bone marrow transplants, insurers faced a mandate for coverage at the same time that Medicaid began offering coverage of the procedure. Because private insurance coverage of bone marrow transplants was statutorily mandated, there was no opportunity for private insurers to drop such coverage. In the case of kidney and liver transplants, private insurers continue to cover these transplants even though there is Medicaid coverage for kidney and liver transplants.

Would providing state funding for adult heart transplants result in increased pressure to fund other organ transplants as they become available?

Transplant technology is continuing to evolve. Currently, transplants for the pancreas and intestines remain in the experimental stages. Lung transplants have recently become non-experimental and seem to be the transplant procedure most likely to be given consideration as a covered service for purposes of private insurance and legislative consideration as a covered service under Medicaid. Other than these three referenced procedures, no other transplant types appear on the horizon for which coverage, private or public, will likely be sought.

One transplant center representative suggested that, if other adult organ transplants are considered for coverage in the future, the state should only cover single system failures, not multiple organ failures.

Direct and Ancillary Costs

All of the Florida transplant hospitals surveyed stated that they would require a payment level higher than the comprehensive global payment of \$177,000 per procedure, which was the cost hospitals had agreed to accept from Florida’s Medicaid program for adult heart transplants from July 1, 1997, through June 30, 1998. Survey data provided by the centers ranged from a low of \$178,500 from Tallahassee Memorial to a high of \$272,030 for University Medical Center in Jacksonville. The figures reported for Tampa General, Shands, and Jackson Memorial were \$185,300; \$219,000; and \$222,000, respectively. Since these latter three hospitals are the only transplant centers currently certified to perform Medicaid heart transplants and since they perform the majority of adult heart transplant’s in the state, it was decided to use cost data from these centers to estimate high end costs. Therefore, the cost data provided by Jackson Memorial (\$222,000) were used as the maximum the state would be required to pay for the average adult heart transplant patient (high range cost estimates). None of the out-of-state transplant centers surveyed provided a timely response including necessary cost data.

According to the Milliman and Robertson study, estimated first year charges for a heart transplant patient are \$253,200. The report also estimates one year survival rates at 83 percent and 5 year survival rates at 67 percent. Annual charges for follow-up care are estimated at \$10,600, and annual charges for immunosuppressants are \$10,600.

The data provided by Milliman and Robertson are charge data, not cost data. In order to convert these charge data to cost data, charges were multiplied by 50

percent, which is the average cost-to-charge ratio reported by AHCA for hospital charges. No data are available for calculating a cost-to-charge ratio on physician charges, so the same ratio of 50 percent was used. This same ratio was used to determine cost data for follow-up care. However, since actual cost data were available for immunosuppressant drugs from Florida’s Medicaid program, that figure (\$12,000 per year) was used.

In terms of the numbers of patients to be served by the program, AHCA estimated that 60 patients would be evaluated for transplant during the first year of the program, and that 20 of these patients would receive a transplant. In addition, the agency estimated that the number of patients participating in the program would increase by one each year and that one third of these patients would receive a transplant.

Providing Adult Heart Transplant Coverage Through a Medicaid or Non-Medicaid Program

If it is determined that the state will provide funding for heart transplants, there are both advantages and disadvantages to providing services through Medicaid. Advantages of using the Medicaid program include federal financial participation, and an existing administrative network. The federal government participates financially in the Medicaid program, contributing 56 percent of funds to pay for services (\$1.22 for every dollar contributed by Florida) and 50 percent of most administrative funds. Also, Medicaid already has in place an administrative structure which includes participant eligibility determination, a provider network, a reimbursement schedule and a claims payment system, a peer review program, and a fraud and abuse program.

The disadvantage of using the Medicaid program is that Medicaid is a federal entitlement program. This means that if the state decides to cover heart transplants under Medicaid, no limit may be established on the number of transplants provided. All Medicaid eligible recipients for whom the procedure is medically necessary must be funded. Also, the provision of heart transplants would be subject to all the other requirements of the Medicaid program, including: uniformity of services (must be provided throughout all political subdivisions of the state); amount, duration, and scope of services (must be equally available to all recipients); reimbursement (must be made to Medicaid providers only); public funds as state share (limits are placed on the use of certain funds as Medicaid match, including funds from local governments); and freedom of choice (Medicaid recipients must be given freedom of choice in the selection of a health care provider).

If the state were to establish a heart transplant program outside Medicaid, the state would have the flexibility to limit the number of procedures for which it would provide reimbursement in any one year, and could establish its own limitations on eligibility, provider network, and reimbursement levels. The state, however, would have to forego federal financial participation and would have to establish or contract for an administrative system for eligibility determination, provider networks, reimbursement levels, and claims payment.

RECOMMENDATIONS

Section 3 of ch. 98-192, L.O.F., did not require the development of recommendations. The intent of this fact-finding project was to present public policy and cost implications. Therefore, no recommendations are proffered.

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MEMBER OVERSIGHT
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