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 Committee on Appropriations

BILL:	SB 2506
INTRODUCER:	Appropriations Committee
SUBJECT:	Health Care
DATE:	February 2, 2018
REVISED:	

ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1. Williams	Hansen		**AP Submitted as Committee Bill**

I. Summary:

SB 2506 addresses a number of issues specific to health care. Included are provisions that:

- Modify the direct care subcomponent and the quality incentive payment pool subcomponent of the parameters upon which Medicaid nursing home prospective payment rates are to be calculated when implemented on October 1, 2018. This is being done in conjunction with an increase in nursing home reimbursement as proposed in SPB 2500, the General Appropriations Act for Fiscal Year 2018-2019.
- Recognize the prospective payment system as the reimbursement basis for Medicaid-participating nursing homes.
- Provide for Medicaid-participating nursing homes and institutional care facilities for the developmentally disabled that participate in the quality assessment program to be subject to the existing program penalty provisions for failure to meet monthly reporting requirements specific to their number of resident days.
- Upon the act becoming a law, direct the Agency for Health Care Administration to seek authorization from the federal government to modify the period of retroactive eligibility when determining Medicaid eligibility from 90 days to 30 days. This is to be done in a manner to ensure a July 1, 2018, effective date.
- Authorize an additional not-for-profit Program for All-Inclusive Care (PACE) entity in Miami-Dade County. The new PACE program must have a history of serving primarily the Hispanic population by providing primary care services, nutrition, meals, and adult day care services. Upon approval, the program shall have up to 250 enrollees.
- Increase from five years to six years the period of time that Tier 3 National Cancer Institute (NCI)-designated cancer centers may remain in Tier 3 designation, and increases from five years to six years the period of time that Tier 3 Cancer Centers are authorized to pursue NCI designation as a Cancer Center or a Comprehensive Cancer Center.
- Modify the existing definition of a "qualifying institution" as used for the Statewide Medicaid Residency Program, to add to the definition "a substance abuse treatment facility licensed under Chapter 397, F.S., which has housed residents and fellows since 2013".
- Specify that payment arrangements between Class III psychiatric hospitals and managed care plans are not to be based on Medicaid hospital inpatient diagnosis related group (DRG)

payments, but are to be developed based on federal Centers for Medicare and Medicaid Services (CMS) prospective payment system pricing methodology or limited to compensation amounts agreed to by the plan and the hospital.

Transition payments associated with the October 1, 2018, implementation of the nursing home prospective payment system are $9.78 million annually, of which $3.75 is from the General Revenue Fund and $6.03 million is from federal funds.

The modifications to the nursing home prospective payment methodology will increase payments for quality and direct care from the state totaling $130,412,102 annually, of which $50 million is from the General Revenue Fund and $80.4 million is from federal funds.

By reducing the period of retroactive Medicaid eligibility from 90 day to 30 days, the state is expected to save $98,425,854 annually This results in reductions in the need of $37.5 million from the General Revenue Fund and $60.9 million from federal funds.

The above amounts are reflected in the SB 2500, the General Appropriations Act for Fiscal Year 2018-2019.

Except as otherwise specified, the bill is effective upon becoming a law.

II. Present Situation:

The Medicaid Program

The Florida Medicaid program is a partnership between the federal and state governments. Each state operates its own Medicaid program under a state plan approved by the federal Centers for Medicare & Medicaid Services (CMS). The state plan outlines Medicaid eligibility standards, policies, and reimbursement methodologies.

Florida Medicaid is administered by the Agency for Health Care Administration (AHCA) and financed with federal and state funds. Just under 4 million Floridians are currently enrolled in Medicaid, and the program has estimated expenditures for the 2018-2019 fiscal year of $26.8 billion.[1]

Eligibility for Florida Medicaid is based on a number of factors, including age, household or individual income, and assets. State Medicaid eligibility payment guidelines are provided in s. 409.903, F.S., (Mandatory Payments for Eligible Persons) and s. 409.904, F.S., (Optional Payments for Eligible Persons). Minimum coverage thresholds are established in federal law for certain population groups, such as children.

[1] Social Services Estimating Conference, Medicaid Caseloads and Expenditures, August 9, 2017 and December 18, 2017--Executive Summary: http://edr.state.fl.us/Content/conferences/medicaid/execsummary.pdf (last visited January 26, 2018).

Medicaid Retroactive Eligibility

The Social Security Act provides the requirements under which state Medicaid programs must operate. Federal law directs state Medicaid programs to cover, and provides federal matching funds for, medical bills up to three months prior to a beneficiary's application date.[2] .

In compliance with this federal requirement, the Florida Medicaid State Plan provides [c]overage is available beginning the first day of the third month before the date of application if individuals who are aged, blind or disabled, or who are AFDC-related, would have been eligible at any time during that month, had they applied. These provisions have been applicable to the Florida Medicaid state plan since October 1, 1991.

More recently, several states have reduced retroactive eligibility periods, primarily as cost-saving measures. These states include Iowa, New Hampshire, Arkansas, and Indiana, all of which made the change in conjunction with Medicaid program expansion under the terms of the Affordable Care Act (ACA). Several other states whose modified retroactive coverage provisions predate the ACA, including Delaware, Massachusetts, Maryland, Tennessee, and Utah.[3]

Medicaid Nursing Home Prospective Payment System

The AHCA currently reimburses nursing facility care using facility-specific, cost-based per diem rates. Beginning September 1, 2015, these rates are updated yearly. Prior to September 1 of each year, annual rates are calculated using inflated historical facility-specific cost information. The rates and reimbursements may be adjusted post-payment if cost reports for the timeframe in which services were rendered are audited or adjusted. For rate year 2016/17, which started on September 1, 2016, these per diem rates ranged from $161.25 to $308.35 per patient day. The unweighted (each facility counted once) average per diem was $228.79. Thus, the facility with the lowest per diem receives 70 percent of the statewide average and the facility with the highest per diem receives 135 percent of the statewide average.

The nursing facility industry in Florida is sizeable and is dependent heavily on Medicaid reimbursement. As of September 1, 2017, there were 658 nursing facilities participating in the Florida Medicaid program,[4] accounting for 83,817 beds.[5] The estimated total Medicaid spend for nursing facility care is approximately $4.1 billion for the 2017-2018 fiscal year.

Since 2013, nearly all long term care for Florida Medicaid has been administered through Medicaid managed care. The managed care plans are required to pay nursing facilities the same rates that are calculated for Medicaid fee-for-service. The contracts between the AHCA and the managed care plans specify:

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[2] 42 U.S.C. 1396a.
[3] MaryBeth Musumeci and Robin Rudowitz, *Medicaid Retroactive Coverage Waivers; Implications for Beneficiaries, providers, and States*, Kaiser Family Foundation, available at: https://www.kff.org/medicaid/issue-brief/medicaid-retroactive-coverage-waivers-implications-for-beneficiaries-providers-and-states/, (last visited January 26, 2018).
[4] Agency for Health Care Administration, *Medicaid Cost Reimbursement*, available at http://ahca.myflorida.com/medicaid/cost_reim/nh_rates.shtml (last visited January 26, 2018).
[5] Agency for Health Care Administration, *Medicaid Cost Reimbursement*, available at*:* http://ahca.myflorida.com/MCHQ/Central_Services/Training_Support/Reports.shtml, (last visited January 26, 2018).

> "The Agency will set facility–specific payment rates based on the rate methodology outlined in the most recent version of the Florida Title XIX Long-term Care Reimbursement Plan. The Managed Care Plan shall pay nursing facilities an amount no less than the nursing facility specific payment rates set by the Agency and published on the Agency website. The Managed Care Plan shall use the published facility-specific rates as a minimum payment level for all payments."

Thus, the calculated per diem rates currently apply to both the Medicaid fee-for-service and managed care programs.

Current statutory provisions specific to Medicaid reimbursement are found in s. 409.908(2), F.S.

The proposed new method described in report balances financial incentives for high quality care with incentives for efficiency. The payment method also attempts to provide fair and equitable payments for similar services. More specifically, the new payment method contains the following components:

- Standardized rates, some with pricing floors, for Direct Care, Indirect Care, and Operations components of per diems. This will reward facilities that operate and provide care most efficiently;
- Facility peer groupings, which take into account higher costs in South Florida;
- A Quality Incentive Program, which uses quality metrics to increase reimbursement to high performing facilities. Facilities with, for example, low infection rates, high star ratings, Gold Seal status, or external industry quality accreditation can earn higher rates. The new system projects to provide approximately $10 million in additional reimbursement to four star, five star, and Gold Seal facilities in the first year of implementation, given the quality scores modelled to date;
- A fair rental value property component, which pays a reasonable amount to providers for well-maintained and updated facilities;
- A transition period that allows facilities to adjust to the new incentive structure;
- No case mix adjustment; and
- Additional payments for specific high cost services to promote access to care.

With these outlined components, the report indicated that all providers have the opportunity to earn higher rates through demonstration of high quality and/or increased efficiency. The report's recommendations reflected 18 decision areas and 28 options selected in these decision areas.

In 2017, the Legislature amended s. 409.908(2), F.S., to provide for the transition from a cost based nursing home reimbursement methodology to a prospective payment reimbursement methodology beginning October 1, 2018.[6] Beginning October 1, 2018, and ending September 30, 2021, the Agency must reimburse a nursing home provider the greater of its September 2016 cost-based reimbursement rate or its prospective payment rate. Effective October 1, 2021, the Agency must reimburse a provider the greater of 95 percent of its cost-based rate or its rebased

[6] Section 8, ch. 2017-129, Laws of Florida.

prospective rate, using the most recently audited cost report for each facility. Pediatric, Florida Department of Veterans Affairs, and government-owned facilities are exempt from this new payment model. Related provisions are modified to keep in place applicable rate-setting ceilings and targets for those facilities that remain on cost-based reimbursement. Changes are made for calculations of direct care costs, and other patient care costs. Prospective rates are to be rebased every four years, and direct care supplemental payments may be made under specified circumstances.

Nursing Home and Institutional Care Facilities for the Developmental Disabled (ICF-DD) Medicaid Quality Assessments

Section 409.9082, F.S., describes the purpose, responsibilities, and remedies related to the payment of a Nursing Home Quality Assessment Fee. Since Fiscal Year 2009-2010, most nursing home facilities have been required to remit a monthly nursing home assessment fee, based on the bed rate set by the agency, and the number of resident days of their Medicaid beds for the month. The reporting of this information is necessary to determine the amount of the facility's assessment fee.

The revenues generated by this assessment fee is used as state match to draw down federal Medicaid funds to pay Medicaid claims submitted by nursing home providers. The law and administrative rules specify enforcement measures the Agency may take if the assessment fee is not remitted timely to the Agency. However, there are no enforcement mechanisms in law to ensure that a facility reports the required information to determine the monthly assessment fee. If the information is not reported monthly, the Agency has no basis upon which to impose the assessment fee. Without adequate revenue from the assessment fees, moneys from the General Revenue Fund may be needed as state match for the nursing home payment.

Comparable provisions specific to ICF-DDs are found in s. 409.9083, F.S., and, like the similar nursing home authority, have been in place since the 2009-2010 fiscal year.

While there have been issues with the required monthly reporting of days by nursing homes, there have been no reporting issues for ICF-DDs.

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

PACE is a capitated benefit model[7] 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 the federal Centers for Medicare and Medicaid Services (CMS) demonstration projects that began in the mid-1980s. The PACE model was developed to address the needs of long-term care clients, providers, and payers.

For most participants, the comprehensive service package permits them to receive services while living at home rather than living in other more costly long term care settings. Capitated

[7] Under such a model, the contracted provider entity is paid a set dollar amount per month to see patients regardless of how many treatments or the number of services the patient receives. The agreement is that the provider will get a flat, prearranged payment in advance per member per month.

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.

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 recipients as a state option without a Medicaid waiver. The state plan must include PACE as an optional Medicaid benefit before the state and federal governments can enter into program agreements with PACE providers.

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

- 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.

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

Florida PACE Program

The Florida PACE program provides alternative, long-term care options for elders who qualify for Medicare and the state Medicaid program. The PACE program was initially authorized in ch. 98-327, L.O.F., and was codified in s. 430.707(2), F.S. The PACE model targets individuals who would otherwise qualify for Medicaid nursing home placement to provide a comprehensive array of home and community-based services at a cost less than the cost of nursing home care. The PACE program is administered by the Department of Elder Affairs in consultation with the AHCA.

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 systems.

PACE projects have been authorized in 46 counties in Florida. PACE projects have been approved and are operational in several Florida counties, including Lee, Charlotte, Collier, Miami-Dade, Pinellas, Palm Beach, and Broward. Most recently PACE projects have been approved and are in various stages of the application process in Leon and surrounding counties,

Duval and surrounding counties, and Lake, Orange, Osceola, Seminole, Martin, Indian River, Okeechobee, St. Lucie, and Hillsborough counties.

In Fiscal Year 2017-2018, the total appropriations for the PACE program is $47.7 million, which funds a 2,325 slots statewide.

National Cancer Institute Cancer Center Designations

Established in 2014, section 381.915, F.S., authorizes Florida-based cancer centers to seek National Cancer Institute (NCI) designation to enhance the quality and competitiveness of cancer care in Florida and further a statewide biomedical research strategy directly responsive to the health needs of Florida's citizens. In Fiscal Year 2017-2018, $62.2 million is appropriated for the Florida Consortium of NCI Centers Program, and proviso language designates one entity as a Tier One comprehensive cancer center and two entities as a Tier Three cancer center seeking designation as a NCI cancer center or comprehensive cancer center. The NCI designation is generally considered the "gold standard" for cancer centers nationally. The specific strategy to achieve the goals of the NCI program is to fund the only existing Florida-based NCI comprehensive cancer center — Moffitt Cancer Center and Research Institute — and to support efforts of the University of Miami (UM) Sylvester Comprehensive Cancer Center and the University of Florida (UF) Health to achieve NCI designation. The funding for the program is distributed based on a competitive statutory formula, and the current year appropriation of $62.2 million is dispersed as follows: Moffitt, $25.4 million; UF, $20.3 million; and UM, $16.6 million. Under current statutory requirements the two cancer centers seeking NCI designation, UF and UM, were given five years, until June 30, 2019, to achieve NCI designation. Otherwise, the NCI-designation incentive funding will revert solely to Moffitt. While much progress is being made towards preparedness to seek designation, the two institutions need additional time given the rigorous process involved to receive NCI designation.

Medicaid Graduate Medical Education Program

The Medicaid Graduate Medical Education Program was established in s. 409.909, F.S., in 2013. The program is administered by the agency, and payments are made to qualifying hospitals and federally qualified health centers (FQHCs) for graduate medical education (GME) services associated with the provision of care for Medicaid patients. State general revenue funds and federal matching funds are combined to provide support to participating institutions. For the fiscal year 2017-2018, $197.3 million is appropriated for the program. There are currently 62 participating GME hospitals, reporting 5,009 resident full-time equivalents (FTEs). Compared to 2013, the initial year of the program, there has been 29 percent growth in resident FTEs from 3,896. Of the increase, 920 FTEs were in 21 hospitals that had not previously participated in the program.[8]

[8] Teaching Hospital Council of Florida and Safety Net Hospital Alliance of Florida, *Training Tomorrow's Doctors, Graduate Medical Education in Florida, 2017 Annual Report*, (on file with staff of Senate Appropriations Subcommittee on Health and Human Services)

Class III Psychiatric Hospitals

The Agency for Health Care Administration regulates hospitals under the provisions of ch. 395, F.S. Per Rule 59A-3.252, Florida Administrative Register (FAR), there are four classes of hospitals that are licensed by the agency: Class I or general hospitals; Class II or specialty hospitals (children and women); Class III or specialty hospitals offering a restricted range of services appropriate to the diagnosis, care, and treatment of patients with specific categories of medical or psychiatric illnesses or disorders, which include specialty medical, specialty rehabilitation, psychiatric, and substance abuse hospitals; and Class IV or specialty hospitals restricted to offering intensive residential treatment programs for children and adolescents. According to the agency's website, there are currently 36 Class III psychiatric hospitals in the state.[9]

Medicaid generally does not pay for inpatient psychiatric services due to federal restrictions on payment of federal funds for services rendered in Institutions for Mental Disease (IMDs). When a Medicaid-eligible individual is a patient in an IMD, he or she cannot receive Medicaid coverage for services provided inside or outside the IMD, with limited exceptions for individuals 65 years of age and older and for inpatient psychiatric hospital services for individuals under age 21.[10] The only reference in Florida statutes specific to Class III psychiatric hospitals is found in s. 409.908(1)(a)2., F.S., which provides for a series of specific exclusions from the diagnosis related group (DRG)-based prospective payment system for hospital inpatient services under Medicaid. Class III psychiatric hospitals are among the types of hospitals and services for which an alternative methodology is to be used.

III. Effect of Proposed Changes:

Section 1 amends s. 381.915(4)(c), F.S., relating to the Florida Consortium of National Cancer Institute Centers Program, to increase from five years to six years the period of time that Tier 3 National Cancer Institute (NCI)-designated cancer centers may remain in Tier 3 designation, and increases from five years to six years the period of time that Tier 3 Cancer Centers are authorized to pursue NCI designation as a Cancer Center or a Comprehensive Cancer Center.

Section 2 amends s. 409.908(1)(a), F.S., to delete reference to Class III psychiatric hospitals from a series of specific exclusions from the diagnosis related group (DRG)-based prospective payment system for hospital inpatient services under Medicaid.

Section 3 amends s. 409.908(2), F.S., relating to Medicaid nursing home reimbursement under the prospective payment system, to modify the parameters upon which Medicaid nursing home prospective payments rates are to be calculated when implemented on October 1, 2018. The direct care subcomponent is changed from 100 percent of the median cost to 105 percent, and the quality incentive payment pool subcomponent is changed from 6 percent to 7.5 percent of the

[9] Agency for Health Care Administration facility regulation information available at: http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Hospital_Outpatient/Reports.shtml, (last visited on February 1, 2018).
[10] Congressional Research Service, *Medicaid's Institutions for Mental Disease (IMD) Exclusion*, (May 8, 2015), available at: https://digital.library.unt.edu/ark:/67531/metadc806197/, (last visited on February 1, 2018).

September 2016 non-property payments of included facilities. This section is effective October 1, 2018.

Section 4, amends s. 409.908(23), F.S., relating to Medicaid rate setting for specified provider types, to specify the prospective payment system reimbursement for nursing home services will be governed by s. 409.908(2), F.S., and the General Appropriations Act. Language relating to county health department reimbursement is restructured but not changed substantively. This section is effective October 1, 2018.

Section 5 amends s. 409.9082(7), F.S., relating to the nursing home quality assessment, to authorize the Agency to impose penalties on a nursing home that fails to report its total number of residential days. The penalty is a fine up to $1,000 per day, not to exceed the amount of the nursing home's assessment fee.

Section 6 amends s. 409.9083(6), F.S., relating to the institutional care facilities for the developmentally disabled quality assessment, to authorize the Agency to impose penalties on an ICF/DD that fails to report its total number of residential days. The penalty is a fine up to $1,000 per day, not to exceed the amount of the ICF/DD's quality assessment fee.

Section 7 amends s. 409.909(2)(c), F.S., relating to the Statewide Medicaid Residency Program, to add "a substance abuse treatment facility licensed under Chapter 397, F.S., which has housed residents and fellows since 2013" to the existing definition of a "qualifying institution". The effect of this change is to authorize the entity Drug Abuse Comprehensive Coordinating Office (DACCO) to qualify as a qualifying institution for purposes of participation in the Medicaid Residency Program.

Section 8 adds a new subsection (4) to s. 409.968, F.S., relating to Medicaid managed care plan payments, to specify that payment arrangements between Class III psychiatric hospitals and managed care plans are not to be based on Medicaid hospital inpatient diagnosis related group (DRG) payments, but are to be developed based on federal CMS prospective payment system pricing methodology or limited to compensation amounts agreed to by the plan and the hospital.

Section 9 amends s. 409.906(13)(d), F.S., relating to home and community based services as a Medicaid optional service, to incorporate a conforming cross-reference revision.

Section 10 directs the Agency to seek federal authorization from federal CMS to modify the period of retroactive Medicaid eligibility from 90 days to 30 days. This section is effective upon becoming a law, to ensure that the modification can be implemented July 1, 2018.

Section 11 authorizes an additional not-for-profit Program for All-Inclusive Care for the Elderly (PACE) in Miami-Dade County. The new PACE program must have a history of serving primarily the Hispanic population by providing primary care services, nutrition, meals, and adult day care services. Upon approval, the program may have up to 250 enrollees.

Section 12 specifies that the act shall take effect upon becoming law, except as otherwise specified in the act.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Nursing homes may receive higher reimbursement for providing quality care and for providing increased direct services to their residents.

A nursing home that has been deficient in submitting required information regarding monthly Medicaid days for purposes of the nursing home quality assessments may be subject to a new fine

Hospitals, nursing homes, and physicians who provided services to newly eligible Medicaid recipients 31 to 90 days prior to the recipient applying for Medicaid will receive no Medicaid reimbursements for those services.

C. Government Sector Impact:

Transition payments associated with the October 1, 2018, implementation of the nursing home prospective payment system are included in SB 2500, the General Appropriations Act for Fiscal Year 2018-2019. Specific Appropriations 217 and 218 provide $9.78 million, of which $3.75 is from the General Revenue Fund and $6.03 million is from federal funds.

The modifications to the nursing home prospective payment methodology specified in section 1 of this bill will result in increased payments by the state totaling $130,412,102, of which $50 million is funded from the General Revenue Fund and $80.4 million is funded by federal funds. Specific Appropriation s 217 and 218 of SB 2500 include the necessary appropriations for these payments.

By reducing the period for retroactive Medicaid eligibility from 90 day to 30 days, the Medicaid program avoids the payment of claims totaling $98,425,854 annually. This

reduces the need for $37.5 million from the General Revenue Fund and $60.9 million from federal funds. This reduction is reflected in SB 2500.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 409.908, 409.9082, and 409.9083.

This bill creates two undesignated sections of Laws of Florida.

IX. Additional Information:

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

None.

B. Amendments:

None.