

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 5301 PCB HCAS 12-02 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, 4 N	Hicks	Pridgeon
1) Appropriations Committee	15 Y, 7 N	Hicks	Leznoff

SUMMARY ANALYSIS

This bill conforms statutes to the funding decisions included in the proposed General Appropriations Act (GAA) for Fiscal Year 2012-2013. The bill:

- Directs the Department of Children and Families (DCF) and the Agency for Health Care Administration (AHCA) to work cooperatively to develop a new system of eligibility determination for Medicaid and the Children's Health Insurance Program (CHIP) consistent with federal and state laws; specifies the business objectives, system components, executive management team and timeline for the project; directs that the system must be developed in a manner that is approved by the Legislative Budget Commission; and, provides that development of the system is subject to appropriation.
- Limits payment for emergency room services for non-pregnant Medicaid recipients 21 years of age or older.
- Eliminates optional Medicaid coverage for chiropractic and podiatric services for adult Medicaid recipients 21 years of age or older.
- Continues 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.
- Deletes references to the Adult Day Health Care Waiver program.
- Authorizes the expansion of the home health agency monitoring pilot project.
- Authorizes the expansion of the comprehensive care management pilot project for home health services.
- Authorizes two additional Program of All-inclusive Care for the Elderly (PACE) sites and approves up to 150 initial enrollees for each site, subject to a specific appropriation:
 - Duval, Clay, and Alachua counties, and
 - Manatee, Sarasota, and DeSoto counties.

The House Proposed GAA appropriates:

- \$246.6 million to implement the changes in DSH program funding;
- \$1.4 million to expand the scope of the two home health agency services pilot projects; and
- \$700,000 to develop a new the Medicaid and CHIP eligibility system.

The House Proposed GAA includes the following reductions:

- \$16.3 million due to limitations placed on emergency room visits;
- \$5.8 million due to expansion of scope of the two fraud prevention pilot projects;
- \$4.3 million for the elimination of chiropractic and podiatry coverage for adults; and
- \$1.9 million due to the sunset of the Adult Day Health Care Waiver program.

This bill has an effective date of July 1, 2012.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

The FLORIDA System and the Patient Protection and Affordable Care Act (PPACA)

The Agency for Health Care Administration (AHCA) is designated as the single state agency authorized to administer the Medicaid program for the state. State law delegates certain functions to other state agencies, including the Department of Children and Families, the Agency for Persons with Disabilities, and the Department of Elderly Affairs. The Department of Children and Families (DCF) is given the responsibility for Medicaid eligibility determinations.

The Florida Medicaid Management Information System (FMMIS) is operated by AHCA and is used to enroll providers, process Medicaid claims, adjudicate claims, accept and process encounter claims for data collection and reimburse providers. The DCF operates the Florida Online Recipients Integrated Data Access (FLORIDA) system to determine eligibility for Medicaid, Children's Health Insurance Program (CHIP), and other public assistance. The FLORIDA System sends data to FMMIS nightly to add and remove individuals based on changes in eligibility.

The FLORIDA System was implemented in 1992. The system was transfer technology from the State of Ohio which was originally designed in the early 1980s. The FLORIDA System was designed to support a service model where face-to-face interviews were conducted at area offices and relies heavily on manual data entry by state employees with no option for direct input by clients. The DCF is facing problems related to the aging of the system including limited availability of hardware and software support; limited pool of trained users; and declining availability of third-party support for new technology and functions.

The DCF has identified risks related to continuing to operate the FLORIDA System without modification including the escalation of system maintenance and modification costs; potential of system failures due to aging infrastructure; and inability to comply with federal law. Since the Medicaid program is a partnership between the state and the Federal government, the program must comply with all Federal requirements, including those outlined in the Patient Protection and Affordable Care Act (PPACA).

The U.S. Congress passed PPACA, and President Barack Obama signed the bill into law on March 23, 2010¹. Key policy areas of reform include: mandated individual coverage; mandated employer offers of coverage; expansion of Medicaid; individual cost-sharing subsidies and tax penalties for non-compliance; employer tax penalties for non-compliance; health insurance exchanges; expanded regulation of the private insurance market; and revision of the Medicare and Medicaid programs.

On the same day that PPACA was signed into law by the President, Florida's Attorney General filed a federal lawsuit in Pensacola challenging the constitutionality of the new law.² On January 31, 2011, the Federal District Court for the Northern District of Florida, Pensacola Division, declared the individual mandate provision of PPACA unconstitutional, and since the law lacks a severability clause, the entire Act was void.³

This decision was appealed to the United States Court of Appeals for the Eleventh Circuit. The Eleventh Circuit affirmed the decision that the individual mandate violates the Commerce Clause, but

¹ P.L. 111-148, 124 Stat. 119 (2010).

² State of Florida v. U.S. Dept. of Health and Human Services, Case No.: 3:10-cv-91-RV/EMT (N.D. Fla.)

³ See Florida v. U.S. Dept. of HHS, Case No. 3:10-cv-91-RV/EMT (N.D. Fla.), *Order and Memorandum Opinion on Defendants' Motion to Dismiss*, October 14, 2010.

upheld the remaining portions of PPACA.⁴ The Supreme Court of the United States has granted review of the case.⁵ In addition to reviewing the constitutionality of the individual mandate, the Court will also review whether the changes to the Medicaid program are an unlawful coercion. The Court has scheduled oral arguments on March 26, 27, and 28. The Court will likely render its decision before the end of this year.

If the Medicaid provisions of PPACA are upheld, the state must comply with certain provisions of PPACA or risk the loss of federal funding. Specifically, PPACA requires that as condition of a state's continued participation in the Medicaid program that by January 1, 2014, the state must:⁶

- Maintain a web site that allows individuals to apply for and enroll in Medicaid and CHIP and to apply for cost sharing benefits through a health benefits exchange. The system must allow for the use of electronic signatures.
- Maintain a web site that allows individuals to compare benefits, premiums, and cost-sharing available to the individual under Medicaid, CHIP, and a health benefits exchange.
- Be able to accept application for and enrollment in Medicaid and CHIP from individuals who applied through a health benefits exchange.
- Provide information to individuals about a health benefits exchange, including premium assistance, to individuals who apply for Medicaid or CHIP but are not eligible.
- Utilize a secure electronic interface with a health benefits exchange sufficient to share information sufficient to allow for determination of an individual's eligibility for Medicaid, CHIP, and premium assistance.

To the extent funds are appropriated, the bill directs the DCF to collaborate with the AHCA to develop a system for eligibility determination for Medicaid and the Children's Health Insurance Program (CHIP) that complies with all applicable federal and state laws and requirements. The AHCA must complete a feasibility study of two alternative methods of compliance and submit a system development plan to the Legislative Budget Commission for approval. The system must be completed by October 1, 2013 and be ready for implementation by January 1, 2014.

In addition to timely and accurately enrolling individuals in public assistance programs, the bills directs that the system must provide a single point of access to information that explains benefits, premiums, and cost-sharing available through Medicaid, CHIP, or any state or federal health insurance exchange, prevent eligibility fraud, and provide fiscal analysis of eligibility cost drivers.

The bill requires the following functions for the system:

- Allow completion and submission of an online application for eligibility determination that includes the use of electronic signatures.
- Allow automatic enrollment of qualified individuals in Medicaid, CHIP, or other state or federal exchanges.
- Allow for the determination of Medicaid eligibility that is based on the Modified Adjusted Gross Income.
- Allow determination of specific categories of Medicaid eligibility and interface with the FMMIS to support a determination.
- Produce transaction data, reports, and performance information.

The bill designates the Director of Economic Self-Sufficiency for the DCF as having overall responsibility for the project. The project will be governed by an executive steering committee that is comprised of: three staff members of the DCF appointed by the DCF Secretary and three staff members of the AHCA, including at least two Medicaid program staff, appointed by the AHCA Secretary. The executive steering committee shall have the overall responsibility for ensuring that the

⁴ State of Florida v. U.S. Dept. of Health and Human Services, 780 F. 3d 1235 (2011).

⁵ NFIB v. Sebelius (No. 11-393), HHS v. Florida (No. 11-398), Florida v. HHS (No. 11-400)

⁶See PPACA at Sec. 2201 and Medicaid Program: Eligibility Changes Under the Affordable Care Act of 2010, Proposed Rule, 76 Fed. Reg. 51148-51199 (April 17, 2011)

project meets its primary business objectives. If the executive steering committee determines that the primary business objectives cannot be achieved, it shall recommend suspension or termination of the project to the Governor, President of the Senate, and Speaker of the House of Representatives.

Expand Fraud and Abuse Pilot Projects

Chapter 2009-223, Laws of Florida, establishes two pilot projects relating to home health services to combat an increase in fraud and abuse relating to Medicaid-enrolled home health agencies. Miami-Dade County was designated as the health care fraud area of special concern.

The AHCA was authorized to enter into a contractual arrangement to develop and implement a home health agency monitoring pilot project by January 1, 2010 to verify the utilization and the delivery of home health services and provide an electronic billing interface. The AHCA was also authorized to implement a comprehensive care management pilot project for home health services by January 1, 2010 using face-to-face assessments by a state-licensed nurse, consultation with physicians ordering services to substantiate the medical necessity for services, and on-site or desk reviews of recipients' medical records.

The AHCA was directed to submit a report evaluating the home health agency monitoring pilot project by February 1, 2011. The initial evaluation of the pilot project indicates that Medicaid expenditures for home health visits in Miami-Dade County and statewide have decreased due to onsite reviews of home health agencies and strict enforcement of prior authorization requirements. Medicaid expenditures for home health visits in Miami-Dade County have decreased by over 35% since 2006-2007.

The vendor for the comprehensive care management pilot project has the responsibility of identifying potential problem areas through data analysis and monitoring of selected cases, verifying through medical record review the existence of problems or violations of provider obligations, and reporting findings to the provider and the AHCA. The vendor has completed 3,450 recipient face-to-face assessments, made 116 recommendations for termination of services, and made 114 recommendations for reduction in services.

Since the implementation of these two pilot projects in July 2010, the AHCA has terminated two large home health providers (each serving over 250 Medicaid recipients with annual reimbursement exceeding \$1 million) from participation in the Medicaid program and suspended another provider. The number of Medicaid recipients receiving home health visits and the number of home health agencies in Miami-Dade County have also declined. Medicaid expenditures for home health visits in Miami-Dade County for Fiscal Year 2010-2011 are approximately 50 percent lower than the Medicaid expenditures incurred for Fiscal Year 2009-2010.

This bill expands the scope of the two pilot projects to include additional services and counties that have the highest Medicaid expenditures for home health visits, effective July 1, 2012. The home health agency monitoring pilot project in Miami-Dade County is expanded to include Broward, Escambia, Martin, and Palm Beach counties. The comprehensive care management pilot project for home health services is expanded to include private duty nursing and personal care services in Miami-Dade, Broward, Orange, and Palm Beach counties.

Medicaid Services

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

States can choose to limit the amount, duration and scope of mandatory and optional services for non-pregnant adults, and may amend the state plan (upon federal approval) to modify coverage of these services at any time. However, states must provide services at a level sufficient to achieve their purpose. Limits must be sufficient to provide services to a vast majority of recipients. Current Medicaid reimbursement to providers is as follows for chiropractic, podiatric, and emergency room services.

- **Chiropractic Services** – Medicaid reimburses for 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. Medicaid reimbursement for chiropractic services is limited to one visit per provider, per recipient, per day. For Fiscal Year 2012-2013, it is estimated that approximately 8,708 adult recipients will utilize this Medicaid coverage.
- **Podiatric Services** – Medicaid reimburses for podiatry services rendered by licensed podiatrists, as defined in chapter 461, F.S., who are participating in Medicaid. Medicaid reimburses for routine foot care if the recipient is under a physician's care for a metabolic disease, has conditions of circulatory impairment, or has conditions of desensitization of the legs or feet. Medicaid reimbursement for podiatry services is limited to one visit per podiatrist or podiatrist group, per recipient, per day, except for emergency services. For Fiscal Year 2012-2013, it is estimated that approximately 25,091 adult recipients will utilize this Medicaid coverage.
- **Emergency Room Services** – There is no limit on the number of emergency room visits for which Medicaid will reimburse during a fiscal year. Any person needing emergency medical care or any woman in active labor shall not be denied access to appropriate emergency medical services and care. Emergency services and care means medical screening, examination and evaluation by a physician, or by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition exists. Current statutory authority authorizes a \$15 copayment for the use of a hospital emergency department for non-emergency services. A recently enacted provision in Florida law directs the AHCA to seek federal approval to require Medicaid recipients to pay a \$100 copayment for non-emergency services and care furnished in a hospital emergency department.⁷ Federal approval is pending. For Fiscal Year 2012-2013, it is estimated that a limitation on reimbursement would impact approximately 2,000 non-pregnant adult Medicaid recipients and decrease the number of emergency room visits by 15,000.

The bill eliminates Medicaid optional coverage for chiropractic and podiatric services for an adult Medicaid recipient 21 years of age or older, effective August 1, 2012. This bill also limits reimbursement for emergency room visits for non-pregnant Medicaid recipients to 12 visits per fiscal year.

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 implement the changes in DSH program funding for Fiscal Year 2012-2013. The bill:

- Continues to use the 2004, 2005, and 2006 audited data in calculating disproportionate share payments to hospitals for Fiscal Year 2012-2013;
- Continues disproportionate share payments for any non-state government owned or operated hospital eligible for payment on July 1, 2011 for Fiscal Year 2012-2013;
- Revises the time period from Fiscal Year 2011-2012 to 2012-2013 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 2012-2013 be distributed as provided in the GAA; and

⁷ Section 409.9081(1)(c), F.S.

- Revises the time period from Fiscal Year 2011-2012 to Fiscal Year 2012-2013 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.⁸ 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.⁹

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 an optional state plan service 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.¹⁰

A PACE organization is a not-for-profit private or public entity that is primarily engaged in providing the PACE services and must:¹¹

- 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-site 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.¹²

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

⁸ Centers for Medicare and Medicaid Services website: <http://www.cms.hhs.gov/PACE/> (last visited on January 17, 2012).

⁹ *Id.*

¹⁰ *Id.*

¹¹ PACE Fact Sheet, available at <http://www.cms.hhs.gov/PACE/Downloads/PACEFactSheet.pdf>.

¹² *Id.*

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.

Section 17, chapter 2011-61, L.O.F., directed AHCA to contract for a new PACE site in Palm Beach County and authorized up to 150 initial enrollee slots.

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.

The bill authorizes, subject to an appropriation, up to 150 initial enrollee slots each to two new PACE projects in Duval, Clay, and Alachua counties and Manatee, Sarasota, and DeSoto counties.

Medicaid Home and Community Based Services Waiver Program

In 1981, the U.S. Congress approved the use of Medicaid home and community-based-services (HCBS) waiver programs to allow states to provide certain Medicaid services in the home for persons who would otherwise require institutional care in a hospital, nursing facility, or intermediate care facility. These programs are federally-approved Medicaid initiatives authorized by Title XIX of the Social Security Act, Section 1915.

The HCBS waiver programs are initially approved for 3 years and may be renewed at 5-year intervals. If a state terminates an HCBS waiver, federal law requires that recipients receive continued services in an amount that does not violate the comparability of service requirements established in the Social Security Act.¹³ In effect, the state has to transition recipients into programs with comparable services. Florida currently operates 15 home and community-based-services waiver programs.¹⁴

¹³ 42 C.F.R. 441.356.

¹⁴ Found at: http://www.fdhc.state.fl.us/Medicaid/hcbs_waivers/index.shtml (last visited on January 17, 2012).

The Adult Day Health Care Waiver program, initially implemented in April 2004, is designed to meet the health and supportive needs of adults with functional and/or cognitive impairments through an individual plan of care implemented at an adult day health care center. This program serves adults who are physically impaired or mentally confused and may require supervision, increased social opportunities, and assistance with personal care or other daily living activities. Adult day health care services allow frail elders to remain in their home or community instead of going to a nursing facility.

The Adult Day Health Care Waiver program is available only to residents of Lee County. Currently, there are approximately 25 recipients enrolled in this waiver program, and it is set to expire in March 2012. It is anticipated that the 25 recipients will choose to transition into either the Nursing Home Diversion Waiver or the Aged and Disabled Adult Waiver programs. Both programs offer comparable services.

The bill modifies statutory authority by deleting references to the Adult Day Health Care Waiver in provisions relating to Medicaid eligibility and duties and responsibilities of the DOEA.

B. SECTION DIRECTORY:

Section 1: Amends s. 409.902, F.S., creating, subject to appropriation, an Internet-based system for eligibility determination for Medicaid and the CHIP Program; requiring the system to accomplish specified business objectives; requiring the department to develop the system contingent upon an appropriation; requiring the system to be completed and implemented by specified dates; requiring the department to implement governance structure pending implementation of the program; providing for the membership and duties of an executive steering committee.

Section 2: Amends s. 409.905, F.S., limiting payment for emergency room services for a non-pregnant Medicaid recipient 21 years of age or older under certain circumstances.

Section 3: Amends s. 409.906, F.S., eliminating Medicaid optional coverage for chiropractic and podiatric services for a Medicaid recipient 21 years of age or older.

Section 4: Amends s. 409.911, F.S., continuing the audited data specified for use in calculating amounts due to hospitals under the disproportionate share program.

Section 5: Amends s. 409.9112, F.S., continuing the prohibition against distributing moneys under the disproportionate share program for regional perinatal intensive care centers.

Section 6: Amends s. 409.9113, F.S., continuing the authorization for the distribution of moneys to certain teaching hospitals under the disproportionate share program.

Section 7: Amends s. 409.9117, F.S., continuing the prohibition against distributing moneys under the primary care disproportionate share program.

Section 8: Amends s. 409.979, F.S., deleting references to the Adult Day Health Care Waiver in provisions relating to Medicaid eligibility.

Section 9: Amends s. 430.04, F.S., deleting references to the Adult Day Health Care Waiver in provisions relating to duties and responsibilities of the Department of Elderly Affairs.

Section 10: Amends s. 31, ch. 2009-223, Laws of Florida, as amended, and redesignate the section as s. 409.9132, F.S., expanding the scope of the home health agency monitoring pilot project.

Section 11: Amends s. 32, ch. 2009-223, Laws of Florida, and redesignate the section as s. 409.9133, F.S., expanding the scope of the comprehensive care management pilot project for home health services.

Section 12: Amends s. 430.707, F.S., providing for an additional PACE site in Duval, Clay, and Alachua counties.

Section 13: Amends s. 430.707, F.S., providing for an additional PACE site in Manatee, Sarasota, and DeSoto counties.

Section 14: Providing an effective date of July 1, 2012.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

\$143,208,191 million in federal Medicaid funds will be generated through the implementation of the DSH programs.

2. Expenditures:

	<u>FY 2012-13</u>
DISPROPORTIONATE SHARE PROGRAM	
General Revenue	\$ 750,000
Grants & Donations Trust Fund	\$102,613,386
Medical Care Trust Fund	<u>\$143,208,191</u>
Total	\$246,571,577
EXPAND FRAUD PREVENTION PILOT PROJECTS	
General Revenue	\$ 707,813
Medical Care Trust Fund	<u>\$ 707,813</u>
Total	\$ 1,415,626
MEDICAID ELIGIBILITY SYSTEM EVALUATION	
General Revenue	\$ 350,000
Medical Care Trust Fund	<u>\$ 350,000</u>
Total	\$ 700,000
LIMIT EMERGENCY ROOM VISITS	
General Revenue	(\$ 6,798,783)
Medical Care Trust Fund	(\$ 9,470,479)
Refugee Asst Trust Fund	<u>(\$ 38,391)</u>
Total	(\$ 16,307,653)
SAVINGS FROM EXPANSION OF FRAUD PREVENTION PILOT PROJECTS	
General Revenue	(\$ 2,327,948)
Medical Care Trust Fund	(\$ 3,438,317)
Refugee Asst Trust Fund	<u>(\$ 370)</u>
Total	(\$ 5,766,635)
ELIMINATE CHIROPRACTIC SERVICES	
General Revenue	(\$ 394,960)
Medical Care Trust Fund	(\$ 541,932)
Refugee Asst Trust Fund	<u>(\$ 2,459)</u>
Total	(\$ 939,351)

ELIMINATE PODIATRIC SERVICES

General Revenue	(\$ 1,406,723)
Medical Care Trust Fund	(\$ 1,921,224)
Refugee Asst Trust Fund	<u>(\$ 8,733)</u>
Total	(\$ 3,336,680)

SUNSET OF ADULT DAY HEALTH CARE WAIVER PROGRAM

General Revenue	(\$ 822,937)
Operations & Maintenance Trust Fund	<u>(\$ 1,123,921)</u>
Total	(\$ 1,946,858)

BUDGETARY INCREASES

General Revenue	\$ 1,807,813
Grants & Donations Trust Fund	\$102,613,386
Medical Care Trust Fund	<u>\$144,266,004</u>
Grand Total of Increases	\$248,687,203

BUDGETARY DECREASES

General Revenue	(\$ 11,751,351)
Medical Care Trust Fund	(\$ 15,371,952)
Refugee Asst Trust Fund	(\$ 49,953)
Operations & Maintenance Trust Fund	<u>(\$ 1,123,921)</u>
Grand Total of Decreases	(\$ 28,297,177)

TOTAL BUDGETARY IMPACT

General Revenue	(\$ 9,943,538)
Grants & Donations Trust Fund	\$102,613,386
Medical Care Trust Fund	\$128,894,052
Refugee Asst Trust Fund	(\$ 49,953)
Operations & Maintenance Trust Fund	<u>(\$ 1,123,921)</u>
Grand Total of All	\$220,390,026

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

Local governments and other local political subdivisions may provide \$102,612,386 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 reimbursement 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/ COMMITTEE SUBSTITUTE CHANGES