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:	SPB 2518
INTRODUCER:	For consideration by Appropriations Committee
SUBJECT:	Health Care
DATE:	March 30, 2021
REVISED:	

ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
McKnight	Sadberry		**Pre-meeting**

I. Summary:

SPB 2518 conforms statutes to the funding decisions related to Health Care in the Senate proposed General Appropriations Act for Fiscal Year 2021-2022. The bill:

- Continues the income threshold of $130 per month above which residents of State Veterans' Nursing Homes would be required to contribute to their personal needs account.
- Makes the following revisions to the state's Medicaid Program:
  - Reduces the collection threshold for the Medicaid nursing home lease bond alternative from $25 million to $10 million.
  - Removes optional Medicaid coverage for 19 and 20-year olds effective January 1, 2022.
  - Continues the policy of retroactive Medicaid eligibility for non-pregnant adults to the first day of the month in which an application for Medicaid is submitted.
  - Reduces certain Medicaid optional services for adult Medicaid recipients.
  - Removes the nursing home Medicaid reimbursement rate freeze established on July 1, 2011, thereby allowing for the recurring rate increase provided in Fiscal Year 2020-2021.
- Requires the Letters of Agreement (LOA) for the Low Income Pool program to be received by the Agency for Health Care Administration (AHCA) by October 1 and the funds outlined in the LOA to be received by October 31.
- Updates the years of audited data used to determine disproportionate share payments to hospitals, teaching hospitals, and specialty hospitals for children.
- Reduces the duplication of effort between Statewide Medicaid Managed Care plans and the MomCare Network.
- Redesignates the West Florida Regional Medical Center memory disorder clinic to the Medical Center Clinic in Pensacola.
- Requires the Florida Healthy Kids Corporation to validate and calculate a refund amount for Title XXI providers who achieve a Medical Loss Ratio below 85 percent and to deposit any refunds into the General Revenue Fund, unallocated.
- Prohibits the Attorney General and the Department of Health from using funds received as part of a settlement agreement to administer the Prescription Drug Monitoring Program.

- Authorizes the AHCA, upon federal approval, to contract with an organization that meets all specified requirements to be a site for the Program of All Inclusive Care for the Elderly (PACE) program and provide comprehensive long-term care services for up to:
  - 200 enrollees who reside in Escambia, Okaloosa, and Santa Rosa Counties;
  - 100 enrollees who reside in Northwest Miami-Dade County;
  - 500 enrollees who reside in Hillsborough, Hernando or Pasco Counties; and
  - 300 enrollees who reside in Broward County.
- Expands the existing North East PACE authorization into Alachua and Putnam Counties.

The bill takes effect on July 1, 2021, except as otherwise expressly provided in the bill.

II. Present Situation:

State Veterans' Homes

Once Medicaid eligibility is established for an individual requiring an institutional level of care, some of his or her income is used to pay for Medicaid services. For individuals residing in an institution, most of their incomes are applied to the cost of that care, with the exception of a small personal needs allowance used to pay for personal needs that are not covered by Medicaid.[1] A personal needs allowance is the amount of income a resident may retain for personal expenditures not covered by the nursing home such as toiletries and haircuts.

The Florida Department of Veterans' Affairs operates six skilled nursing facilities and one assisted living facility.[2] Every resident of a state veteran domiciliary or nursing home who receives a pension, compensation, or gratuity from the United States Government or income from any other source of more than $130 per month is required to contribute to his or her maintenance and support while residing in a home, pursuant to a schedule of payment determined by the home administrator and department director that shall not exceed the actual cost of operating and maintaining the home.[3] For the past three fiscal years the General Appropriations Act (GAA) implementing legislation increased the income threshold from $105 to $130 per month above which residents of State Veterans' Nursing Homes would be required to contribute to their personal needs account.[4]

Nursing Home Lease Bond Alternative

As a condition of being issued a license by the Agency for Health Care Administration (AHCA), a nursing home leasing the property where services are provided is required to annually submit a Surety Bond in the amount of three months' Medicaid payments or pay a nonrefundable fee for one percent of the surety bond amount. This is required to ensure that providers operating leased facilities satisfy their Medicaid overpayment liabilities.[5]

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[1] 42 U.S.C. s. 396a (q).
[2] Florida Department of Veterans' Affairs, *State Veterans' Homes, available at* https://floridavets.org/locations/state-veterans-nursing-homes/ (last visited Mar. 22, 2021).
[3] Section 296.37, F.S
[4] Chapters 2018-10, s. 31, 2019-116, s. 47, and 2020-114, s. 37, Laws of Fla.
[5] Section 400.179(d), F.S.

These funds are deposited into the Grants and Donations Trust Fund within the AHCA and are held separately in a Medicaid nursing home overpayment account. The AHCA has the sole discretion to use the fees to repay nursing home Medicaid overpayments. The AHCA annually reviews the financial viability of the Medicaid nursing home overpayment account after all overpayments have been repaid and, if the balance is greater than $25 million, collections of the fee are suspended for the subsequent fiscal year.[6] For the past two fiscal years the GAA implementing legislation reduced the collection threshold for the Medicaid nursing home lease bond alternative from $25 million to $10 million.[7]

Florida 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 and Medicaid Services (CMS). The state plan establishes groups of individuals covered under the Medicaid program, services that are provided, payment methodologies, and other administrative and organizational requirements.

Florida's Medicaid program is administered by the AHCA and financed with federal and state funds. According to the most recently published estimates, approximately 4.6 million Floridians are currently enrolled in Medicaid,[8] and the program's projected expenditures for the 2021-2022 fiscal year are $32.6 billion.[9]

In order to participate in Medicaid, federal law requires states to cover certain population groups (mandatory eligibility groups[10]) and gives states the flexibility to cover other population groups (optional eligibility groups[11]). States set individual eligibility criteria within federal minimum standards. The AHCA may seek an amendment to the state plan as necessary to comply with federal or state laws or to implement program changes. States send state plan amendments to the federal CMS for review and approval.[12]

Medicaid enrollees generally receive benefits through one of two service-delivery systems: fee-for-service (FFS) or managed care. Under FFS, health care providers are paid by the state Medicaid program for each service provided to a Medicaid enrollee. Under managed care, the AHCA contracts with private managed care plans for the coordination and payment of services for Medicaid enrollees. The state pays the managed care plans a capitation payment, or fixed monthly payment, per recipient enrolled in the managed care plan.

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[6] *Id.*
[7] Chapters 2019-116, s. 28, and 2020-114, s. 50, Laws of Fla.
[8] Agency for Health Care Administration (AHCA), *Monthly Eligible Report for February 2021* (on file with the Senate Appropriations Subcommittee on Health and Human Services).
[9] See Social Services Estimating Conference, *Medicaid Caseloads and Expenditures, November 19, 2020, December 2, 2020, and December 8, 2020, respectively, available at* http://edr.state.fl.us/Content/conferences/medicaid/index.cfm (last visited Mar. 22, 2021).
[10] Section 409.903, F.S.
[11] Section 409.904, F.S.
[12] Medicaid.gov, *Medicaid State Plan Amendments, available at* https://www.medicaid.gov/medicaid/medicaid-state-plan-amendments/index.html (last visited Mar. 22, 2021).

In Florida, the majority of Medicaid recipients receive their services through a managed care plan contracted with the AHCA under the Statewide Medicaid Managed Care (SMMC) program.[13] The SMMC program has two components, the Managed Medical Assistance (MMA) program and the Long-term Care program. Florida's SMMC offers a health care package covering both acute and long-term care.[14] The SMMC benefits are authorized by federal authority and are specifically required in ss. 409.973 and 409.98, F.S.

The AHCA contracts with managed care plans on a regional basis to provide services to eligible recipients. The MMA program, which covers most medical and acute care services for managed care plan enrollees, was fully implemented in August 2014, and the current contracts expire in 2024.[15]

Medicaid 19 and 20-Year Old Optional Child Eligibility Group

Low-income families, qualified pregnant women and children, and individuals receiving Supplemental Security Income (SSI) are examples of mandatory eligibility groups.[16] Florida Medicaid currently includes coverage of the optional eligible group known as 19 and 20-year olds. Medicaid is provided to individuals who are 19 and 20-years old who are unmarried or whose marriage was annulled.

Medicaid Retroactive Eligibility

The Social Security Act provides requirements under which state Medicaid programs must operate. For most eligibility groups, federal law authorizes state Medicaid programs to reimburse Medicaid-covered services for a period of 90 days prior to the date of a recipient's application for assistance.[17] This requirement may be waived pursuant to federal waiver laws and regulations.

In 2018, the AHCA was directed to seek a waiver from the federal CMS to limit the retroactive eligibility period for non-pregnant adults aged 21 and older.[18] For these adults, eligibility would become retroactively effective on the first day of the month in which their Medicaid application was filed, instead of three months prior to the date of a recipient's Medicaid application. AHCA submitted to the federal CMS an amendment to the federal waiver for Florida's section 1115 demonstration project, titled Managed Medical Assistance (MMA) Program (Project No. 11-W-00206/4), on April 27, 2018, and it was subsequently approved on November 30, 2018.

In 2019 and 2020, the Legislature renewed the 2018 Medicaid retroactive eligibility policy, thereby enabling the waiver authority to continue for Fiscal Year 2019-2020[19] and 2020-2021,[20]

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[13] Medicaid.gov, *Medicaid State Plan Amendments, available at* https://www.medicaid.gov/medicaid/medicaid-state-plan-amendments/index.html (last visited Mar. 22, 2021).
[14] *Id.*
[15] Chapter 2020-156, s. 44, Laws of Fla.
[16] Medicaid.gov, *List of Medicaid Eligibility Groups, available at* https://www.medicaid.gov/sites/default/files/2019-12/list-of-eligibility-groups.pdf (last visited Mar. 15, 2021).
[17] 42 U.S.C. s. 1396a(a)(34).
[18] Chapter 2018-10, s. 20, Laws of Fla.
[19] Chapter 2019-116, s. 24, Laws of Fla.
[20] Chapter 2020-114, s. 16, Laws of Fla.

which required the AHCA to make payments to Medicaid providers for Medicaid-covered services as follows:

- On behalf of eligible children and pregnant women, retroactive for a period of no more than 90 days before the month in which an application for Medicaid is submitted; or
- On behalf of eligible non-pregnant adults, retroactive to the first day of the month in which an application for Medicaid is submitted.

Medicaid Adult Optional Services

Federal law requires states to provide certain mandatory services and allows states the choice of covering other optional services. Mandatory services include inpatient and outpatient hospital services, physician services, laboratory and x-ray services, family planning services, and home health services, among others. Optional services include prescription drugs, case management, physical therapy, and occupational therapy.[21] Florida's Medicaid Program currently provides reimbursement for a number of optional services for adult Medicaid recipients including the optional services listed above as well as vision, hearing, chiropractic, and podiatry services, among others.[22]

Nursing Home Reimbursement

In 2008, the AHCA was directed to establish provider rates for hospitals, nursing homes, community intermediate care facilities for the developmentally disabled, and county health departments that would result in the elimination of automatic cost-based rate (rate) increases for a period of two fiscal years, effective July 1, 2009.[23] Rate freezes were set to expire July 1, 2011, however, in 2011, the sunset date was repealed, rates were capped at July 1, 2011 rate levels, and it was established that reimbursement rates would be as provided in the GAA. In effect, annual automatic Medicaid rate increases for nursing homes were capped at 2011 levels.[24] In 2016, nursing homes hit the July 1, 2011, rate cap thereby triggering a rate freeze until Fiscal Year 2020-2021.[25] In 2020, the Legislature appropriated $74.8 million in recurring funding to provide a nursing home reimbursement rate increase.[26]

Low Income Pool Program

The Low Income Pool (LIP) program was created to provide supplemental payments to providers for the costs of uncompensated charity care for low-income individuals who are uninsured. Uncompensated care does not include uncompensated care for insured individuals,

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[21] Medicaid.gov, *Mandatory & Optional Medicaid Benefits, available at* https://www.medicaid.gov/medicaid/benefits/mandatory-optional-medicaid-benefits/index.html (last visited Mar. 13, 2021).
[22] AHCA, *Schedule VIIIB-2: Priority Listing of Agency Budget Issues for Possible Reduction in the Event of Revenue Shortfalls for Legislative Budget Request Year, available at* http://floridafiscalportal.state.fl.us/Document.aspx?ID=20954&DocType=PDF (last visited Mar. 13, 2021).
[23] Chapter 2008-143, s. 5, Laws of Fla.
[24] Chapter 2011-61, s. 4, Laws of Fla.
[25] In Fiscal Year 2018-2019, nursing homes received $9.8 million in nonrecurring funding to transition to the Nursing Home Prospective Payment System and $128.5 million in nonrecurring funding in the direct care rate and the quality incentive pool under the prospective payment system. An additional $15.5 million in nonrecurring funding was provided to nursing homes in Fiscal Year 2019-2020 in the quality incentive pool under the prospective payment system. Chapter 2019-115, Specific Appropriation 221, and Chapter 2018-9, Specific Appropriation 217, Laws of Fla.
[26] Chapter 2020-111, Specific Appropriation 212, Laws of Fla.

"bed debt," or Medicaid and Children's Health Insurance Program (CHIP) shortfall.[27] The current LIP program is authorized for $1.5 billion total computable and has federal approval to operate through the 2029-2030 state fiscal year.[28]

Counties, municipalities, hospital taxing districts and entities operated by a state or local government are eligible to provide the non-federal share of LIP distributions through Intergovernmental Transfers (IGTs). An IGT is a method in which local (non-state) governments and public hospitals can transfer funds to the AHCA to help fund the Medicaid program. The IGTs received by the AHCA are then used to draw down funds from the federal government as "match" funding to support the Medicaid program.

The local taxing authorities commit to sending these funds to the state in the form of an executed Letter of Agreement (LOA) with the AHCA. An LOA is a contract between the AHCA and an IGT contributor holding the IGT contributor accountable for transferring funds to the AHCA on behalf of the specified provider listed on the LOA. The LOA lays out the total amount of IGTs that the contributor pledges for the state fiscal year.

Local governments, who participate in IGT-funded programs, are required to submit to the AHCA the final executed LOA containing the total amount of the IGTs by the entity, no later than October 1 of each year. Additionally, local governments are required to transfer IGT funds to the AHCA by October 31. There is currently no requirement for local governments to comply with these date requirements for the participation in the LIP program.[29]

Disproportionate Share Hospital Program

Federal law requires state Medicaid programs to make payments to qualifying hospitals that serve a large number of Medicaid and uninsured individuals. This is known at the Disproportionate Share Hospital (DSH) program. The federal government annually provides a limited DSH allotment to each state based on the amount of state dollars appropriated as matching funds for the federal DSH allotment, up to, but not exceeding the federal limit. The legislature determines each year how DSH funds will be distributed to each qualifying hospital in the GAA and according to parameters within Florida law. For states to receive DSH payments, federal law requires states to submit an independent certified audit and an annual report to the secretary of the United States Department of Health and Human Services, describing DSH payments made to each qualifying hospital. Florida law requires the AHCA to use audited data from specified years to determine the amount of Medicaid and charity care to be used in calculating DSH payments.[30]

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[27] See Reimbursement and Funding Methodology For Demonstration Year 15, Florida's 1115 Managed Medical Assistance Waiver, Low Income Pool, page 10, *available at* https://ahca.myflorida.com/Medicaid/Finance/finance/LIP-DSH/LIP/pdfs/Reimbursement_and_Funding_Methodology_Document_01-15-21.pdf (last visited Feb. 10, 2021).
[28] See the January 15, 2021, the federal Centers for Medicare and Medicaid Services (CMS) letter and waiver approval document, including the waiver Special Terms and Conditions, *available at* https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/FL_MMA_Extension_STCs_1.15.2021.pdf (last visited Feb. 10, 2021).
[29] AHCA, *Intergovernmental Transfers Frequently Asked Questions*, *available at* https://ahca.myflorida.com/Medicaid/Finance/finance/LIP-DSH/LIP/pdfs/IGT_FAQs.pdf (last visited Mar. 13, 2021).
[30] Section 409.911(2), F.S.

Healthy Start

Healthy Start is a free home visiting program that provides education and care coordination to pregnant women and families of children under the age of three. The goal of the program is to lower risk factors associated with preterm birth, low birth weight, infant mortality and poor developmental outcomes.[31]

Responsibility for coordination of Healthy Start resides with the local Healthy Start Coalitions. There are currently 33 coalitions, organized as non-profit agencies which serve all 67 counties.[32] The coalitions are overseen by the Department of Health (DOH). Each coalition may receive up to $150,000 in state and federal grant funding from the DOH provided the coalition has demonstrated a local match of 25 percent.[33] For Fiscal Year 2020-2021, Healthy Start received recurring base funding totaling $24.5 million.[34]

In 2001, the AHCA, in collaboration with the DOH and the Healthy Start Coalition Association, developed a 1915(b) waiver to provide additional funds for Healthy Start services in order to increase the state's capacity to improve maternal and child health outcomes. The waiver, known as MomCare, was approved, and beginning July 1, 2001, Healthy Start services became eligible for Medicaid reimbursement for pregnant women and children up to age three who are enrolled in Medicaid.[35]

In 2011, the Legislature directed the AHCA to contract with an administrative services organization representing all Healthy Start Coalitions in order to continue the MomCare waiver services of care coordination, and other services. All managed care plans were also required to contract with the Healthy Start Coalitions in their regions in order to coordinate services provided to pregnant women and infants.[36]

Healthy Start MomCare Network

The Healthy Start MomCare Network, Inc. (MomCare) is an administrative service organization representing all Healthy Start Coalitions under the provisions of s. 409.975(4)(a), F.S. MomCare is tasked with implementing services provided to Medicaid recipients during pregnancy and after delivery, and contracts with the AHCA and the coalitions to establish specific programs and procedures to improve pregnancy outcomes and infant health among Medicaid recipients. In addition, MomCare coordinates with managed care plans in providing care for Healthy Start participants.[37] The current multi-year contract amount for MomCare is $82.3 million with annual

[31] Department of Health (DOH), *Healthy Start, available at* http://www.floridahealth.gov/programs-and-services/childrens-health/healthy-start/index.html (last visited Mar. 22, 2021).
[32] Florida Association of Healthy Start Coalitions, *Healthy Start Health Plan Contact List, available at* https://www.healthystartflorida.com/wp-content/uploads/2021/01/HS-CONNECT-REFFERAL-AND-COORDINATION-CONTACT-INFORMATION-Update-12-2-20.pdf (last visited Mar. 22, 2021).
[33] Section 383.216(7), F.S.
[34] Chapter 2020-111, Specific Appropriation 453, Laws of Fla
[35] DOH, *Healthy Start Standards and Guidelines, available at* http://www.floridahealth.gov/programs-and-services/childrens-health/healthy-start/_documents/chapter-1-the-healthy-start-system-2008.pdf (last visited Mar. 22, 2021).
[36] Chapter 2011-134, s. 16, Laws of Fla.
[37] Florida Healthy Start, *Healthy Start MomCare Network, available at* https://www.healthystartflorida.com/about-us/healthy-start-momcare-network/ (last visited Mar. 21, 2021).

payments capped at $41.2 million, contingent on appropriations for the program.[38] This funding is separate from the $24.5 million recurring base funding Healthy Start receives through the DOH.[39]

Healthy Start MomCare Network, Inc.			
Renewal Year Two (2) – January 1, 2021 – December 31, 2021			
Service Name	**Unit Reimbursement Amount**	**Estimated* Maximum Allowable Units Per Year**	**Estimated* Maximum Reimbursement Amount**
Coordinated Intake and Referral – Pregnant Women	$105 per unit	Up to 58,000 units	$6,090,000
Coordinated Intake and Referral – Infants and Children	$105 per unit	Up to 30,000 units	$3,150,000
Care Coordination with the Medicaid Managed Care Plans	$55 per unit	Up to 40,600 units	$2,233,000
Healthy Start Prenatal Pathways	$254 per unit (up to 18 visits per recipient)	Up to 45,300.637 units	$11,506,362**
Healthy Start Infant-Child Pathways	$254 per unit (up to 36 visits per recipient)	Up to 47,000 units	$11,938,000
Interconception Care Pathway – Face-to-Face	$254 per unit	Up to 13,500 units	$3,429,000
Interconception Care Pathway – Phone Based	$55 per unit	Up to 51,389 units	$2,826,395
Renewal Year (2) Total			**$41,172,757****
* Maximum units and maximum reimbursement amounts may vary between the service line items above; however, the total Contract amount will not change. **Standard rounding rules apply. Payment is contingent upon receipt and approval of required supporting documentation and evidence of meeting established performance and quality standard requirements.			

Statewide Medicaid Managed Care Plans

The AHCA is responsible for administering the SMMC program. Statewide Medicaid Managed Care plans are also required to establish programs and procedures to improve pregnancy outcomes and infant health, inter-conception care, and reproductive life planning, and to conduct risk assessments to identify pregnant enrollees at risk of poor pregnancy outcomes. Managed Care Plans are also required to manage and provide care coordination for pregnant woman, and services provided by Healthy Start that are already covered in the plan contracts, including screening, care coordination, education, and general family planning services.[40]

[38] Florida Accountability Contract Tracking System, *AHCA Contract No. FP076, Amendment No. 3, available at* https://facts.fldfs.com/Search/ContractDetail.aspx?AgencyId=680000&ContractId=FP076 (last visited Mar. 21, 2021).
[39] Section 383.216(7), F.S.
[40] Section 409.975(4)(b), F.S.

Services Provided by Medicaid Managed Care Plans 2018-2023 Model Health Plan Contract Managed Medical Assistance Program – October 1, 2020[41]	
Notification of Enrollee Pregnancy	• Responsible for newborns of pregnant enrollees from the date of their birth. • Newborns are enrolled in the Managed Care Plan of the mother unless the mother chooses another plan or the newborn does not meet the enrollment criteria of the mother's plan. When a newborn does not meet the criteria of the mother's plan, the newborn will be enrolled in a plan.
Continuity of Care in Enrollment	The following services may extend beyond the 60 day continuity of care period, and the Managed Care Plan must continue the entire course of treatment with the recipient's current provider as described below: • Prenatal and postpartum care – The Managed Care Plan shall continue to pay for services provided by a pregnant woman's current provider for the entire course of her pregnancy, including the completion of her postpartum care (six weeks after birth), regardless of whether the provider is in the Managed Care Plan's network.
Care Coordination	• Provide care coordination through the gestational period according to the needs of the enrollee. • Contact enrollees who fail to keep their prenatal appointments as soon as possible, and arrange for their continued prenatal care. • Assist enrollees in making delivery arrangements. • Ensure each enrollee receiving services in the Early Steps program is assigned a Child Health Services Targeted Case Manager.
Early Intervention Services	• Promote increased use of prevention and early intervention services (EIS) for at-risk enrollees, birth through 36 months of age. • Cover early intervention screening and evaluation services without authorization. The Managed Care Plan must not impose any administrative or clinical barriers that impede the early intervention screening and evaluation from being completed within 45 days of the enrollee's referral to the Early Steps program. • Ensure that all early intervention services are provided to enrollees in their natural environment (i.e., home, school, daycare, etc.), when appropriate.
Pregnancy Prevention	• Conduct regularly scheduled pregnancy prevention programs or make a good faith effort to involve enrollees in existing community pregnancy prevention programs. The programs are required to be targeted towards teen enrollees, but are open to all enrollees, regardless of age, gender, pregnancy status, or prenatal consent.
Pregnancy-Related Programs	• Provide regular home visits, conducted by a home health nurse or aide, and counseling and educational materials to pregnant and postpartum enrollees who are not in compliance with the Managed Care Plan's prenatal and postpartum programs. • Coordinate its efforts with the local Healthy Start care coordinator/case manager to prevent duplication of services. • Ensure providers supply voluntary family planning, including a discussion of all methods of contraception, as appropriate. • Ensure that providers give all women of childbearing age HIV counseling and offer them HIV testing. (Chapter 381, F.S.)

[41] AHCA, *2018-2023 Model Health Plan Contract, Managed Medical Assistance Program – October 1, 2020, available at* https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2020-10-01/Exhibit_II_A_MMA-2020-10-01.pdf (last visited Mar. 21, 2021).

Services Provided by Medicaid Managed Care Plans (continued) 2018-2023 Model Health Plan Contract Managed Medical Assistance Program – October 1, 2020	
Healthy Start Services	• Develop agreements with each local Healthy Start Coalition in the region to provide risk-appropriate care coordination/case management for pregnant women and infants. • The program for pregnant women and infants must be aimed at promoting early prenatal care to decrease infant mortality and low birth weight and to enhance healthy birth outcomes. • Collaborate with the Healthy Start care coordinator within the enrollee's county of residence to assure delivery of risk-appropriate care. • Ensure submission of a completed Practitioner Disease Report Form to the Perinatal Hepatitis B Prevention Coordinator for all prenatal or postpartum enrollees and their infants who test positive for Hepatitis B.
Nutritional Assessment/ Counseling	• Ensure that providers supply nutritional assessment and counseling to all pregnant enrollees, and postpartum enrollees and their children. • Determine the need for non-covered services and referral of the enrollee for assessment and refer the enrollee to the appropriate service setting (to include referral to WIC and Healthy Start and other social services) with assistance. • Ensure the provision of safe and adequate nutrition for infants by promoting breast-feeding and the use of breast milk substitutes. • Offer a mid-level nutrition assessment. • Provide individualized diet counseling and a nutrition care plan by a public health nutritionist, a nurse, or physician following the nutrition assessment. • Refer all enrollees under the age of five, and pregnant, breast-feeding and postpartum enrollees to the local WIC program office using the Florida WIC Program Medical Referral Form. • For subsequent WIC certifications, the Managed Care Plan must ensure that providers coordinate with the local WIC office to provide the above referral data from the most recent well-child visit. • Each time the provider completes a WIC referral form, the Managed Care Plan must ensure that the provider gives a copy of the form to the enrollee.
Family Planning Services	• Furnish family planning services on a voluntary and confidential basis. • Allow each enrollee to obtain family planning services and supplies from any provider and not require a referral for such services. • Make available and encourage all pregnant women and mothers with infants to receive postpartum visits for the purpose of voluntary family planning, including discussion of all appropriate methods of contraception, counseling, and services for family planning to all women and their partners. The Managed Care Plan is required to direct providers to maintain documentation in the enrollee records to reflect this provision. • Implement an outreach program and other strategies for identifying every pregnant enrollee, including care coordination/case management, claims analysis, and use of health risk assessment, etc. The Managed Care Plan must require its participating providers to notify the plan of any enrollee who is identified as being pregnant.

Memory Disorder Clinic

In 1985, the Legislature established a memory disorder clinic (MDC) at each of the three medical schools in the state of Florida, a major private nonprofit research-oriented teaching hospital, and/or any of the other affiliated teaching hospitals, for the purpose of conducting research and training in a diagnostic and therapeutic setting for persons suffering from Alzheimer's Disease and related memory disorders.[42]

There are currently 17 MDCs operating in 13 distinct service areas throughout the state. All 17 MDCs participate in funded research projects and are required to provide comprehensive assessments, diagnostic services, and treatment to individuals who exhibit symptoms of Alzheimer's disease and related dementias.[43] Memory Disorder Clinic locations are as follows:

- AdventHealth Orlando (Orlando)
- Broward Health North (Deerfield Beach)
- Florida Atlantic University (Boca Raton)
- Health First (Melbourne)
- Lee Memorial (Fort Myers)
- Mayo Clinic (Jacksonville)
- Miami Jewish Health (Miami)
- Mt. Sinai Medical Center (Miami Beach)
- Morton Plant (Clearwater)
- Orlando Health (Orlando)
- St. Mary's Medical Center (West Palm Beach)
- Sarasota Memorial (Sarasota)
- Tallahassee Memorial (Tallahassee)
- University of Florida (Gainesville)
- University of Miami (Miami)
- University of South Florida (Tampa)
- West Florida Hospital (Pensacola)

Florida Healthy Kids Corporation

The Florida Healthy Kids Corporation (FHKC) was created in 1990 by the Florida Legislature as a public-private effort to improve access to health insurance for the state's uninsured children. In 1998, the FHKC was combined with two other existing state health care programs for children (Medicaid and Children's Medical Services) and a new program (MediKids) to create Florida's KidCare program.[44]

The FHKC is required to purchase goods and services in the most cost-effective manner consistent with the delivery of quality medical care to uninsured and underinsured children through contracts with health care providers. Federal CMS regulations require a minimum Medical Loss Ratio (MLR) no lower than 85 percent for all Medicaid and CHIP managed care programs, and require a specific calculation of the MLR.[45] The FHKC contracts with health care providers to maintain maximum administrative costs of 15 percent and a minimum medical loss ratio (MLR) of 85 percent.[46] If a provider's MLR comes in below that level, the provider must

[42] Chapter 85-145, s. 2, Laws of Fla.
[43] Department of Elder Affairs (DOEA), *Programs and Services, Memory Disorder Clinics Report 2020, available at* http://elderaffairs.state.fl.us/doea/documents/MDC%202020%20Annual%20Report_FINAL.pdf (last visited Mar. 21, 2021).
[44] Florida Healthy Kids Corporation, *History, available at* https://www.healthykids.org/healthykids/history/#:~:text=The%20Florida%20Healthy%20Kids%20Corporation,of%20Medicine%20by%20Steve%20A (last visited Mar. 13, 2021).
[45] 42 CFR 457.1203 and 438.8.
[46] Section 624.91(10), F.S.

return the money to the FHKC. Any refunds are transferred to the General Revenue Fund, unallocated.

Florida's Prescription Drug Monitoring Program (PDMP)

The Florida prescription drug monitoring program (PDMP) is a state-run electronic database used to track the prescribing and dispensing of certain controlled prescription drugs.[47] Only prescribers and dispensers have direct access to information in the database. Other entities, such as health care regulatory boards and law enforcement, have indirect access and must make a request to the PDMP program to obtain information from the database. The PDMP became operational on September 1, 2011, when it began receiving prescription data from pharmacies and dispensing practitioners.[48] Health care practitioners began accessing the PDMP on October 17, 2011.[49]

A dispensing practitioner is required to report specified information by the close of the next business day for each controlled substance[50] dispensed to a patient in Florida. All acts of administration, the dispensing of a controlled substance to a person under the age of 16, and the dispensing of a controlled substance in a health care system of the Department of Corrections are exempt from the requirement to report.

In 2018, the Comprehensive Controlled Substance Bill[51] was signed into state law increasing regulation on prescribers and dispensers, expanding the use of the PDMP, amending criminal laws, and making appropriations.[52] Each prescriber or dispenser or his or her designee is now required to consult the PDMP system to review a patient's controlled substance dispensing history each time a controlled substance is prescribed or dispensed to a patient age 16 or older unless a statutory exemption applies.[53] Previously, a dispensing or prescribing health care practitioner was authorized, but not required, to check the PDMP prior to dispensing or prescribing a controlled substance. In addition, the law expanded access to the PDMP to Medical Examiners and employees of the United States Department of Defense and Indian Health Service who provide health care services.[54]

Program of All-Inclusive Care for the Elderly

The Program of All-Inclusive Care for the Elderly (PACE) provides comprehensive medical and social services to certain frail, community-dwelling elderly individuals, most of whom are dually

[47] Section 893.055(2)(a), F.S.
[48] DOH, *2012-2013 Prescription Drug Monitoring Program Annual Report* (Dec. 1, 2013), *available at* http://www.floridahealth.gov/reports-and-data/e-forcse/news-reports/_documents/2012-2013pdmp-annual-report.pdf (last visited on Mar. 22, 2021).
[49] *Id*.
[50] Section 893.055, F.S., defines "controlled substance" as "a controlled substance listed in Schedule II, Schedule III, Schedule IV, or Schedule V of s. 893.03 or 21 U.S.C. s. 812."
[51] Chapter 2018-13, Laws of Fla.
[52] DOH, *2017-2018 Prescription Drug Monitoring Program Annual Report* (Dec. 1, 2018), *available at* http://www.floridahealth.gov/statistics-and-data/e-forcse/health_care_practitioners/_documents/2018-pdmp-annual-report.pdf (last visited on Mar. 22, 2021).
[53] Chapter 2018-13, Laws of Fla.
[54] DOH, *2017-2018 Prescription Drug Monitoring Program Annual Report* (Dec. 1, 2018).

eligible for Medicare and Medicaid benefits. An interdisciplinary team of health professionals provides PACE participants with coordinated care. For most participants, the coordinated care and services enables them to remain in the community rather than receive care in a nursing home.[55]

In Florida, the PACE is administered by the Department of Elder Affairs (DOEA) in consultation with the AHCA. The DOEA oversees the contracted PACE organizations, but is not a party to the contract between the federal CMS, the AHCA, and the PACE organizations. The DOEA, the AHCA, and the federal CMS must approve any applications for new PACE organizations if expansion is authorized by the Legislature.[56]

PACE Organizations

A PACE organization is a non-profit private or public entity that is primarily engaged in providing PACE health care services.

To qualify for PACE, organizations must have:
- A governing board that includes community representation;
- A physical site to provide adult day services;
- A defined service area;
- The ability to provide the complete service package regardless of frequency or duration of services;
- Safeguards against conflict of interest; and
- Demonstrated fiscal soundness.[57]

Eligibility and Benefits

In order to enroll in a PACE program, federal law requires individuals meet the following criteria:
- Be 55 years of age or older;
- Be determined by the state to need the level of care required under the State Medicaid plan for coverage of nursing facility services;
- Reside in the service area of the PACE organization; and
- Be able to live in a community setting without jeopardizing his or her health or safety.[58]

Individuals enrolled in PACE have both their medical and long-term care needs managed through a single organization. Some of the services PACE covers includes adult day care,

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[55] Medicaid.gov, *Program of All-Inclusive Care for the Elderly*, *available at* https://www.medicaid.gov/medicaid/long-term-services-supports/program-all-inclusive-care-elderly/index.html (last visited Mar. 22, 2021).
[56] DOEA and AHCA, *Program of All-Inclusive Care for the Elderly and Statewide Medicaid Managed Care Long-term Care Program Comparison Report* (January 14, 2014), *available at* https://ahca.myflorida.com/Medicaid/recent_presentations/PACE_Evaluation_2014.pdf (last visited Mar. 22, 2021).
[57] Medicaid.gov, *Program of All-Inclusive Care for the Elderly*, *available at* https://www.medicaid.gov/medicaid/long-term-services-supports/program-all-inclusive-care-elderly/index.html (last visited Mar. 22, 2021).
[58] United States Department of Health and Human Services, federal CMS, *CMS Manual System: Pub. 100-11 Programs of All-Inclusive Care for the Elderly (PACE) Manual* (issued June 9, 2011), *available at* https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pace111c01.pdf (last visited Mar. 22, 2021).

dentistry, primary care, hospital care, laboratory/x-ray services, meals, nursing home care, physical therapy, and prescription drugs, among others.[59]

Enrollment, Organizational Slots, and Funding

Currently, six PACE organizations operate in Florida and provide services to participants within specific zip codes in Broward, Charlotte, Clay, Collier, Duval, Lee, Miami-Dade, Palm Beach, and Pinellas counties. There are 2,347 individuals enrolled in Florida PACE organizations as of February 2021.[60]

Slots are authorized by the Legislature for a specific PACE area; however, slots may not always be fully funded in the same year the program is authorized. Some PACE providers need additional time to complete the application process, obtain necessary licensures, or to finalize operations. The 2020-2021 GAA provided just over $73 million in PACE program funding to PACE organizations around the state.[61]

The following table includes allocation and enrollment information outlined in the 2020-2021 fiscal year GAA:

Current PACE Programs[62]				
PACE Organization		**Enrollment**		
Service Area	**Organization**	**Authorized Slots**	**Funded Slots**	**Enrollment (Feb. 2021)[63]**
Broward	Florida PACE	150	125	99
Charlotte	Hope Select PACE	150	150	89
Clay, Duval	Northeast PACE Partners	300	150	57
Collier	Hope Select PACE	120	120	63
Lake, Orange, Osceola, Seminole, Sumter	InnovAge PACE	300	150	0
Lee	Hope Select PACE	380	380	260
Martin	Florida PACE	150	125	0
Miami-Dade	Florida PACE	828	828	816
Palm Beach	Morse PACE	706	706	649
Pinellas	Empath PACE	325	325	314
Total		**3,409**	**3,059**	**2,347**

[59] Medicaid.gov, *Program of All-Inclusive Care for the Elderly*.
[60] AHCA, *Florida Statewide Medicaid Monthly Enrollment Report* (February 28, 2021), *available at* https://ahca.myflorida.com/Medicaid/Finance/data_analytics/eligibles_report/docs/program_cnty_2021-02-28.pdf (last visited Mar. 21, 2021).
[61] Chapter 2020-111, Laws of Fla.
[62] Email from the DOEA, (March 9, 2021) (on file with the Senate Appropriations Subcommittee on Health and Human Services).
[63] AHCA, *Florida Statewide Medicaid Monthly Enrollment Report* (February 28, 2021), *available at* https://ahca.myflorida.com/Medicaid/Finance/data_analytics/eligibles_report/docs/program_cnty_2021-02-28.pdf (last visited Mar. 21, 2021).

III. Effect of Proposed Changes:

Section 1 amends s. 296.37(1) and (3), F.S., to permanently set the personal needs allowance at $130 per month for residents of State Veterans' Homes.

Section 2 amends s. 393.0661(7), F.S., to provide for technical corrections to statutory cross references in the Home and Community-Based Services Delivery System due to reducing certain Medicaid optional services for adult Medicaid recipients in s. 409.906, F.S.

Section 3 amends s. 400.179(2)(d), F.S., to decrease the collection threshold for the nursing home lease bond alternative from $25 million to $10 million.

Section 4 amends s. 409.903(3), F.S. to remove Medicaid optional coverage for 19 and 20-year olds effective January 1, 2022.

Section 5 amends s. 409.904(12), F.S., to provide payments for Medicaid eligible services for eligible non-pregnant adults retroactive to the first day of the month in which an application for Medicaid is submitted. Eligible children and pregnant women will continue to have retroactive Medicaid eligibility for a period of 90 days prior to the date of a recipient's application for Medicaid is submitted.

Section 6 amends s. 409.906(7), (12), (17), (19), and (23) F.S., to remove Medicaid optional coverage of vision, hearing, chiropractic, and podiatry services for adult Medicaid recipients.

Section 7 amend s. 409.908(23), F.S., to provide nursing homes a unit cost increase add-on to the greater of the cost-based rate or their prospective payment rate and remove the nursing home rate freeze.

Section 8 amends s. 409.908(26), F.S., to include the Low Income Pool (LIP) program among the other programs that rely on Intergovernmental Transfers provided to Agency for Health Care Administration (AHCA). Local governments, on behalf of providers participating in the LIP program, will be required to submit a final, executed Letter of Agreement (LOA) to the AHCA no later than October 1, which will outline the amount of funds the local government will submit to the AHCA. The funds pledged in the LOA must be transferred to the AHCA no later than October 31, unless an alternative plan is approved by the AHCA.

Sections 9 through 11 amend ss. 409.911(2), (3), and (10), 409.9113(3), and 409.9119(4), F.S., to require the AHCA to use the three most recent years of audited Disproportionate Share Hospital (DSH) data to determine the number of Medicaid days and charity care days used to calculate DSH payments for each state fiscal year.

Section 12 amends s. 409.968(4), F.S., to provide for technical corrections to statutory cross references in Managed Care Plan Payments due to reducing certain Medicaid optional services for adult Medicaid recipients in s. 409.906, F.S.

Section 13 amends s. 409.975(4), F.S., to remove the requirement for the AHCA to contract with an administrative services organization that represents all Healthy Start Coalitions, and instead

require managed care plans to coordinate and enter into agreements with an administrative services organization that represents all Healthy Start Coalitions.

Section 14 amends s. 430.502(1), F.S., to redesignate the West Florida Regional Medical Center as the Medical Center Clinic in Pensacola.

Section 15 amends s. 624.91(5), F.S., to require the Florida Healthy Kids Corporation to validate and calculate a refund amount for authorized insurers and providers of health care services who achieve a Medical Loss Ratio below 85 percent. These refunds shall be deposited into the General Revenue Fund, unallocated.

Section 16 amends s. 893.055(17), F.S., to prohibit the Attorney General and the Department of Health from using funds received as part of a settlement agreement to administer the Prescription Drug Monitoring Program.

Sections 17 through 20 authorize the AHCA, upon federal approval, to contract with an organization that meets all specified requirements to be a site for the Program of All-Inclusive Care for the Elderly (PACE) and provide comprehensive long-term care services, subject to an appropriation for up to:

- 200 enrollees who reside in Escambia, Okaloosa, and Santa Rosa Counties;
- 100 enrollees who reside in Northwest Miami-Dade County;
- 500 enrollees who reside in Hillsborough, Hernando or Pasco Counties; and
- 300 enrollees who reside in Broward County.

Section 21 authorizes an existing PACE organization to expand services into Alachua and Putnam Counties.

Section 22 provides an effective date of July 1, 2021, except as otherwise expressly provided in the bill.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

With the collection threshold for the Lease Bond Alternative decreasing from $25 million to $10 million, private sector nursing homes may pay less in lease bond alternative fees.

The retroactive eligibility policy that has been in effect since February 1, 2019, will become permanent, meaning that Medicaid providers who provide covered services to newly-eligible, non-pregnant Medicaid recipients aged 21 or older, earlier than the first day of the month in which the recipient applies for Medicaid, will continue to receive no Medicaid reimbursement for those services.

The Fiscal Year 2020-2021 nursing home reimbursement rate increase provided a recurring $74.8 million increase in funding to nursing homes, effective July 1, 2020.[64]

With the reduction of duplicative efforts between Medicaid Managed Care Plans and the MomCare Network, the Agency for Health Care Administration (AHCA) will no longer be required to contract with an administrative services organization representing all Healthy Start Coalitions. Managed Care Plans will be required to coordinate and enter into agreements with an administrative services organization representing all Healthy Start Coalitions to provide risk-appropriate care coordination for pregnant women and infants.

C. Government Sector Impact:

Residents in a State Veterans' Nursing Home whose income is less than $130 per month will continue to not be required to contribute to their personal needs account.

With the collection threshold for the Lease Bond Alternative decreasing from $25 million to $10 million, revenues would decrease due to the new, lower threshold for halting collections. The fund would also keep a lower balance, leading to a decrease in interest earned. As of December 31, 2020, the cash balance of the fund was $10.35 million.[65]

For Fiscal Year 2021-2022, the AHCA estimates:

[64] Chapter 2020-111, Specific Appropriation 212, Laws of Fla.
[65] Email from the AHCA, (January 15, 2021) (on file with the Senate Appropriations Subcommittee on Health and Human Services).

- Removing optional Medicaid coverage for 19 and 20-year olds effective January 1, 2022, the state will save $67.3 million in recurring funding, of which $26.1 million is General Revenue.
- If the waiver authority for retroactive eligibility granted by the federal Centers for Medicare and Medicaid Services is not continued, the Legislature would need to appropriate an additional $131.9 million in recurring funding, of which $51.1 million is general revenue, in order to restore the reduction made in Fiscal Year 2018-2019. [66]
- Removing certain Medicaid optional services for adult Medicaid recipients, such as vision, hearing, chiropractic, and podiatry services, the state will save $21.2 million in recurring funding, of which $8.2 million is General Revenue.

The Legislature appropriated $74.8 million in recurring funding in Fiscal Year 2020-2021 effective July 1, 2020,[67] to provide nursing homes a unit cost increase add-on to the greater of the cost-based rate or their prospective payment rate.

In order for providers to earn matching federal dollars for the Low Income Pool (LIP) Program, local governments and other local subdivisions will be required to provide to the AHCA an executed letter of agreement by October 1 of each fiscal year and the transfer of all funds as pledged in the LIP intergovernmental transfers letter of agreement, no later than October 31 of each fiscal year, unless an alternative plan is approved by the AHCA.

Reducing the duplication of effort between Medicaid Managed Care Plans and the MomCare Network, it is estimated that the state will save $41.2 million in recurring funding, of which $15.9 million is General Revenue.

The contract between the Florida Healthy Kids Corporation (FHKC) and Title XXI provider plans requires providers to meet a minimum Medical Loss Ratio of 85 percent. If a provider's experience comes in below that level, the provider must return the money to the FHKC. Any refunds are transferred to the General Revenue Fund, unallocated.

The Attorney General and the Department of Health cannot use funds received as part of a settlement agreement to administer the Prescription Drug Monitoring Program. This has no fiscal impact since settlement agreement funds are not currently used to support the administration of the program.

The Program of All-Inclusive Care for the Elderly (PACE) may approve more enrollees in the program; however, funding is contingent on legislative appropriation in the General Appropriations Act.

VI. Technical Deficiencies:

None.

[66] Email from the AHCA, (October 15, 2020) (on file with the Senate Appropriations Subcommittee on Health and Human Services).
[67] Chapter 2020-111, Specific Appropriation 212, Laws of Fla.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 296.37, 393.0661, 400.179, 409.903, 409.904, 409.906, 409.908, 409.911, 409.9113, 409.9119, 409.968, 409.975, 430.502, 624.91, and 893.055.

The bill creates undesignated sections of law.

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.