The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

APPROPRIATIONS SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES
Senator Grimsley, Chair
Senator Flores, Vice Chair

MEETING DATE: Wednesday, February 13, 2013
TIME: 3:30 —5:30 p.m.
PLACE: *Pat Thomas Committee Room,* 412 Knott Building

MEMBERS: Senator Grimsley, Chair; Senator Flores, Vice Chair; Senators Bean, Benacquisto, Galvano, Garcia, Gibson, Lee, Montford, Richter, Smith, Sobel, and Thrasher

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1		Presentation on Diagnosis Related Groups (DRGs) Conversion Implementation Plan	Presented
2		Presentation on Resource Utilization Groups (RUGs) Reimbursement Methodology for Long Term Care	Presented
3		Agency Proposed Schedule VIIIB Reductions	Presented
		Other Related Meeting Documents	

Medicaid Hospital Inpatient Methodology:
Transition to a Diagnosis Related Group Methodology

Background:

- Section 409.905(5)(f), Florida Statutes, as amended by House Bill 5301, 2012 session, directed the Florida Medicaid program to convert Medicaid fee-for-service inpatient hospital reimbursement to a prospective payment system (PPS) which categorizes stays using Diagnosis Related Groups (DRGs)
- The Agency was directed to submit a Medicaid DRG plan no later than January 1, 2013 and to implement DRG pricing by July 1, 2013
- AHCA engaged MGT of America, and its subcontractor Navigant Healthcare, for project

Current Hospital Rate Setting Methodology:

- **Cost-Based "Per Diem" Methodology**:
    - Payments are based on hospitals' spending. Rates for hospitals are set on a facility specific basis, based on each facility's reported costs.
    - Hospital rates are all inclusive, "per diem" rates, based on reported costs for services provided by the hospital to Medicaid recipients on a fee-for-service basis.
    - There is no portion of the per diem calculated specifically for graduate medical education. However, to the extent that teaching hospitals have higher costs incurred through their physician education programs, the cost-based per diems are higher for teaching hospitals.

Diagnosis Related Group (DRG) Methodology

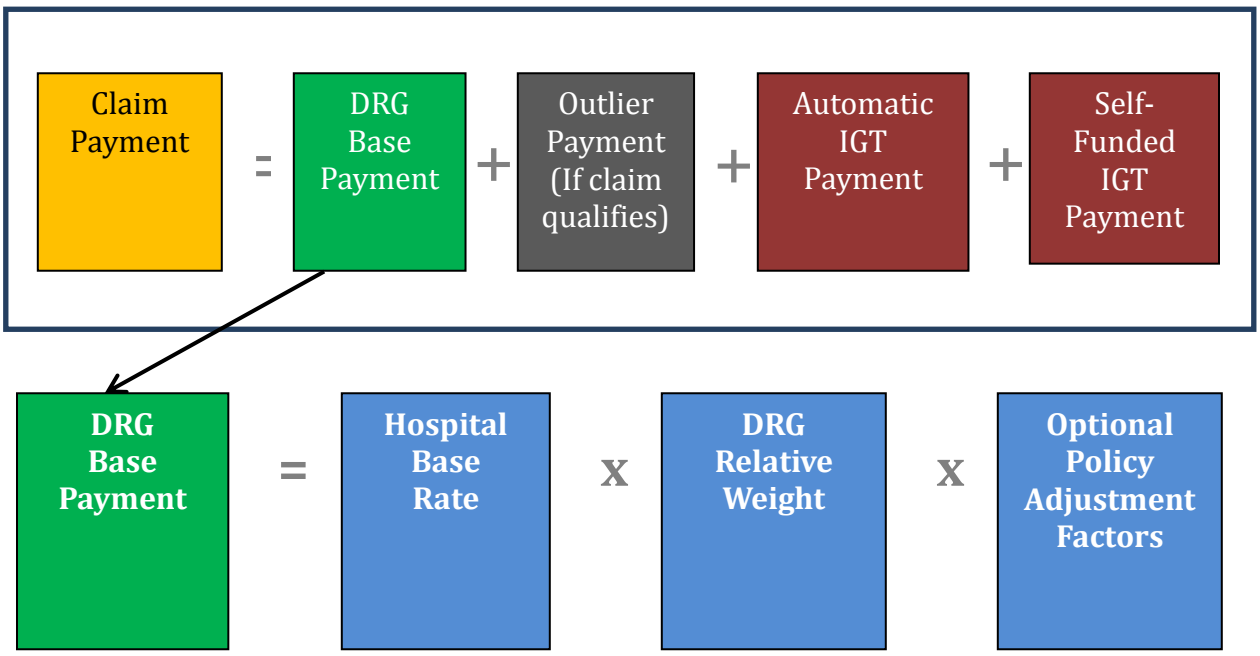
- **Diagnosis Based "Per Stay" Methodology**:
    - Payments are based on patients' needs. Higher payments are made for sicker patients.
    - Each discharge is assigned a DRG code based on information routinely submitted on medical claims (diagnosis codes, procedure codes, age, gender, and birth weight)
    - DRGs categorize patients with similar clinical characteristics and requiring similar hospital resource intensity
    - Each DRG has a relative weight factor, which recognizes the differences in resource requirements for patients assigned to the DRG
    - The DRG relative weight and a hospital base rate are the primary components in calculating DRG payment, which is per discharge

Medicaid Hospital Inpatient Methodology:
Transition to a Diagnosis Related Group Methodology

- Payment is generally a fixed amount based on the DRG assignment, thus rewarding hospitals that reduce cost
- Payment is generally determined by multiplying a hospital's "base rate" by the assigned DRG's relative weight factor
- An "outlier" payment provision is typically incorporated to provide additional payments where the base DRG amount is not appropriate – generally cases with extraordinarily high costs
- Payment models are also sometimes modified to affect payment for specialty services or providers to ensure fair reimbursement and access to care for Medicaid recipients. AHCA is recommending similar adjustments and they are referred to as "policy adjustors".

- **Impact of Change in Payment Methodology**
  - The move from a cost-based payment method (current method) to an acuity-based payment method has a tendency to increase reimbursement for hospitals that have relatively low costs and decrease reimbursement for hospitals with relatively high costs.
  - Hospitals with relatively high costs can mitigate the projected changes in reimbursement level by reducing their costs. For example, a reduction in average length stay, which would reduce a hospital's revenue under the current payment method, will increase its pay-to-cost ratio under the new DRG payment method.

Building Blocks of Final DRG Payment:



Medicaid Hospital Inpatient Methodology:
Transition to a Diagnosis Related Group Methodology

Key DRG Design Considerations:

Key Design Considerations	*Decision*
Affected providers	All inpatient acute care providers except the four state-owned psychiatric facilities
Affected services	All services at these providers (including psychiatric and rehabilitation), excluding only: Transplants currently paid via global fee – will continue reimbursement via global fee AND Technical component of newborn hearing test will be paid in addition to DRG payment
DRG Grouper	APR- DRGs - version 30, released 10/1/2012
DRG Relative Weights	National weights re-centered to 1.0 for Florida Medicaid; Re-centering factor is 0.7614 which is the casemix of the 2010/2011 simulation dataset; For each DRG, the Florida Medicaid relative weight equals [national relative weight / 0.7614]
Hospital Base Rates	One standardized amount; No wage area adjustment; Base rates used to distribute funds from General Revenue and Public Medical Assistance Trust Fund
Per-Claim Add-On Payments	Used to distribute the IGT funds paid on a per-claim basis today; Two add-ons per claim, one for automatic IGTs and another for self-funded IGTs
Targeted Service Adjustors	Service adjustor for rehabilitation services
Targeted Provider Adjustors	Rural hospitals, Free-standing long term acute care (LTAC) hospitals, and High Medicaid utilization and high outlier hospitals (more than 50% Medicaid utilization – FFS and MC, and more than 30% payments in the form of outliers)
Outlier Payment Policy	Adopt “Medicare-like” stop-loss model with a single threshold; Apply to cases with unpredictably high hospital cost
Transition Period	None
Total Payment Adjustment for Casemix Difference between Simulation Data and First Year of Implementation	7.50%

Impact on Funding for Graduate Medical Education

- No specific provider adjustment was made for statutory teaching hospitals or other facilities that provide graduate medical education / have residency slots. The statutory teaching hospitals are estimated to receive a pay-to-cost ratio of 89%, which is one percentage point above the statewide average, is four percentage points below the statewide average for hospitals who receive IGT payments, and is 9% below what they are predicted to receive under the current per diem payment method.
- S.408.07(45), F.S. defines a statutory teaching hospital as: “any Florida hospital officially affiliated with an accredited Florida medical school which exhibits activity in the area of

graduate medical education as reflected by at least seven different graduate medical education programs accredited by the Accreditation Council for Graduate Medical Education or the Council on Postdoctoral Training of the American Osteopathic Association and the presence of 100 or more full-time equivalent resident physicians."

- If an adjustor for GME is added, the result would be a reduction in the DRG base rate, thus reducing payment for all hospitals who are not impacted by the specific adjustor.

Statewide Medicaid Residency Program

Background:

- **Current Medicaid Funding for GME in Florida**

    - Florida's Medicaid program currently funds graduate medical education (GME) through hospital inpatient reimbursements and the Disproportionate Share Hospital (DSH) program. Funding outside of the DSH program is not tied to specific numbers of residency positions. DSH funding for GME is limited to statutory teaching hospitals.

    - Funding previously appropriated to the Community Hospital Education Program (CHEP) at the Department of Health (DOH) is now in the Medicaid hospital inpatient line item at the Agency for Health Care Administration (AHCA).

- **Status of GME in Florida**

    - Florida's supply of physicians is and will continue to be greatly determined by the capacity of GME or residency slots available since "location of the physician's residency program is a better predictor of where the physician will practice than the location of his or her medical school.

    - Florida's existing residency programs perform well compared to the national average when it comes to retaining physicians in-state.

    - Where Florida has room for improvement is in the number and distribution of residency slots. The state ranks 42nd in the number of residency positions per 100,000 citizens.

Florida Families First Budget

- **Program Characteristics and Funding**

    - The Florida Families First Budget creates the Statewide Medicaid Residency Program to improve access to and quality of care for Medicaid beneficiaries, expand graduate medical education on an equitable basis, and increase the supply of highly-trained physicians statewide. The program will be open to all hospitals licensed under part I of chapter 395, Florida Statutes, with ACGME accredited programs.

    - The new program is funded with $52 million transferred out of the hospital inpatient line item. This $52 million is supplemented with an additional $28 million in new funding. This proposed funding includes federal matching funds under Medicaid. The total appropriation comes to approximately $80 million in recurring funds.

- **Transparency and a Level Playing Field**

    - Under the new program, funding for GME will be kept separate from hospital inpatient reimbursements and “follow the resident.”

    - Funding will be calculated on a "per resident" basis, and adjusted to reflect Medicaid services.

    - The Governor's proposal for Medicaid GME caps the level of funding to the amount appropriated in the GAA. This means hospitals will compete on a level playing field for a finite level of funding.

Medicaid Nursing Home Reimbursement: Transition to Resource Utilization Groups (RUGs)

Background:

- **Prospective Payment**

    - Implementing an RUG reimbursement system for nursing homes is akin to implementing a DRG reimbursement system for hospitals. Like hospitals, nursing homes are currently paid under a cost-based reimbursement system in Florida's Medicaid program.

    - Under DRGs and RUGs, patients' needs determine rates, not providers' spending. When rates are based on patients' needs and prospective, then efficient delivery of quality care is incentivized across all patients.

    - The federal Balanced Budget Act of 1997 expanded the use of prospective payment in Medicare, including the use of RUGs for nursing homes. The RUGs system was fully implemented in 1998.

    - Currently, over 30 states have a case mix system for nursing homes in their Medicaid programs. Most of these are based on the RUG models. The RUG model is the only prospective payment system based on case mix used in more than one state.

- **Long-Term Managed Care Statewide Medicaid Managed Care**

    - Under LTC Medicaid Managed Care, nursing homes will still be reimbursed at rates set by the Agency for Health Care Administration (AHCA), pursuant to Florida Statutes.

Florida Families First Budget:

- **Proviso**
    - The Florida Families First budget includes proviso directing AHCA to develop a plan to transition to an acuity-based prospective payment system for Medicaid nursing home reimbursement. This direction is similar to what was provided to the agency last year regarding the implementation of DRGs for hospital inpatient rates.

NAME OF HOSPITAL	NUMBER OF RESIDENTS	TOTAL MEDICAID REVENUE	TOTAL ALLOCATION FRACTION
Hospital A	1000	$500,000,000	33%
Hospital B	500	$1,000,000,000	29%
Hospital C	500	$1,500,000,000	38%
Total:	2000	$3,000,000,000	100%

NAME OF HOSPITAL	NUMBER OF RESIDENTS	TOTAL MEDICAID REVENUE	TOTAL ALLOCATION FRACTION
Hospital A	500	$500,000,000	17%
Hospital B	1000	$1,000,000,000	33%
Hospital C	1500	$1,500,000,000	50%
Total:	3000	$3,000,000,000	100%

NAME OF HOSPITAL	NUMBER OF RESIDENTS	TOTAL MEDICAID REVENUE	TOTAL ALLOCATION FRACTION
Hospital A	500	$1,500,000,000	27%
Hospital B	1000	$1,000,000,000	29%
Hospital C	1500	$1,500,000,000	44%
Total:	3000	$4,000,000,000	100%

$$THAF = [0.5 \times (HFTE/TFTE) \times (HMP/HFTE) / (TMP/TFTE)] + [0.5 \times (HFTE/TFTE)]$$

THAF = A hospital's total allocation fraction.
HFTE = A hospital's total number of full-time equivalent residents.
TFTE = The sum of all participating hospitals' full-time equivalent residents.
HMP = A hospital's total Medicaid payments.
TMP = The sum of all participating hospitals' total Medicaid payments.

Senate Appropriations Subcommittee on Health and Human Services

FY 2013-14 Proposed Budget Reductions

	ISSUE TITLE	PROPOSED BUDGET REDUCTION FTE	GR	TF	TOTAL	EXPLANATION OF ISSUE	IMPACT OF REDUCTION
1	**AGENCY FOR HEALTH CARE ADMINISTRATION**						
2	**IN GOVERNOR'S RECS**						
3	ADMINISTRATIVE REDUCTION IN OTHER PERSONAL SERVICES CATEGORY			(1,211,650)	(1,211,650)	This issue recommends a reduction to the appropriation in the Other Personal Services category in the Executive Direction/Support Services and Health Care Regulation budget entities.	This recommended reduction would not have an impact on services.
4	ELIMINATION OF THE SUBSCRIBER ASSISTANCE PANEL	(2.00)		(192,319)	(192,319)	This issue recommends the elimination of the Subscriber Assistance Panel (SAP) authorized under s. 408.7056, F.S. The elimination of the SAP would include the reduction of 2 FTE positions.	The President's Health Care Law now allows health maintenance organizations to use IROs to resolve subscribers grievances against providers; therefore, the elimination of the SAP would not impact regulatory efforts because the function would be performed using IROs instead of the SAP. To implement this reduction, a statutory change would be required.
5	VENDOR MANAGEMENT INITIATIVE SAVINGS		(70,574)	(129,554)	(200,128)	This issue recommends a reduction in the Contracted Services category due to the Agency's ability to renegotiate certain contracts.	This recommended reduction would not have an impact on services.
6	REAL ESTATE INITIATIVE SAVINGS		(7,071)	(7,071)	(14,142)	This issue recommends a reduction as a result of renegotiating private leases for office space held by the agency.	This recommended reduction would not have an impact on services.
7	REDUCTIONS FROM TECHNOLOGY SERVICE CONSOLIDATIONS			(72,328)	(72,328)	This issue recommends the realignment of budget based upon projected billings from the Northwood Shared Resource Center.	This recommended reduction would not have an impact on services.
8	DELETE UNFUNDED BUDGET			(230,434,150)	(230,434,150)	This issue recommends the deletion of unfunded budget authority in the Medicaid Waiver programs due to general revenue funds being transferred from DCF and DOEA.	This recommended reduction would not have an impact on services. The Agency will no longer need this budget authority to process claim payments associated with the various waiver programs due to transferring the General Revenue to the Agency.
9	ELIMINATION OF THE CHIROPRACTIC PROGRAM		(312,814)	(445,357)	(758,171)	This issue recommends the elimination of the Chiropractic Program as a covered Medicaid benefit for adults, effective October 1, 2013. Chiropractic services is an optional Medicaid service.	Approximately 8,779 adult beneficiaries would be eligible to use this optional service in Fiscal Year 2013-2014. These adult beneficiaries would be able to receive services from their primary care physician. To implement this reduction, a statutory change would be required. Medicaid recipients are still able to see a general practitioner to receive care and treatment for services that may have been rendered by these specialists. With the upcoming implementation of Statewide Medicaid Managed Care, recipients enrolled in managed care will be able to choose among plans that offer expanded benefits. Chiropractic services may be offered as expanded benefits if the plans choose to include services for potential enrollees.
10	REDUCE CLINIC SERVICES REIMBURSEMENT RATES		(3,729,312)	(5,347,187)	(9,076,499)	This issue recommends a 5 percent adjustment to the reimbursement rates for Clinic Services and includes the impact to the prepaid health plans.	This recommended change would not have an impact on services or the number of beneficiaries eligible to receive services , but would adjust the reimbursement rates to providers.

Senate Appropriations Subcommittee on Health and Human Services

FY 2013-14 Proposed Budget Reductions

	ISSUE TITLE	PROPOSED BUDGET REDUCTION FTE	GR	TF	TOTAL	EXPLANATION OF ISSUE	IMPACT OF REDUCTION
11	ELIMINATE PODIATRIST PROGRAM		(1,111,153)	(1,581,960)	(2,693,113)	This issue recommends the elimination of the Podiatrist Program as a covered Medicaid benefit for adults, effective October 1, 2013. Podiatric services is an optional Medicaid services.	Approximately 25,584 adult beneficiaries would be eligible to use this optional service in Fiscal Year 2013-2014. These adult beneficiaries would be able to receive services from their primary care physician. To implement this reduction, a statutory change would be required. Medicaid recipients are still able to see a general practitioner to receive care and treatment for services that may have been rendered by these specialists. With the upcoming implementation of Statewide Medicaid Managed Care, recipients enrolled in managed care will be able to choose among plans that offer expanded benefits. Podiatric services may be offered as expanded benefits if the plans choose to include services for potential enrollees.
12	HOSPITAL INPATIENT RATE REDUCTION		(23,038,080)	(58,747,837)	(81,785,917)	This issue recommends a 2 percent adjustment to the reimbursement rates for Hospital Inpatient Services and includes the impact to the prepaid health plans.	This recommended change would not have an impact on services or the number of beneficiaries eligible to receive services, but would adjust the reimbursement rates to providers. Children's and rural hospitals are exempted from this adjustment. For the hospitals impacted, Medicaid represents an average of 10 percent of their revenue.
13	**NOT IN GOVERNOR'S RECS**						
14	REDUCTION IN CONTRACTED SERVICES CATEGORY		(278,404)	(278,405)	(556,809)	This issue recommends a reduction in the Contracted Services category due to the Agency's ability to renegotiate certain contracts.	This reduction is included in the Vendor Management adjustment.
15	REDUCE FLORIDA HEALTHY KIDS THIRD PARTY ADMINISTRATOR CONTRACT		(1,014,202)	(1,884,912)	(2,899,114)	This issue proposes to reduce the contracted services category in the Children's Special Health Care budget entity as a result of the Florida Healthy Kids Corporation's ability to negotiate lower rates for the new Third Party Administrator (TPA) contract, effective August 1, 2013.	This reduction is included in the Kidcare realignment issue. Therefore, if this reduction is taken, the FHKC program would be underfunded based upon the estimates from the Social Services Estimating Conference for the Florida KidCare Program.
16	OCCUPATIONAL THERAPY SERVICES RATE REDUCTION		(260,433)	(368,958)	(629,391)	This issue proposes a two percent adjustment to provider reimbursement rates for Occupational Therapy services, effective August 1, 2013.	Approximately 959,055 beneficiaries would be eligible to utilize this service in Fiscal Year 2013-2014.
17	RESPIRATORY THERAPY SERVICES RATE REDUCTION		(145,320)	(205,910)	(351,230)	This issue proposes a two percent adjustment to provider reimbursement rates for Respiratory Therapy services, effective August 1, 2013.	Approximately 959,055 beneficiaries would be eligible to utilize this service in Fiscal Year 2013-2014.
18	SPEECH THERAPY SERVICES RATE REDUCTION		(398,363)	(564,384)	(962,747)	This issue proposes a two percent adjustment to provider reimbursement rates for Speech Therapy services, effective August 1, 2013.	Approximately 959,055 beneficiaries would be eligible to utilize this service in Fiscal Year 2013-2014.
19	LIMIT ELIGIBILITY FOR MEDICALLY NEEDY TO 138 PERCENT OF THE FEDERAL POVERTY LEVEL		(45,357,256)	(74,167,129)	(119,524,385)	This issue proposes to eliminate coverage for those participants in the Medically Needy eligibility group currently above 138 percent of the federal poverty level, effective January 1, 2014.	Approximately 10,417 beneficiaries would be impacted. Impacted beneficiaries would be eligible to receive coverage through the health exchange.
20	LIMIT ELIGIBILITY FOR PREGNANT WOMEN TO 150 PERCENT OF THE FEDERAL POVERTY LEVEL		(14,419,549)	(21,029,579)	(35,449,128)	This issue proposes to eliminate coverage for those participants in the Pregnant Women greater than 100 percent of the federal poverty level eligibility category currently above 150 percent of the federal poverty level, effective January 1, 2014.	Approximately 7,389 beneficiaries would be impacted. Impacted beneficiaries would be eligible to receive coverage through the health exchange.

	ISSUE TITLE	PROPOSED BUDGET REDUCTION FTE	GR	TF	TOTAL	EXPLANATION OF ISSUE	IMPACT OF REDUCTION
21	NURSING HOME RATE REDUCTION		(113,491,076)	(160,774,452)	(274,265,528)	This issue proposes an adjustment in the reimbursement rates for nursing home services by 8.8 percent. This reduction includes the impact to the reimbursement rates for hospice services.	This recommended change would not have an impact on services or the number of beneficiaries eligible to receive services , but would adjust the reimbursement rates to providers.
22	HOSPITAL OUTPATIENT RATE REDUCTION		(34,943,258)	(84,511,213)	(119,454,471)	This issue proposes an adjustment in the reimbursement rates for hospital outpatient services by 8.8 percent. This reduction includes the impact to the reimbursement rates for prepaid health plans.	This recommended change would not have an impact on services or the number of beneficiaries eligible to receive services , but would adjust the reimbursement rates to providers.
23	INTERMEDIATE CARE FACILITY FOR THE DEVELOPMENTALLY DISABLED (ICF-DD) RATE REDUCTION		(7,044,371)	(9,979,242)	(17,023,613)	This issue proposes an adjustment in the reimbursement rates for ICF/DD services by 8.8 percent.	This recommended change would not have an impact on services or the number of beneficiaries eligible to receive services , but would adjust the reimbursement rates to providers.
24	**TOTAL - AGENCY FOR HEALTH CARE ADMINISTRATION**	**(2.00)**	**(245,621,236)**	**(651,933,597)**	**(897,554,833)**		
25	**AGENCY FOR PERSONS WITH DISABILITIES**						
26	**IN GOVERNOR'S RECS**						
27	PROHIBIT BILLING FOR BEHAVIOR ASSISTANT SERVICES RENDERED TO RESIDENTIAL HABILITATION CLIENTS		(2,750,373)	(3,904,292)	(6,654,665)	Behavior assistance is a service that is used primarily to help train caregivers on the behavior program and procedures that have been developed to address inappropriate behaviors and to teach alternative appropriate behaviors. The service is not typically intended for individuals who are living in group home settings in which the group home staff are trained to follow behavior programs. If behavior assistance services are needed in a group home setting it should be for a short term basis to address an acute situation.	The agency will review each of these situations to ensure duplicative services are not provided and to reduce or terminate behavior services in settings that are not appropriate for that service.
28	COMPREHENSIVE TRANSITIONAL EDUCATION PROGRAM MARKET		(482,207)	(684,517)	(1,166,724)	Comprehensive Transitional Education Program (CTEP) is an all inclusive intensive behavior residential program. Services provided include a sequential series of educational care, training, treatment, habilitation, and rehabilitation services to persons who have developmental disabilities and who have severe or moderate maladaptive behaviors.	This reduction equates to a 4.7% rate cut for CTEP providers. It also reduces the average cost plan for these individuals to approximately $150,000. Currently there is only one provider operating in the state that meets all of the statutory requirements to operate this program. The Governor's Recommendations includes a Conforming Bill which removes some of the licensure requirements in s. 393.18 (5), F.S., with the intent to open this program to additional providers, enhance choice, and encourage competition.
29	REDUCTIONS FROM TECHNOLOGY SERVICE CONSOLIDATIONS		(23,589)	(38,773)	(62,362)	Southwood Shared Resource Center.	Realign services within the data centers.
30	ROOM AND BOARD CATEGORY - GENERAL REVENUE REDUCTIONS		(651,127)		(651,127)	Provides for basic group/foster home payments for long-term residential care (LTRC) services. This does not include supplemental services such as training or homemaker services. These funds must be solely used for direct services. General administrative costs and support costs related to other special categories are not allowable from this category.	This intent of this reduction is to reduce recurring surplus funds.
31	**NOT IN GOVERNOR'S RECS**						

	ISSUE TITLE	PROPOSED BUDGET REDUCTION FTE	GR	TF	TOTAL	EXPLANATION OF ISSUE	IMPACT OF REDUCTION
32	HOME AND COMMUNITY BASED SERVICES WAIVER REDUCTIONS		(23,156,538)		(23,156,538)	Provides Medicaid eligible persons in the Developmental Disabilities Home and Community Based Services (HCBS) Waiver with an array of community supports and services.	A reduction in this category could impact the agency's ability to provide needed waiver services and potentially create a deficit in the waiver.
33	INDIVIDUAL AND FAMILY SUPPORTS CATEGORY REDUCTION			(732,791)	(732,791)	Funding from this category is used for individuals who are eligible for services from APD but may not be eligible for waiver services. Services provided are designed to support families and individuals and include services such as: supported living coaching, day training, therapy, supported employment, community inclusion, residential habilitation, transportation, respite care, medical services, behavior analysis services, parent education and training, diagnostic testing, adaptive equipment, environmental modifications to residences, and temporary employment services. Typically only temporary, short-term or one-time services are provided to clients who are not enrolled in a Home and Community-Based Services Waiver; however, some ongoing services are provided to individuals on the waiting list for the Home and Community Based Services Waiver to avoid crisis situations.	A reduction in this category could impact the agency's ability to provide needed services to individuals who are on the Home and Community Based Services Waiver waiting list or who are eligible for APD services but may not be eligible for the waiver.
34	REDUCTION IN ADMINISTRATION			(124,905)	(124,905)	This reduces the Federal Grants Trust Fund.	The only grant that the agency had was the Medicaid Infrastructure Grant. This grant ended on December 31, 2012. A one year extension was approved to spend the remaining funds on the grant but this amount will not exceed the trust fund if it is reduced. There is no impact to the agency for this reduction.
35	**TOTAL - AGENCY FOR PERSONS WITH DISABILITIES**		**(27,063,834)**	**(5,485,278)**	**(32,549,112)**		
36	**DEPARTMENT OF ELDER AFFAIRS**						
37	**IN GOVERNOR'S RECS:**						
38	HEADQUARTER EXPENSES			(29,396)	(29,396)	This issue proposes to reduce the expenses budget category in the Executive Direction and Support Services budget entity by $29,396 in the Federal Grants Trust Fund.	This category is used to pay for travel, office supplies, leases, phones and utilities. This reduction proposal would reduce general expenses in the Executive Direction and Support Services budget entity by limiting travel and office supply expenditures by $29,396 in order to meet the 10% reduction exercise.
39	VENDOR MANAGEMENT INITIATIVE SAVINGS			(4,182)	(4,182)	This issue was a direct result of the Department's efforts to renegotiate the fingerprint contract which resulted in $4,182 of annual savings. The savings will reduce the amount in the contracted services category.	The impact will yield savings to the Department.
40	REAL ESTATE INITIATIVE SAVINGS		(97,206)		(97,206)	This issue was a direct result of the Department's efforts to renegotiate its leases which resulted in $97,206 of annual savings. The savings will reduce the amount in the expense budget category.	The impact will yield savings to the Department.

Senate Appropriations Subcommittee on Health and Human Services

FY 2013-14 Proposed Budget Reductions

	ISSUE TITLE	PROPOSED BUDGET REDUCTION FTE	GR	TF	TOTAL	EXPLANATION OF ISSUE	IMPACT OF REDUCTION
41	ELIMINATE DOUBLE BUDGET FOR WAIVERS - TRANSFERRED TO AGENCY FOR HEALTH CARE ADMINISTRATION (AHCA)			(298,541,412)	(298,541,412)	To ensure a smooth transition into the Statewide Medicaid Management Program, the appropriation for Nursing Home Diversion, Aged & Disabled Adult, Channeling, and Assisted Living waivers were transferred to AHCA. This appropriation is actually a double budget since AHCA has always paid the providers directly.	The Department will no longer pay the state match portion of the Medicaid waivers to AHCA since the related federal budget authority and state match is transferring to AHCA. This transfer will not create any impact to the Department since the fiscal and programmatic monitoring of the services will continue with DOEA.
42	AGED AND DISABLED ADULT MEDICAID WAIVER		(2,527,434)	(3,501,750)	(6,029,184)	This issue proposes to cap participation in the Aged and Disabled Adult Medicaid Waiver to 9,100 program slots for the entire fiscal year of 2013-2014 that will generate a reduction of $2,527,434 in General Revenue.	This Medicaid program provides alternative, less restrictive long-term care options for elders who quality for skilled nursing home cares. Services include adult day health care, attendant care, case aide, case management, chore, companionship, consumable medical supplies, counseling, emergency alert response, environmental modifications, escort, family training and support, financial assessment, home-delivered meals, homemaker, personal care, pest control, rehabilitative engineering evaluation, respite, risk reduction, skilled nursing, specialized medical equipment and supplies, and therapies. The average care plan cost for this program is $11,057 per year. Capping this program at 9,100 slots for an entire year would impact approximately 545 seniors. Based on client frailty in this program it is estimated that 41% of the impacted Aged and Disabled Adult Medicaid Waiver clients (224 clients) could end up in nursing home care at a total annual cost of $13,701,908 of which $5,743,840 would be General Revenue.

Senate Appropriations Subcommittee on Health and Human Services

FY 2013-14 Proposed Budget Reductions

	ISSUE TITLE	PROPOSED BUDGET REDUCTION				EXPLANATION OF ISSUE	IMPACT OF REDUCTION
		FTE	GR	TF	TOTAL		
43	ALZHEIMER'S DISEASE INITIATIVE		(526,541)		(526,541)	This issue proposes to cap participation in the Alzheimer's Disease Initiative program to 800 program slots for the entire fiscal year of 2013-2014 that will generate a reduction of $526,541 in General Revenue.	Many Alzheimer's victims require care 24 hours a day, especially in the late stages of the disease. ADI respite includes in-home, facility-based (usually at adult day care centers), emergency and extended care (up to 30 days) respite for caregivers who serve victims of memory disorders. On average, fewer than three hours of respite care per week is provided per person. In addition to respite care services, caregivers and consumers may receive supportive services essential to maintaining persons with Alzheimer's disease or related dementia in their own homes. The supportive services may include caregiver training and support groups, counseling, consumable medical supplies and nutritional supplements. The average care plan cost of this program is $7,352 per year. Capping this program at 800 slots for an entire year would impact approximately 72 seniors. Based on client frailty in this program it is estimated that 51% of the impacted ADI clients (37 clients) could end up in nursing home care at a total annual cost of $2,263,262 of which $948,759 would be General Revenue.
44	ASSISTED LIVING FOR FRAIL ELDERS MEDICAID WAIVER		(903,035)	(1,251,152)	(2,154,187)	This issue proposes capping participation in the Assisted Living for the Frail Elders Waiver program to 3,400 slots for the entire fiscal year 2013-2014 that will generate a reduction of $903,035 in General Revenue.	This Medicaid program provides alternative, less restrictive long-term care options for elders who quality for skilled nursing home cares. Appropriate services are made available based on the recipient's level of need. The program includes three broad services: assisted living, case management and incontinence supplies. The components of these services include: attendant call system, attendant care, behavior management, case management, chore services, companion services, homemaker, incontinence supplies, intermittent nursing, medication management, occupational therapy, personal care, physical therapy, specialized medical equipment and supplies, speech therapy, and therapeutic social and recreational services. The average care plan cost for this program is $10,324 per year Capping this program at 3,400 slots for an entire year would impact approximately 209 seniors. Based on client frailty in this program it is estimated that 61% of the impacted Assisted Living Medicaid Waiver clients (127 clients) could end up in nursing home care at a total annual cost of $7,768,492 of which $3,256,552 would be General Revenue.

Senate Appropriations Subcommittee on Health and Human Services

FY 2013-14 Proposed Budget Reductions

	ISSUE TITLE	PROPOSED BUDGET REDUCTION FTE	GR	TF	TOTAL	EXPLANATION OF ISSUE	IMPACT OF REDUCTION
45	COMMUNITY CARE FOR THE ELDERLY		(686,152)		(686,152)	This issue proposes to cap participation in the Community Care for the Elderly program to 6,600 program slots for the entire fiscal year 2013-2014 that will generate a reduction of $686,152 in General Revenue	The Community Care for the Elderly (CCE) Program provides community-based services organized in a continuum of care to help functionally impaired older people live in the least restrictive yet most cost-effective environment suitable to their needs. Services in this program include: adult day care, adult day health care, case management, case aide, chore, companionship, consumable medical supplies, counseling, escort, emergency alert response, emergency home repair, home-delivered meals, home health aide, homemaker, home nursing, information and referral, legal assistance, material aid, medical therapeutic services, personal care, respite, shopping assistance, transportation, and other community-based services. The average care plan cost for this program is $6,181 per year The capping of this program at 6,600 slots would impact approximately 111 seniors. Based on client frailty in this program it is estimated that 36% of the impacted CCE clients (40 clients) could end up in nursing home care at a total annual cost of $2,446,769 of which $1,025,686 would be General Revenue.
46	HOME CARE FOR THE ELDERLY		(651,766)		(651,766)	This issue proposes to cap participation in the Home Care for the Elderly Program for fiscal year 2013-2014 to 1,800 program slots that will generate a reduction of $651,766 in General Revenue.	The Home Care for the Elderly (HCE) program encourages the provision of care for elders age 60 and older in family-type living arrangements in private homes as an alternative to institutional or nursing home care. Individuals must be 60 or older, have income less than the Institutional Care Program (ICP) standard, meet the ICP asset limitation, be at risk of nursing home placement, and have an approved adult caregiver living with them who is willing and able to provide or assist in arranging for care. A basic subsidy is provided each month to the adult caregiver for support and maintenance of the elder, including some medical costs. A special subsidy may also be provided for services/supplies. The average care plan cost for this program is $4,029 per year The capping of this program to 1,800 slots would impact approximately 162 seniors. Based on client frailty in this program it is estimated that 35% of the impacted HCE clients (57 clients) could end up in nursing home care at a total annual cost of $3,486,646 of which $1,461,602 would be General Revenue.

Senate Appropriations Subcommittee on Health and Human Services

FY 2013-14 Proposed Budget Reductions

	ISSUE TITLE	PROPOSED BUDGET REDUCTION FTE	GR	TF	TOTAL	EXPLANATION OF ISSUE	IMPACT OF REDUCTION
47	CAPITATED NURSING HOME DIVERSION WAIVER		(10,370,810)	(14,368,718)	(24,739,528)	This issue proposes to cap participation in the Capitated Nursing Home Diversion Waiver at 19,600 program slots for the entire fiscal year of 2013-2014 which will generate a reduction of $10,370,810 in General Revenue.	The Long-Term Care Community Diversion Pilot Project (diversion program) is designed to target the frailest individuals who would otherwise qualify for Medicaid nursing home placement, instead offering them community based alternatives. The project uses a managed care delivery system to provide comprehensive acute and long-term care services to individuals who are dually eligible for Medicare and Medicaid. Specifically, clients choose to receive care in a managed care delivery setting intended to increase the coordination of their care between service providers and Medicare. The state, through a monthly capitated rate, pays for Medicare co-insurance and deductibles and other medical services not covered by Medicare. The rate also covers all home and community based services and nursing home care. Contractors are at risk for in-home and nursing home services and may choose to use assisted living facilities at a lower-cost option to nursing home care when appropriate as an alternative to nursing home care. By receiving integrated acute and long-term services, such as home-delivered meals, coordination of health services and intensive case management, clients are better able to remain in the community. The average capitated rate in this program is $17,056 per year. Capping the number of program slots at 19,600 for an entire year would impact approximately 1,450 seniors. Based on client frailty in this program it is estimated that 66% of the impacted Capitated Nursing Home Diversion Waiver clients (950 clients) could end up in nursing home care at a total annual cost of $58,110,770 of which $24,360,035 would be General Revenue.
48	**TOTAL - DEPARTMENT OF ELDER AFFAIRS**		**(15,762,944)**	**(317,696,610)**	**(333,459,554)**		

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/13/13
Meeting Date

Topic DRG

Bill Number _____ *(if applicable)*

Name Justin Senior

Amendment Barcode _____ *(if applicable)*

Job Title Deputy Secretary for Medicaid (AHCA)

Address 2727 Mahan Dr
Street

Phone 412-3600

Tallahassee FL 32308
City *State* *Zip*

E-mail justin.senior@ahca.myflorida.com

Speaking: ☐ For ☐ Against ☐ Information

Representing AHCA

Appearing at request of Chair: ☒ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

_____
Meeting Date

Topic Malcolm Ferguson

Bill Number _____ *(if applicable)*

Name Margaret Malcolm Ferguson

Amendment Barcode _____ *(if applicable)*

Job Title Associate Director

Address _____ Phone _____
Street

_____ E-mail _____
City *State* *Zip*

Speaking: ☐ For ☐ Against ☒ Information

Representing Navigant

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

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S-001 (10/20/11)

Tab 2

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/13/2013
Meeting Date

Topic GME and Nursing Home RUG Proposals — Bill Number _____ *(if applicable)*

Name Karen Zeiler — Amendment Barcode _____ *(if applicable)*

Job Title Deputy Chief of Staff

Address The Capitol *Street* — Phone _____

Tallahassee *City* — Florida *State* — 32399-0[illegible] *Zip* — E-mail _____

Speaking: ☐ For ☐ Against ☑ Information

Representing Executive Office of the Governor

Appearing at request of Chair: ☑ Yes ☐ No — Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

Meeting Date

Topic Agency Reductions

Bill Number *(if applicable)*

Name Tonya Kidd

Amendment Barcode *(if applicable)*

Job Title Deputy Secretary of Operations

Address 2727 Mahan *Street*

Phone 412-3602

Tall *City* FL *State* 32308 *Zip*

E-mail Tonya.Kidd@ahca.myflorida.com

Speaking: ☐ For ☐ Against ☑ Information

Representing Agency for Health Care

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/13/13.
Meeting Date

Topic Agency Proposed Schedule VIIIB Reductions.

Bill Number _____ *(if applicable)*

Name Sharon Bradford

Amendment Barcode _____ *(if applicable)*

Job Title Deputy Director of Budget and Planning.

Address 4030 Esplanade Way, Suite 380.
Street
Tallahassee FL 32399.
City *State* *Zip*

Phone (850) 414-6058.

E-mail sharon_bradford@apd.state.fl.us

Speaking: ☐ For ☐ Against ☑ Information

Representing Agency for Persons with Disabilities.

Appearing at request of Chair: ☑ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/13/13
Meeting Date

Topic Agency Reductions

Name Jon Manalo

Job Title DOEA Chief Financial Officer

Address _____
Street

_____
City *State* *Zip*

Bill Number _____ *(if applicable)*

Amendment Barcode _____ *(if applicable)*

Phone 414-2077

E-mail _____

Speaking: ☑ For ☐ Against ☐ Information

Representing Elder Affairs

Appearing at request of Chair: ☑ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/13/13
Meeting Date

Topic NH RUGS

Bill Number _____ *(if applicable)*

Name TONY MARSHALL

Amendment Barcode _____ *(if applicable)*

Job Title SR. DIRECTOR OF REIMBURSEMENT

Address 307 W. PARK AVE.
Street

Phone 850 224 3901

TALLAHASSEE FL 32301
City *State* *Zip*

E-mail tmarshall@fhca.org

Speaking: ☐ For ☐ Against ☒ Information

Representing FLORIDA HEALTH CARE ASSOCIATION

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

02/13/13
Meeting Date

Topic Medicaid DRG

Bill Number _____ *(if applicable)*

Name Michael Garner

Amendment Barcode _____ *(if applicable)*

Job Title Pres & CEO

Address 200 W. College Ave Suite 104
Street

Phone (850) 386-2964

Tallahassee FL 32301
City *State* *Zip*

E-mail michael@fahp.net

Speaking: ☐ For ☐ Against ☒ Information

Representing Florida Association of Health Plans

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/13/13
Meeting Date

Topic DRG's

Bill Number _____ *(if applicable)*

Name Paul Belcher

Amendment Barcode _____ *(if applicable)*

Job Title Senior Vice President

Address 306 East College Ave.
Street
Tallahassee, FLA. 32309
City *State* *Zip*

Phone 850-222-9800

E-mail paul@fha.org

Speaking: ☐ For ☐ Against ☑ Information

Representing Florida Hospital Association

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/13/13
Meeting Date

Topic DRG & Reimbursement Methodology GME's

Bill Number ——— *(if applicable)*

Name Tammy Perdue

Amendment Barcode _____ *(if applicable)*

Job Title General Counsel

Address 516 N. Adams St
Street

Phone 850-224-7173

Tallahassee FL 32301
City *State* *Zip*

E-mail tperdue@aif.com

Speaking: ☑ For ☐ Against ☐ Information

Representing Associated Industries of Florida

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

Feb 13 2013 (Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)
Meeting Date

Topic DRG

Bill Number DRG *(if applicable)*

Name Tony Carvalho

Amendment Barcode *(if applicable)*

Job Title President

Address 101 N. Gadsden

Phone 850 2012096

Street Tallahassee 32309

E-mail tkennedy@chqnet.com

City State Zip

Speaking: ☐ For ☐ Against ☑ Information

Representing

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/20/11)

CourtSmart Tag Report

Room: KN 412 **Case:** **Type:**
Caption: Senate Appropriations Subcommittee on Health and Human Services **Judge:**

Started: 2/13/2013 3:37:08 PM
Ends: 2/13/2013 5:29:36 PM Length: 01:52:29

3:37:11 PM Meeting called to order
3:37:18 PM Roll call
3:37:26 PM Chair Grimsley speaking
3:37:58 PM Tab 1: Presentation on Diagnosis Related Groups (DRGs) Conversion Implementation Plan
3:38:09 PM Justin Senior, Deputy Secretary for Medicaid, Agency for Health Care Administration
3:49:40 PM Malcolm Ferguson, Associate Director, Navigant
4:09:58 PM Tab 2: Presentation on Resource Utilization Groups (RUGs) Reimbursement Methodology for Long Term Care
4:10:15 PM Karen Zieler, Deputy Chief of Staff, Executive Office of the Governor
4:35:56 PM Tab 3: Agency Proposed Schedule VIIIB Reductions
4:36:56 PM Tonya Kidd, Deputy Secretary for Operations, Agency for Health Care Administration
4:38:35 PM Justin Senior, Deputy Secretary for Operations, Agency for Health Care Administration
4:53:30 PM Sharon Bradford, Deputy Director, Budget Planning & Administration, Agency for Persons with Disabilities
4:58:23 PM Jon Manalo, Chief Financial Officer, Department of Elder Affairs
5:09:40 PM Public Testimonies:
5:10:43 PM Tony Marshall, Senior Director of Reimbursement, Florida Health Care Association
5:15:47 PM Michael Garner, President & CEO, Florida Association of Health Plans
5:17:15 PM Paul Belcher, Senior Vice President, Florida Hospital Association
5:21:58 PM Tammy Perdue, General Counsel, Associated Industries of Florida
5:24:38 PM Tony Carvalho, President, SafetyNet Hospital Association
5:28:26 PM Adjourned