The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	CS/SB 1658
INTRODUCER:	Committee on Health and Human Services Appropriations and Senator Peaden
SUBJECT:	Health Care
DATE:	April 1, 2009 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Kynoch	Peters	HA	**Fav/CS**
2.			GO	
3.			WPSC	
4.			RC	
5.				
6.				

Please see Section VIII. for Additional Information:

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

I. Summary:

The Proposed Committee Substitute:

- Provides for the mandatory provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) which include documentation of citizenship and identity at application and renewal. For the Healthy Kids plan only, the bill provides dental benefits equivalent to benchmark packages or actuarial equivalents to those packages; mental health parity, and the reimbursement of Federally Qualified Health Centers and rural health clinics using the Medicaid prospective payment system.
- Provides Medicaid coverage for the Medicaid Aged and Disabled Program (Meds AD) and the Medically Needy Program through December 2010.
- Includes Medicaid fraud and abuse provisions that require home health agencies exceeding the statewide home health services utilization rate by 50 percent, to undergo prior authorization for Medicaid home health service visits not associated with a skilled nursing visit; requires the Agency for Health Care Administration (AHCA) to implement a home health agency monitoring pilot project in Miami-Dade County by January 1, 2010, and requires the AHCA to implement a comprehensive home health care management pilot project by January 1, 2010.

- Revises the criteria for adjusting a hospital's inpatient per diem rate to reflect the cost of serving the Medicaid population in order to continue eligibility for currently qualified hospitals.
- Prohibits inpatient hospitals, outpatient hospitals, nursing homes, county health departments, community intermediate care facilities for the developmentally disabled, prepaid health plans, and nursing home diversion programs from receiving an increase in Medicaid reimbursement rates due to a change in unit cost, unless the increase is specifically appropriated in the General Appropriations Act.
- Authorizes an exemption to the nursing home quality assessment or the ability to apply a lower assessment to certain nursing home facilities.
- Removes the requirement that the quality assessment on nursing home facility providers shall terminate and the agency shall discontinue collection of the assessment if the weighted average Medicaid rate paid to nursing home facilities is reduced below the rate in effect on December 31, 2008.
- Transfers the administration and appropriations related to the Medicaid waivers and programs that serve the elders, from the Agency for Health Care Administration to the Department of Elder Affairs;
- Revises the years of audited data used in determining Medicaid and charity care days for each hospital in the Disproportionate Share (DSH) program changes the distribution criteria for Medicaid Disproportionate Share (DSH) Program payments, which are necessary to implement the DSH funding decisions included in Senate Proposed Committee Bill 7064.
- Removes the requirement for the AHCA to implement the Florida Senior Care program.
- Increases the number of years for the provider service network phase-in of financial risk in the Medicaid reform Pilot.

The bill implements the extension of the Medically Needy and Meds AD programs. Proposed Committee Bill (PCB) 7064 provides $160,687,163 from the General Revenue Fund and $368,061,245 from trust funds for the Medically Needy Program and $113,039,411 from the General Revenue Fund and $254,813,015 from trust funds for the Meds AD program.

The bill eliminates the requirement for the AHCA to implement the Florida Senior Care program. Proposed Committee Bill 7064 reduces $260,958 from general revenue funds and $260,957 from trust funds for this purpose.

The bill implements expansions of fraud and abuse recoupment initiatives in the Medicaid program. Proposed Committee Bill 7064 provides 5 positions, $1,607,796 from the General Revenue Fund, and $1,607,797 from trust funds and savings of $4,567,836 from general revenue funds and $9,547,851 from trust funds

This bill substantially amends ss. 408.040, 409.814, 409.815, 409.818, 409.904, 409.905, 409.908, 409.9082, 409.911, 409.9112, 409.9113, 409.9117, 409.91195, 409.91196, 409.912, 409.91211, 430.04, 641.386, F.S.

The bill deletes s. 409.912(5), F.S.

The bill creates two undesignated sections of law.

II. Present Situation:

State Children's Health Insurance Program

The State Children's Health Insurance Program (SCHIP), enacted as part of the Balanced Budget Act of 1997, created Title XXI of the federal Social Security Act, which provides health insurance to uninsured children in low-income families either through a Medicaid expansion, a separate children's health program, or a combination of both. The SCHIP was designed as a federal/state partnership, similar to Medicaid, with the goal of expanding health insurance to children whose families earn too much money to be eligible for Medicaid, but not enough money to purchase private insurance. On February 4, 2009, new federal legislation, the Children's Health Insurance Program Reauthorization Act of 2009 (Act), was signed into law reauthorizing the children's medical program through federal FY 2013.

The Act includes certain required provisions such as documentation of citizenship and identity at application and renewal. For the Healthy Kids Plan only, the Act requires the provision of dental benefits equivalent to benchmark packages or actuarial equivalents to those packages; mental health parity, and the reimbursement of Federally Qualified Health Centers and rural health clinics using the Medicaid prospective payment system.

The Florida Kidcare Program

The Florida Kidcare program is Florida's SCHIP program. Florida Kidcare was established in 1998 as a combination of Medicaid expansions and public/private partnerships, with a wrap-around delivery system serving children with special health care needs. Family income level, age of the child, and whether the child has a serious health condition are the eligibility criteria that determine which component of Kidcare serves a particular child. As of December 2008, enrollment in the various components of Kidcare was 1,513,073 children.[1]

The Florida Kidcare program, codified in ss. 409.810-409.820, F.S., is an "umbrella" program, the components of which include Medicaid for children, the Florida Healthy Kids program, Medikids, and the Children's Medical Services Network. The program is jointly administered by the Agency for Health Care Administration, the Florida Healthy Kids Corporation, the Department of Health, and the Department of Children and Family Services.

Medicaid Aged and Disabled Program (MEDS AD)

The Medicaid Aged and Disabled Program (MEDS AD) eligibility category is an optional Medicaid eligibility group under s. 409.904(1), F.S. The program provides Medicaid coverage to individuals who are elderly or disabled, whose incomes are under 88 percent of the federal poverty level. Payments for services to individuals in optional eligibility categories are subject to the availability of monies and any limitations established by the General Appropriations Act or chapter 216, F.S. Medicaid is required to provide Medicare "buy-in" coverage for aged and disabled individuals who are Medicare beneficiaries. Therefore, if Medicaid coverage is

[1] Florida Kidcare Coordinating Council 2009 Annual Report and Recommendations. Found at: <http://www.doh.state.fl.us/AlternateSites/KidCare/council/reports/KCC2009report-Web.pdf> (last visited on March 26, 2009).

eliminated for persons eligible under the criteria for the Elderly and Disabled (MEDS AD) program, those who are eligible for Medicare will continue to have Medicaid coverage for Medicare premiums, deductibles, and coinsurance. According to the February 2008 Social Services Estimating Conference for Medicaid caseloads, the estimated average monthly caseload for the MEDS AD program in FY 2009-2010 is 435 individuals.[2]

Medically Needy Program

The Medically Needy eligibility category is an optional eligibility group authorized under Section 409.904, F.S. Title XIX of the Social Security Act specifies categories of individuals that the federal government gives state Medicaid programs the choice of covering (optional coverage groups). The Medically Needy program covers persons who have experienced a catastrophic illness and either have no health insurance, or have exhausted their benefits. The program provides Medicaid coverage for those persons who qualify categorically for Medicaid except that their income or assets are greater than the level allowed under other Medicaid programs. There is no limit to the monthly income an individual can have, but to be eligible for Medicaid payment, the individual must incur enough medical bills to offset his or her income to the income level that would qualify the individual for the Medically Needy program. A person eligible for the Medically Needy Program is eligible for all Medicaid services with the exception of services in a skilled nursing facility, an intermediate care facility for the developmentally disabled, or home and community-based services. Persons eligible must incur medical bills that, if deducted from their income, would reduce their income to $180 per month per individual.

Eligibility is determined based on medical and pharmacy bills provided to the Department of Children and Family Services. Once determined eligible, the state reimburses providers based on the current Medicaid reimbursement rates. Individuals may not actually "spend-down" to the income standards in order to qualify for the program. Bills incurred before the first day of eligibility and used to meet spend-down are never paid by Medicaid. According to the January 2009 Social Services Estimating Conference for Medicaid caseloads, the estimated average monthly caseload for the Medically Needy program for FY 2009-2010 is 2,937 individuals.[3] (something does not look right with these numbers – it appears that the medically needy category is being rolled into the categorically eligible category?)

Medicaid Home and Community-Based-Services Waiver Programs

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.

States may offer a variety of services to consumers under an HCBS waiver program and the number of services that can be provided is not limited. These programs may provide a combination of both traditional medical services (i.e., dental services, skilled nursing services, etc.) and non-medical services (i.e., respite care, case management, environmental modifications,

[2] http://edr.state.fl.us/conferences/medicaid/medcases.pdf (Last visited on March 26, 2009).
[3] http://edr.state.fl.us/conferences/medicaid/medcases.pdf (Last visited on March 26, 2009).

etc.). Family members and friends may be providers of waiver services if they meet the specified provider qualifications. The HCBS waiver programs are initially approved for 3 years and may be renewed at 5-year intervals.[4] 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.[5] In effect, the state has to transition recipients into programs with comparable services. Florida currently operates the following home and community-based-services waiver programs:[6]

- Adult Cystic Fibrosis;
- Aged/Disabled Adult Services;
- Adult Day Health Care;
- Assisted Living for the Elderly;
- Alzheimer's Disease;
- Channeling Services for the Frail Elderly;
- Consumer Directed Care Plus;
- Developmental Disabilities;
- Familial Dysautonomia;
- Family and Supported Living Model;
- Nursing Home Diversion;
- Project AIDS Care (PAC); and
- Traumatic Brain Injury and Spinal Cord Injury.

Home Health Agencies

Prior to 2008, the AHCA saw significant growth in the number of applications and new licenses of home health care agencies.[7] The AHCA received 431 new licensure applications for home health agencies during 2007. Two hundred fifty-two (58.5 percent) of those were for new home health agency licenses in Miami-Dade County. According to the AHCA, the new accreditation requirement has slowed the growth in new licensees, but the agency continues to receive a high volume of applications. Since July 1, 2008, the AHCA received 331 applications, most of which were from Miami-Dade County. As of December 31, 2008, there were 2,225 licensed home health agencies in the state.[8] In Miami-Dade County, the number of licensed home health agencies increased from 216 in August 1999 to 895 as of March 6, 2009, which is a 75 percent increase in licensees in that county.

Nursing Home Assessments

Chapter 2009-4, L.O.F, created s. 409.9082, F.S., to provide for a quality assessment on nursing home facility providers and required the assessment to be imposed beginning April 1, 2009. The assessment is not to exceed 5.5 percent of the total aggregate net patient service revenue of the

[4] U.S. Centers for Medicare and Medicaid Services. Found at: http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/05_HCBSWaivers-Section1915(c).asp (last visited on March 9, 2009).
[5] 42 C.F.R. 441.356.
[6] Found at: http://www.fdhc.state.fl.us/Medicaid/hcbs_waivers/index.shtml (last visited on May 9, 2009).
[7] Florida Senate Interim Project Report 2008-135, November 2007. Found at: <http://www.flsenate.gov/data/Publications/2008/Senate/reports/interim_reports/pdf/2008-135hr.pdf> (Last visited March 24, 2009).
[8] Source: AHCA Home Care Unit, Bureau of Health Facility Regulation.

assessment facility. The bill required the AHCA to calculate the assessment annually on a per-resident-day basis, exclusive of those days funded by the Medicare program. The purpose of the nursing home quality assessment is to assure continued quality of care and that the collected assessments are to be 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.

Senior Care

In 2005, the Florida Legislature passed a comprehensive Medicaid reform initiative (ch. 2005-133, L.O.F.). In addition to creating a pilot reform program for Medicaid beneficiaries using acute care services, the law requires the Agency for Health Care Administration (AHCA) and the Department of Elder Affairs (DOEA) to implement an integrated, fixed-payment system of care, including long-term care, for Medicaid beneficiaries age 60 and older in two areas of the state, currently Central Florida and Miami. This program is commonly referred to as Florida Senior Care.

Chapter 2007-82, L.O.F., substantially amended the design of the pilot program by expanding the eligible population to include persons age 21 years of age or older who are dually eligible for Medicare and Medicaid and provided that enrollment in the pilot is voluntary.

In August 2008, the AHCA in conjunction with the DOEA placed the implementation of the pilot program on hold in order to determine how to effectively achieve the program's goals and objectives.

Disproportionate Share Hospital Programs

There are currently five separate Medicaid disproportionate share hospital programs that are operational in Florida. They are: the original program established in s. 409.911, F.S.; the Teaching Hospitals program established in s. 409.9113, F.S.; the Mental Health Hospital program established in s. 409.9115, F.S.; the Rural Hospital/Financial Assistance program established in s. 409.9116, F.S.; and the Specialty Hospital program established in s. 409.9118, F.S.

Additionally, there are three separate Medicaid disproportionate share hospital programs that are listed in law but are not operational at this time. They are: the Regional Perinatal Intensive Care Center (RPICC) program established in s. 409.9112, F.S.; the Primary Care program established in s. 409.9117, F.S.; and the Specialty Hospitals for Children program established in s. 409.9119, F.S.

Medicaid Managed Care Programs

The state of Florida operates a Medicaid managed care program through a federal 1915(b) waiver obtained from the Centers for Medicare and Medicaid Services in 1991. The managed

care waiver provides the state with the authority to mandatorily assign eligible beneficiaries[9] and, within specific areas of the state, limit choice to approved managed care providers. The federal waiver requires Florida Medicaid recipients to be given a choice of managed care providers. The Medicaid managed care program is broken into two major categories of providers: MediPass and managed care plans. However, s. 409.91211, F.S., codifies the Medicaid reform managed care pilot program in Baker, Broward, Clay, Duval, and Nassau Counties. Eligible Medicaid recipients in these counties must enroll in a managed care plan and do not have the ability to choose the MediPass program. Reform plans offer comprehensive, catastrophic and enhanced benefits which are allowed to vary within certain parameters from plan to plan. Medicaid recipients receive choice counseling to help them select among the plans. As of February 2009, there were 210,565 Medicaid recipients enrolled in Medicaid reform plans.

III. Effect of Proposed Changes:

Section 1 amends s. 408.040, F.S., to conform cross-references related to the repeal of the Florida Senior Care Program in Section 15 of the bill.

Section 2 amends s. 409.814, F.S., to require that Florida Kidcare enrollment will include the verification of the child's citizenship status by January 1, 2010.

Section 3 amends s. 409.815, F.S., to provide for mental health parity as a minimum requirement, for dental services, and the reimbursement of federally qualified health centers and rural health clinics in the Healthy Kids plan by October 1, 2009.

Section 4 amends s. 409.818, F.S., to require that the AHCA monitor the compliance with quality assurance and access standards of the Florida Healthy Kids plan in accordance with state and federal law.

Section 5 amends s. 409.904, F.S., to provide Medicaid coverage for the aged and disabled and medically needy eligibility groups through December 31, 2010.

Section 6 amends s. 409.905, F.S., relating to home health services in the Medicaid program, to require home health agencies that exceed the statewide home health services utilization rate by 50 percent, to undergo prior authorization for Medicaid home health service visits not associated with a skilled nursing visit. The bill specifies that prior authorization includes the submission of a Medicaid recipient's plan of care and documentation that supports the recipient's diagnosis to the AHCA.

The bill requires that Medicaid home health services must be ordered by a physician and meet the following requirements:

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

- The written prescription for service must be signed and dated by the recipient's physician before the development of a plan of care or any request requiring prior authorization;
- The physician ordering the home health services must not be employed by, under contract with, or otherwise affiliated with the home health agency rendering services;
- The physician ordering the services must have examined the recipient no more than 30 days before the initial request for home health services and biannually thereafter;
- The written prescription for the services must include the recipient's acute or chronic medical condition or diagnosis, the home health service required, including the minimum skill level required to perform the service, and the frequency and duration of the services; and
- The national provider identifier, Medicaid identification number, or medical practitioner license number of the physician who ordered the services must be listed on the written prescription for home health services, the claim for home health reimbursement, and the home health service prior authorization request.

Section 7 amends s. 409.908, F.S., to prohibit inpatient hospitals, outpatient hospitals, nursing homes, county health departments, community intermediate care facilities for the developmentally disabled, prepaid health plans, and nursing home diversion programs from receiving an increase in Medicaid reimbursement rates due to a change in unit cost, unless the increase is specifically appropriated in the General Appropriations Act.

Section 8 amends s. 409.9082, F.S., to remove the requirement that the quality assessment on nursing home facility providers shall terminate and the assessments discontinue collection if the weighted average Medicaid rate paid to nursing home facilities is reduced below the rate in effect on December 31, 2008.

Section 9 amends s. 409.911, F.S., to specify that the average audited disproportionate share data from 2003, 2004, and 2005 will be used to determine Medicaid and charity care days for each hospital in the Disproportionate Share program for FY 2009-2010. Previously, data was averaged from 2002, 2003, and 2004.

Section 10 amends s. 409.9112, F.S., to continue the prohibition on distributing funds through the Regional Perinatal Intensive Care Disproportionate Share program, through FY 2009-2010.

Section 11 amends s. 409.9113, F.S., to authorize Disproportionate Share payments to teaching hospitals, through FY 2009-2010.

Section 12 amends s. 409.9117, F.S., to continue the prohibition on distributing funds through the Primary Care Disproportionate Share program, through FY 2009-2010.

Section 13 and Section 14 amend ss. 409.91195, and 409.92296, F.S., respectively, to conform cross-references related to the repeal of the Florida Senior Care Program in Section 15 of the bill.

Section 15 amends s. 409.912(5), F.S., to remove the requirement for the ACHA to implement an integrated fixed payment delivery program for Medicaid recipients who are 60 years of age or older or dually eligible for Medicare and Medicaid. This program is commonly referred to as the Florida Senior Care Program.

Section 16 amends s. 409.91211, F.S., to increase the phase in time, from 3 years to 5 years, for provider service networks participating in Medicaid reform to take on financial risk. The bill also increases the deadline for provider service networks participating in Medicaid reform to be paid with a risk-adjusted capitated rate.

Section 17 amends s. 430.04, F.S., to transfer the administration and appropriations related to the Medicaid waivers and programs that serve the elders, from the Agency for Health Care Administration to the Department of Elder Affairs.

Section 18 amends s. 641.386, F.S., to conform cross-references related to the repeal of the Florida Senior Care Program in Section 15 of the bill.

Section 19 and Section 20 create undesignated sections of law that require the AHCA to implement two home pilot projects.

The first pilot project requires the AHCA to develop and implement a home health agency monitoring pilot project in Miami-Dade County by January 1, 2010. The bill requires the AHCA to contract with a vendor to verify the utilization and delivery of the home health services and provide an electronic billing interface for home health service reimbursement. The pilot project must telephonically verify the delivery of home health services using voice biometrics. The bill requires the AHCA to submit a report evaluating the pilot project by February 1, 2011, to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

The second pilot project requires the AHCA to implement a comprehensive home health care management pilot project by January 1, 2010 that includes face-to-face assessments by a licensed nurse, consultations with prescribing physicians to substantiate the medical necessity of services, and on-site or desk reviews of recipient medical records. The AHCA is directed to implement the pilot in an area of the state that has demonstrated an aberration in the utilization of Medicaid home health services.

The bill provides the AHCA with the authority to amend the Medicaid state plan and apply for federal waivers as necessary to implement the pilot projects.

Section 21 provides that the bill is effective upon becoming a law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Extends the number of years for the provider service network phase-in of financial risk.

C. Government Sector Impact:

The bill implements the appropriations and reductions as included in Senate Proposed Committee Bill 7064 for the following provisions:

		FY 2009-2010					FY 2009-2010 ANNUALIZATION		
LINE	Issue Title	FTE	SALARY RATE	GENERAL REVENUE	OTHER TF	ALL FUNDS	GENERAL REVENUE	OTHER TF	ALL FUNDS
1	Transfer Elder Related Waivers to Dept. of Elder Affairs - Deduct			(107,889,965)		(107,889,965)			
1	Transfer Elder Related Waivers to Dept. of Elder Affairs - Add			107,889,965		107,889,965			
2	Florida Senior Care Program			(260,958)	(260,957)	(521,915)			
3	Medically Needy Program			160,687,163	368,061,245	528,748,408			
4	Medicaid Aged and Disabled Program			113,039,411	254,813,015	367,852,426			
7	Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)*			3,907,944	8,494,290	12,402,234			
5	Fraud and Abuse Recoupment			(4,567,836)	(9,547,851)	(14,115,687)	(2,427,000)	(5,073,000)	(7,500,000)
9	Fraud and Abuse Prevention Resources	5.00	240,904	1,607,796	1,607,797	3,215,593			
46	**TOTAL: AHCA**	**5.00**	**240,904**	**274,413,520**	**623,167,539**	**897,581,059**	**(2,427,000)**	**(5,073,000)**	**(7,500,000)**

* The amounts denoted for the Children's Health Insurance Program Reauthorization Act of 2009 were designated in proviso from existing surplus funds estimated by the Social Services Estimating Conference in February 2009.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

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

CS by Health and Human Services Appropriations on April 1, 2009:
Senate Bill 1658 was originally filed as a shell bill expressing legislative intent to revise laws relating to governmental operations. The Health and Human Services Appropriations Committee adopted the committee substitute as described in this bill analysis. The committee substitute:

- Provides for mandatory CHIRPA provisions from the 2009 reauthorization act.
- Extends the Meds AD and the Medically Needy Program through December 2010.
- Expands Medicaid fraud provisions by requiring prior authorization for home health service visits not associated with a skilled nursing visit and requires AHCA to implement two home health pilot projects.
- Revises the criteria for adjusting a hospital's inpatient per diem rate to reflect the cost of serving the Medicaid population in order to continue eligibility for currently qualified hospitals.
- Prohibits increased reimbursement rates for certain Medicaid providers due to a change in unit cost, unless appropriated in the General Appropriations Act.
- Authorizes an exemption to the nursing home quality assessment or the ability to apply a lower assessment to certain nursing home facilities.
- Eliminates an option for discontinuing the nursing home quality assessment program.
- Transfers Elder related Medicaid waivers and programs from AHCA to the Department of Elder Affairs.
- Modifies the years of audited data and time periods for distribution of funds for various disproportionate share programs.
- Eliminates the Florida Senior Care program.
- Revises the date to convert provider service networks from a fee-for-service model to a capitation model in the Medicaid reform pilot areas.

B. Amendments:

None.