The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

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

MEETING DATE: Wednesday, January 15, 2014
TIME: 2:00 —4:00 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 Graduate Medical Education Funding Methodology by the Agency for Health Care Administration (AHCA)	Presented
2		Presentation on Quality Assessments by the Agency for Health Care Administration (AHCA)	Presented
3		Maintenance Adoption Research by the Office of Program Policy Analysis & Government Accountability (OPPAGA)	Presented
		Other Related Meeting Documents	

Graduate Medical Education/Statewide Residency Program Overview

Background:

Prior to July 1, 2013, Medicaid's inpatient per diem rate development methodology included costs associated with Graduate Medical Education (GME), although those costs were not specifically designated as such. There was no specific dollar amount appropriated in the budget for GME, but as those costs were part of the inpatient per diem rate, the expenditures were included in the total Hospital Inpatient services line item and were funded by a combination of General Revenue and Medical Care Trust Fund dollars.

During the 2013 Legislative Session the 2013-2014 General Appropriations Act (GAA) removed $52 million from the Hospital Inpatient Line, Specific Appropriation 208, to account for Graduate Medical Education. This $52 million was re-appropriated to line item 207A, Graduate Medical Education, and $28 million in additional funds were added for a total appropriation for GME of roughly $80 million.

In addition, Medicaid's 2013 Conforming bill, SB 1520, created the Statewide Medicaid Residency program to become effective July 1, 2013. The overall goal of the program is to improve the quality of care and access to care for Medicaid recipients, expand graduate medical education on an equitable basis, and increase the supply of highly trained physicians statewide. The bill also established a formula to distribute the appropriated funds to participating hospitals. These costs were excluded from the baseline used in establishing inpatient DRG payment rates, which also became effective July 1, 2013.

Reimbursement under Statewide Residency Program:

Statute requires the Agency to calculate an allocation fraction to be used for distributing funds to participating hospitals. This calculation must be made on or before September 15th of each year with the resulting distributions occurring on a quarterly basis throughout the fiscal year, with the first occurring by September 30th.

The allocation fraction formula is laid out in statute, in Sections 409.909(3) and (4), Florida Statutes:

(3) The agency shall use the following formula to calculate a participating hospital's allocation fraction:
HAF=[0.9 x (HFTE/TFTE)] + [0.1 x (HMP/TMP)]
Where:
HAF=A hospital's allocation fraction.
HFTE=A hospital's total number of FTE residents.
TFTE=The total FTE residents for all participating hospitals.
HMP=A hospital's Medicaid payments.
TMP=The total Medicaid payments for all participating hospitals.
(4) A hospital's annual allocation shall be calculated by multiplying the funds appropriated for the Statewide Medicaid Residency Program in the General Appropriations Act by that hospital's allocation fraction. If the calculation results in an annual allocation that exceeds $50,000 per FTE resident, the hospital's annual allocation shall be reduced to a sum equaling no more than $50,000 per FTE resident. The funds calculated for that hospital in excess of $50,000 per FTE resident shall be redistributed to participating hospitals whose annual allocation does not exceed $50,000 per FTE resident, using the same methodology and payment schedule specified in this section.

Graduate Medical Education/Statewide Residency Program Overview

The following definitions are provided by statute (Sections 409.909 (2), Florida Statutes):

> (a) "Full-time equivalent," or "FTE," means a resident who is in his or her initial residency period, which is defined as the minimum number of years of training required before the resident may become eligible for board certification by the American Osteopathic Association Bureau of Osteopathic Specialists or the American Board of Medical Specialties in the specialty in which he or she first began training, not to exceed 5 years. A resident training beyond the initial residency period is counted as 0.5 FTE, unless his or her chosen specialty is in general surgery or primary care, in which case the resident is counted as 1.0 FTE. For the purposes of this section, primary care specialties include:
> 1. Family medicine;
> 2. General internal medicine;
> 3. General pediatrics;
> 4. Preventive medicine;
> 5. Geriatric medicine;
> 6. Osteopathic general practice;
> 7. Obstetrics and gynecology; and
> 8. Emergency medicine.
>
> (b) "Medicaid payments" means the estimated total payments for reimbursing a hospital for direct inpatient services for the fiscal year in which the allocation fraction is calculated based on the hospital inpatient appropriation and the parameters for the inpatient diagnosis-related group base rate, including applicable intergovernmental transfers, specified in the General Appropriations Act, as determined by the agency.
>
> (c) "Resident" means a medical intern, fellow, or resident enrolled in a program accredited by the Accreditation Council for Graduate Medical Education, the American Association of Colleges of Osteopathic Medicine, or the American Osteopathic Association at the beginning of the state fiscal year during which the allocation fraction is calculated, as reported by the hospital to the agency.

The number of residents submitted by facilities is based on the amount of FTE residents enrolled at the facility as of July 1, 2013. The qualifying residents were to be in their initial residency period in which they are being trained, not to exceed 5 years. A resident training beyond the initial residency period is counted as 0.5 FTE, unless his or her chosen specialty is in general surgery or primary care, in which case the resident is counted as 1.0 FTE. The Agency will not be funding a designated number of residency slots, but rather distributing funds based on the allocation fraction.

After consultation with representatives of the industry, including the Safety Net Hospital Alliance of Florida and the Florida Hospital Association, the Agency sent a letter to all hospitals on August 22, 2013 (attached), requesting data to support the calculation of the required allocation fraction. All hospitals licensed under part 1 of the chapter 395 were eligible to submit data. The allocation fraction for each participating hospital is based on the hospital's submission of the number of full-time equivalent (FTE) residents. The following data was requested:

A.) List of residents by name, including:

- Each resident's unique number and specialty,
- The fraction of the year the resident will be in the facility, and
- Residency year.

B.) Copy of the Certification Letter for resident rotation location.

C.) Accreditation letters from the Council of Graduate Medical Education, American Association of Osteopathic Medicine or American Osteopathic Association.

The Agency did not dictate a specific format for submission of the required data. We have reviewed the initial submission formats and will craft a standard submission template for future use. Also, for future submissions, the Agency is evaluating other practices and is considering other mechanisms to ensure accuracy such as requiring the use of Social Security numbers as the unique resident identifier and having each resident sign an attestation that will also be signed by a hospital administrator. Residency data was weighted by the submitting hospitals in accordance with the statutory guidelines. Residents reported by the hospitals for a fraction of the year were counted as a fraction of an FTE. No additional weighting was done by the Agency.

The Agency reviewed submitted data for compliance with statutory accreditation requirements and for reasonableness. Total quarterly distribution under the statutory methodology for SFY 2013-2014 is $19,995,161. Two quarterly payments have been made to qualifying entities to date, on 9/17/13 and again on 12/11/13.

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

August 22, 2013

«PROVNAME»
«PRETITLE» «FNAME» «LNAME»
«ADD1» «ADD2»
«CITY», FL «ZIP»

Dear «PRETITLE» «LNAME»:

During the 2013 legislative session, the Agency was directed to implement the Statewide Medicaid Residency Program:

"The Statewide Medicaid Residency Program is established to improve the quality of care and access to care for Medicaid recipients, expand graduate medical education on an equitable basis, and increase the supply of highly trained physicians statewide. The agency shall make payments to hospitals licensed under part I of chapter 395 for graduate medical education associated with the Medicaid program. This system of payments is designed to generate federal matching funds under Medicaid and distribute the resulting funds to participating hospital on a quarterly basis in each fiscal year for which an appropriation is made."

The calculation will be based on the number of full-time equivalent (FTE) residents in their initial residency period in which they are being trained, not to exceed 5 years. A resident training beyond the initial residency period is counted as 0.5 FTE, unless his or her chosen specialty is in general surgery or primary care, in which case the resident is counted as 1.0 FTE. If you are a hospital licensed under part 1 of the chapter 395, you must submit the following data by September 6, 2013, to be considered in the distribution calculation:

A.) List of Residents by name enrolled at your facility as of July 1, 2013, and please also include the following:
- Each Resident's unique number,
- specialty,
- the fraction of the year the resident will be in your facility,
- and residency year.

B.) Copy of the Certification Letter for resident rotation location.
C.) Accreditation letters from the Council of Graduate Medical Education, American Association of Osteopathic Medicine or American Osteopathic Association.
D.) The submission should include your Medicaid ID number.

The Agency will calculate an allocation fraction to be used for distributing funds for qualified hospitals, and post the final distributions by September 15, 2013.

For more details on the Statewide Medicaid Residency Program plan refer to F.S. 409.909. If you have any further questions regarding the above, please call Lecia Behenna of my staff at (850) 412-4103.

Sincerely,

Tom J. Wallace
Bureau Chief for Medicaid Program Finance

TJW/nbm

Medicaid Quality Assessments

Background Information

Nursing Home and Hospice Rate Setting Overview:

Under the Florida Medicaid program nursing homes are reimbursed on a cost based reimbursement methodology. Rates are established semiannually based on each provider's historic cost of providing services. Medicaid pays a per diem (daily rate) for nursing facility care and treatment. The per diem covers most services and items furnished during a 24-hour period. Each rate setting, a single per diem rate is established for each facility based on five cost components: Operating, Direct Patient Care, Indirect Patient Care, Property, and Return on Equity, which is paid for all Medicaid patient days. Hospice rates are set based on the average nursing home rate in the area. Beginning July 1, 2005, legislatively mandated recurring annual reductions have been put in place on nursing home and hospice rates.

Quality Assessment Overview:

A Quality Assessment is a method of collecting revenue from specific provider types, including nursing homes, and using that revenue to draw down federal funds that are returned to the provider through increased Medicaid payments. Several states have used assessments to provide increased reimbursement to providers, while in Florida the assessments have been used to buy back annual reductions or rate reductions mentioned above. The maximum amount allowable to collect in assessments annually is determined by CMS and is currently 6% of the provider's net patient revenue. The 6% cap has been in place since October 2011. CMS can change the cap and prior to October 2011 the cap was set at 5.5% from January 2008 through September 2011.

It is important to note that hospice providers are not required to pay the assessment, but do benefit from the existence of the assessment for the nursing home program. Hospice rates are set based on the average nursing home rate in the area, so buying back the quality assessment nursing home rate reductions keep the rates higher which benefit hospice providers.

Statutory Authority:

During a Special Session of the Florida Legislature in January 2009, Senate Bill 8-A passed as Chapter 2009-4, Laws of Florida, creating the Quality Assessment on Nursing Home Facility Providers in section 409.9082, Florida Statutes. The effective date of the assessment was April 1, 2009.

Current Methodology

Determining Appropriations:

The annual appropriation is based on the most recent filed cost report for all providers. A calculation of the maximum budget authority allowed under Federal Regulations is performed by taking 6% of total net patient revenue for assessed providers as reported in the cost report

Medicaid Quality Assessments

Calculating Monthly Provider Assessment Payments:

The Agency uses Medicaid cost report data including Medicaid, Medicare, and Private Pay/Other days to calculate the per day assessment rates based on the appropriations amount. A different per day assessment rate is set once a year for each of 3 provider categories.

1) Exempt- Skilled Nursing Units, Continuing Care Retirement Communities, providers under 45 beds, and effective July 1, 2011 public nonstate-owned or operated nursing homes whose total annual indigent census days are greater than 20 percent of the facility's annual total days.
2) High volume- providers with annualized Medicaid days greater than 53,000.
3) Normal- all other providers.

Collection of Monthly Provider Assessment Payments:

The Agency has developed an online reporting application for nursing homes to submit required information each month. Each provider is required to report their actual Medicaid, Medicare, and Private/Other days to calculate their monthly payment amount and remit their total assessment due no later than the 15th of the following month.

Payments to Nursing Facilities:

Facilities pay an assessment on all of their non-Medicare days (Medicaid or Private Pay). Federal match is drawn down on the total assessment amount. A small administrative fee is deducted from the total payment. The assessment amount and the federal match is then distributed back to nursing home providers as follows:

- The assessment amount associated with the Medicaid days for each provider is returned to that specific provider.
- The federal funds are used to buy-back the Medicaid rate reductions, implemented on or after January 1, 2008, for all nursing home providers
- The assessment amount associated with the non-Medicaid days (Private pay) is used to increase the rate paid to all Medicaid nursing home facilities

Historical Appropriations:

The total amount of the appropriation based on the net patient revenue requirements for the last five years is as follows:

	Nursing Home/Hospice Appropriation
SFY 2009-10	295,713,017
SFY 2010-11	349,313,867

Medicaid Quality Assessments

SFY 2011-12	381,103,428
SFY 2012-13	411,627,360
SFY 2013-14	430,234,200

Discrepancy Identified in Reporting

The Agency uses cost report days including Medicaid, Medicare, and Private Pay/Other days to calculate the assessment rates. Providers self-report their Medicaid, Medicare, and Private Pay/Other days to the Agency's online reporting application in order for the Agency to calculate a specific monthly total assessment payment for each individual facility. The number of Medicare days being reported in the web application are significantly higher than what is being reported in the cost report. The difference in days is caused by providers reporting Medicare Advantage days on their nursing home cost report in the Private Pay/Other category but reporting Medicare Advantage days as Medicare days on the web application. This is causing the Agency to collect on fewer days than projected, which is used to establish the per diem rates, and total collections to be under the amount authorized in appropriations. This has caused General Revenue funds to be used to make up the shortfall.

Solution for Resolving Discrepancy:

The Agency will increase the per day assessment rate for January 2014 rate setting to make up for the amount not collected from July 1- December 31, 2013 as well as ensure collections going forward are in line with the appropriations amount. The Medicare days in the assessment model will also be adjusted to reflect the additional Medicare Advantage Days being reported to the online reporting application. Adjusting the days as well as the assessment rate would impact providers who have been reporting different days in their cost report versus the web application more than providers who have been reporting uniformly. This method has support by the Nursing Home Industry and would not be implementing a new assessment increase but rather a deferred collection for the time period of July 1 – December 31, 2013. An increase in assessment would not draw down additional federal match dollars because they have already been pulled down with general revenue funds. These additional assessment dollars collected would be spent in lieu of General Revenue. Hospice rates will not be impacted by this solution.

Intermediate Care Facility (ICF) Overview

ICF providers are reimbursed based on a cost based methodology. Rates are established semiannually on April 1 and October 1. Senate Bill 1658 created the Quality Assessment on privately owned ICF providers in section 409.9083, Florida Statutes and is effective October 1, 2009. The Agency calculates an assessment amount annually on a per-resident-day basis effective October 1. The rate is uniform for all privately owned ICF providers. Each provider reports monthly to the Agency its total number of resident days and remits an amount equal to the assessment rate times the reported number of days. Payment is due no later than the 15th of the next succeeding calendar month. Quality assessment funds are used to draw down federal funds that are returned to the provider through the Medicaid share of the assessment, restoring rate reductions, and increased payments to fund covered services to Medicaid beneficiaries.

Timing Difference between Appropriation and Collections (ICF)

The Agency requests the maximum budget authority for the assessment each fiscal year. This amount is used to set rates for the upcoming October rate semester and the following April rate semester. The updated per day assessment rate is only collected for 9 months of the fiscal year as the July, August, and September per day assessment rate is based on the prior fiscal year calculation.

This has caused collections to come in below the full authority in proviso. Due to the new assessment being collected for nine months and being used to set rates for only nine months the Agency does not believe there is an issue with the ICF assessment collection.

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The Department of Children and Families' Maintenance Adoption Subsidy Program

Justin Graham, Chief Legislative Analyst

January 15, 2014

Maintenance Adoption Subsidy Program

- What is the process for determining the amount of monthly adoption subsidy payments?
- What are the total annual expenditures for the Maintenance Adoption Subsidy Program, and what factors have contributed to their annual increase?
- How do other states determine maintenance adoption subsidy amounts?
- Can adoptive families recoup legal and other adoption-related expenses through federal tax credits?

Maintenance Adoption Subsidy Program

The federal Adoption Assistance and Child Welfare Act of 1980 established the Adoption Assistance Program

- Provides financial assistance to families that adopt children with special needs from foster care
- Financial assistance includes monthly adoption subsidies and non-recurring adoption expenses

Maintenance Adoption Subsidy Program

- Department of Children and Families administers the program
- Community-based care lead agencies determine the child's eligibility for assistance, the subsidy amount, and execute an adoption agreement with adoptive families

Maintenance Adoption Subsidy Program

Fiscal Year 2012-13

- 3,354 children were adopted from foster care
- 33,834 children received subsidy
- $150 million spent on subsidy program

Funding

- Federal Title IV-E adoption funds
- Temporary Assistance for Needy Families (TANF)
- General Revenue

What is the Process for Determining the Amount of Monthly Adoption Subsidy Payments?

- Federal and state laws and rules establish criteria
- Based on specific needs of the child and circumstances of adoptive family
  - Determined through negotiation with adoptive family
  - Cannot consider adoptive parents' income
  - Cannot exceed maximum foster care board rate
- Florida Statute establishes subsidy at $5,000 annually ($417 per month)
  - Lead agencies establish the amount at $417 or begin the negotiation process at this amount

What is the Process for Determining the Amount of Monthly Adoption Subsidy Payments?

- Adoptive families are informed about the availability of assistance
- Adoption workers:
  - Ask parents if willing and able to adopt without assistance
  - Determine child's eligibility
- Adoptive parents and a lead agency representative sign a formal, standardized adoption assistance agreement

What are the Annual Expenditures for the Adoption Subsidy Program?

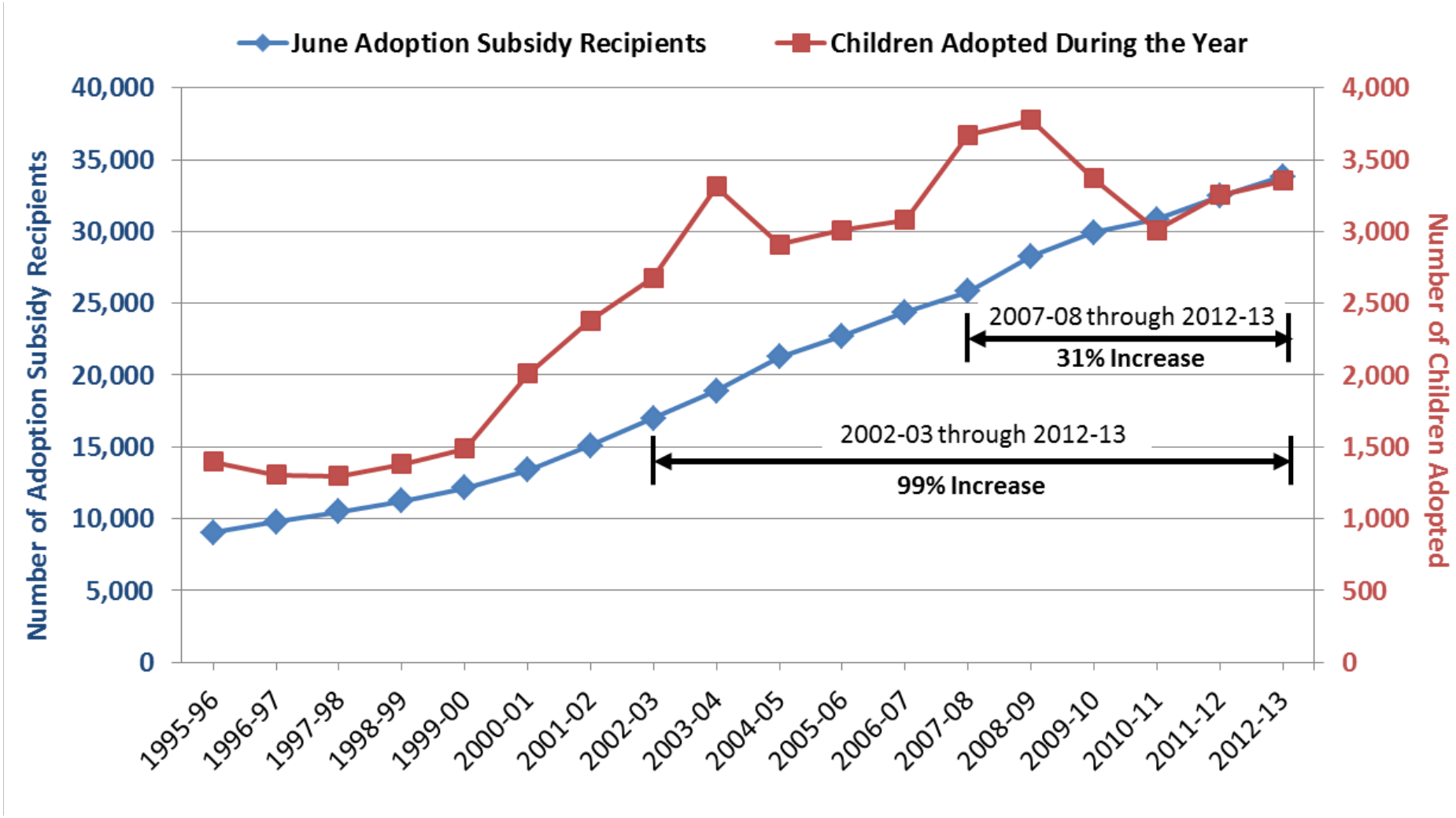
Expenditures increased 49% from Fiscal Year 2007-08 to Fiscal Year 2012-13

State Fiscal Year	Program Expenditures	Cumulative Percentage Change in Expenditures
2007-08	$101 million	
2008-09	113 million	10%
2009-10	125 million	22%
2010-11	133 million	30%
2011-12	142 million	39%
2012-13	150 million	49%

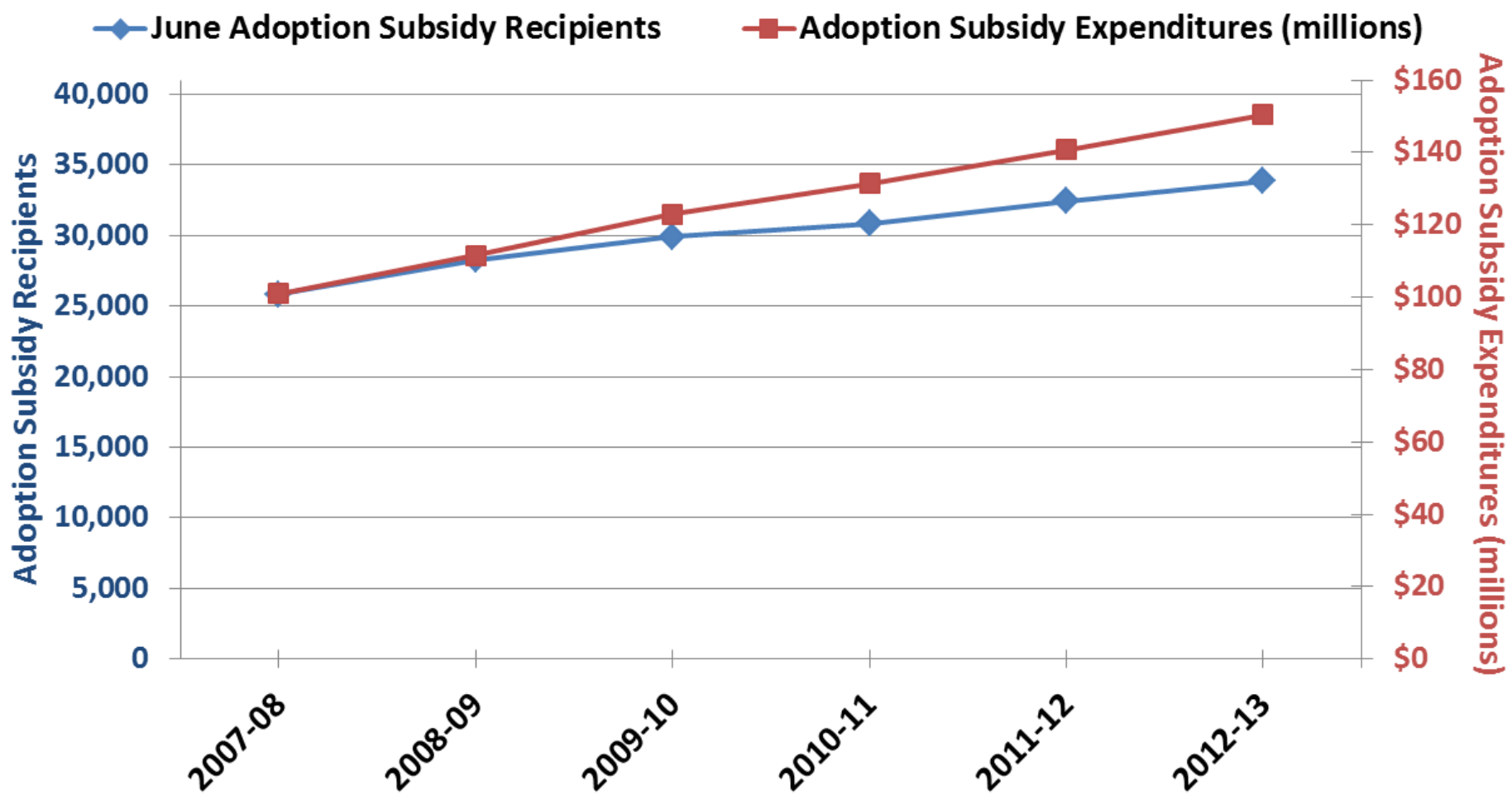
What Factors Contributed to Increases in Annual Expenditures?

- Two factors contributed to increases in annual adoption subsidy expenditures
  - The number of subsidy recipients
  - The average subsidy amount per recipient

The Number of Subsidy Recipients Increased



Average Subsidy Payments Increased



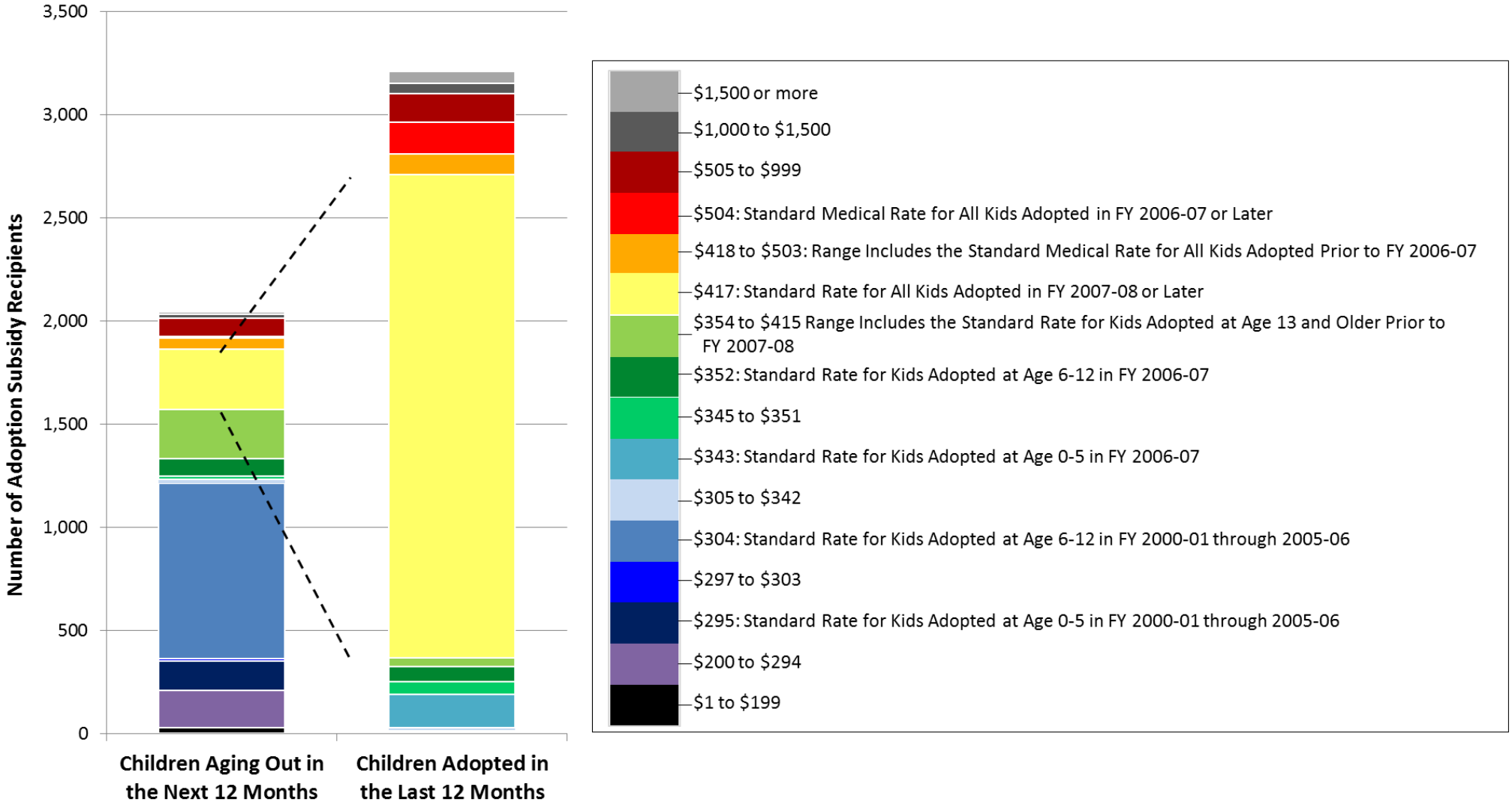
Average Subsidy Payments Increased

The standard subsidy amount increased twice in the last 13 years

Child's Age at Adoption	Standard Subsidy Payments		
	FY 2000-01 through FY 2005-06	FY 2006-07	FY 2007-08 through FY 2013-14
Birth to 5 Years Old	$295	$343	$417
6 Years Old to 12 Years Old	304	352	417
13 Years and Older	364	412	417
Adopted from Medical Foster Care	444	504	504

Average Subsidy Payments Increased

Children receiving lower subsidies are being replaced by children receiving higher subsidies



Adoption Subsidy Expenditures Will Likely Continue to Grow

- If current adoption trends continue, subsidy expenditures will continue to increase because
  - The number of subsidy recipients will continue to increase, and
  - The average subsidy payment will continue to increase

How Do Other States Determine Adoption Subsidy Amounts?

- Some states have taken steps to control adoption subsidy expenditures
  - Two states consider the adoptive family's income for state-funded subsidies (AK & LA)
  - Six states place limits on specialized or enhanced subsidy amounts for medically fragile children or children with mental health issues (AL, GA, LA, MD, MS & TN)
  - Four states attempted or have made modifications to their entire adoption subsidy program (IN, MI, NH & OR)

Can Adoptive Families Recoup Legal and Other Adoption-Related Expenses Through Federal Tax Credits?

- Adoptive families *cannot* claim adoption expenses on their tax returns if they have received any funds for non-recurring adoption expenses
- In Florida, the maximum amount for non-recurring adoption expenses is $1,000

Questions?

OPPAGA
research memorandum
THE FLORIDA LEGISLATURE'S OFFICE OF PROGRAM POLICY ANALYSIS & GOVERNMENT ACCOUNTABILITY

The Maintenance Adoption Subsidy Program

December 20, 2013

Summary

At the request of the Legislature, OPPAGA reviewed the Maintenance Adoption Subsidy Program to answer four questions.

1. What is the process for determining the amount of monthly adoption subsidy payments?
2. What are the total annual expenditures for the Maintenance Adoption Subsidy Program, and what factors have contributed to their annual increase?
3. How do other states determine maintenance adoption subsidy amounts?
4. Can adoptive families recoup legal and other adoption-related expenses through federal tax credits?

Background

The Adoption Assistance and Child Welfare Act of 1980, also known as Title IV-E of the Social Security Act, created a joint federal-state program to support children in foster care and adoptive families.[1] The act established the Adoption Assistance Program, which provides financial assistance to families that adopt children with special needs.[2] Financial assistance includes both non-recurring payments and monthly maintenance adoption subsidies. Non-recurring payments are intended to pay for the expenses associated with an adoption, such as attorney fees. Monthly subsidy payments are intended to assist adoptive parents with the extra costs associated with adopting a special needs child. The family receives monthly subsidy payments until a child's 18th birthday.

Florida funds its Adoption Assistance Program primarily with federal Title IV-E adoption funds.[3] For children who are not eligible for Title IV-E, federal Temporary Assistance for Needy Families (TANF) and state general revenue fund adoption assistance.[4] While federal laws and rules for adoption assistance apply only to Title IV-E funds, under Florida laws and rules they are also used to determine adoption assistance agreements funded with TANF and state general revenue.

The Department of Children and Families (DCF) administers Florida's Adoption Assistance Program; the amount of a maintenance adoption subsidy is determined at the local level by the department's 17 community-based care lead agencies. In Fiscal Year 2012-13, DCF finalized 3,354 foster child adoptions. In total, the department reported that 33,834 children received maintenance adoption subsidies in June 2013, which represents a 99% increase over the number of children who received the subsidies 10 years ago.

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[1] The Adoption Assistance and Child Welfare Act of 1980 (Public Law 96-272).

[2] Special needs children are those in the custody of the Department of Children and Families or a licensed, private child placing agency who have established significant emotional ties with their foster parents or are not likely to be adopted because they are at least eight years old; developmentally disabled; physically or emotionally handicapped; of black or racially mixed heritage; or a member of a sibling group being placed for adoption together.

[3] The state provides general revenue funds for required matching dollars for federal Title IV-E funds.

[4] States may establish state-funded adoption assistance programs for children who are not eligible under the federal Title IV-E adoption assistance program and have the flexibility under federal law and rules to set eligibility criteria for such programs, which vary by state.

What is the process for determining the amount of monthly adoption subsidy payments?

Federal and state laws and rules establish criteria for determining the subsidy amount. Federal policies stipulate that Title IV-E-funded adoption assistance is based on the specific needs of each child and the circumstances of his or her adoptive family, as determined through negotiations between the parents and a representative of the state agency.[5] Federal policies also restrict the monthly subsidy amount to the statewide maximum foster care board rate for which the child would have been eligible had the child remained in foster care. In 2007, the Legislature set Florida's maintenance adoption subsidy amount at $5,000 annually ($417 per month) or an amount other than $5,000 annually as determined by the adoptive parents and the department.[6] The majority of lead agencies reported either establishing the adoption subsidy amount at $417 or beginning the negotiation process at this amount.[7]

Children adopted from Medical Foster Care or Therapeutic Foster Care may have needs that require larger subsidies. For example, some families who adopt medically fragile children are eligible for enhanced payments to help defray the costs of expensive medical treatment. Lead agency officials reported that these children often require 24/7 supervision and care and would be institutionalized if not for being adopted.[8] Lead agencies approve subsidy amounts up to 100% of the statewide standard medical foster care board rate; agency adoption program specialists, the lead agency director, and the DCF regional director must approve higher subsidy amounts.

Lead agency adoption workers must inform adoptive families about the availability of adoption assistance and the purpose for which it is intended and ask if they are able and willing to adopt without a subsidy.[9] Several conditions must be met and documented for adoptive families to be eligible for the adoption subsidy.

- The child must meet all of the medical or disability requirements for Supplemental Security Income (SSI) or one or more of the state's criteria for a special needs child.
- The child's initial removal from his or her home and process for termination of parental rights must meet all judicial requirements.
- Unless the foster parent or a relative is adopting the child, there must be evidence that reasonable but unsuccessful efforts were made to adopt the child without assistance.

Adoption workers also determine whether the child is eligible for federal Title IV-E or TANF funds or general revenue funds.[10]

In documenting eligibility and subsidy amounts, lead agencies use DCF's standardized adoption agreement, which includes all federal and state requirements. Adoptive families must be informed that

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[5] Chapter 8.2D.4 of the federal Child Welfare Policy Manual provides that payment rates cannot exceed the amount the child would have received if he or she had been in a foster family home, but otherwise must be determined through agreement between the adoptive parents and the state or local Title IV-E agency. The document further states that unlike other public assistance programs in the Social Security Act, the Title IV-E Adoption Assistance Program is intended to encourage an action that will be a lifelong social benefit to certain children and that the adoptive parents' income is not relevant to the child's eligibility for the program.

[6] Section 409.166, *F.S.*

[7] Some lead agencies reported encouraging adoptive families to sign an adoption agreement with a zero subsidy amount. This allows the family to request a subsidy later should physical or psychological problems, not diagnosed at the time of the adoption, appear that require care or services beyond what the parents or Medicaid can provide.

[8] For example, a lead agency official told us that a child with profound developmental delays and a seizure disorder adopted in 2010 from Medical Foster Care receives an adoption subsidy of $2,730 per month.

[9] If the adoptive parents do not choose to request an adoption subsidy, they must sign a document that they were informed about the subsidy but decided not to submit a request; lead agency officials told us this is rare.

[10] DCF public assistance eligibility determination staff makes the final eligibility determination for Title IV-E and TANF funds.

they may request an increase in the subsidy amount after approval of the initial subsidy agreement if the child's needs increase or the circumstances of the adoptive family change. Subsidy agreements can only be modified with the concurrence of the adoptive family and can only be terminated under certain circumstances.[11]

What are the total annual expenditures for the Adoption Assistance Program, and what factors have contributed to their annual increase?

In Fiscal Year 2012-13, maintenance adoption subsidy expenditures totaled $150 million. From Fiscal Year 2007-08 through Fiscal Year 2012-13, expenditures for the Adoption Assistance Program increased 49%, from $101 million to $150 million.[12] (See Exhibit 1.) This increase is the result of more adoptions and increases in the amount of subsidy payments. (See Appendices A and B for additional information.)

Exhibit 1
Expenditures for the Adoption Assistance Program Have Increased 49% Since Fiscal Year 2007-08

State Fiscal Year	Adoption Assistance Program Annual Expenditures	Cumulative Percentage Change in MAS Expenditures
2007-08	$101 million	–
2008-09	113 million	10%
2009-10	123 million	22%
2010-11	131 million	30%
2011-12	140 million	39%
2012-13	150 million	49%

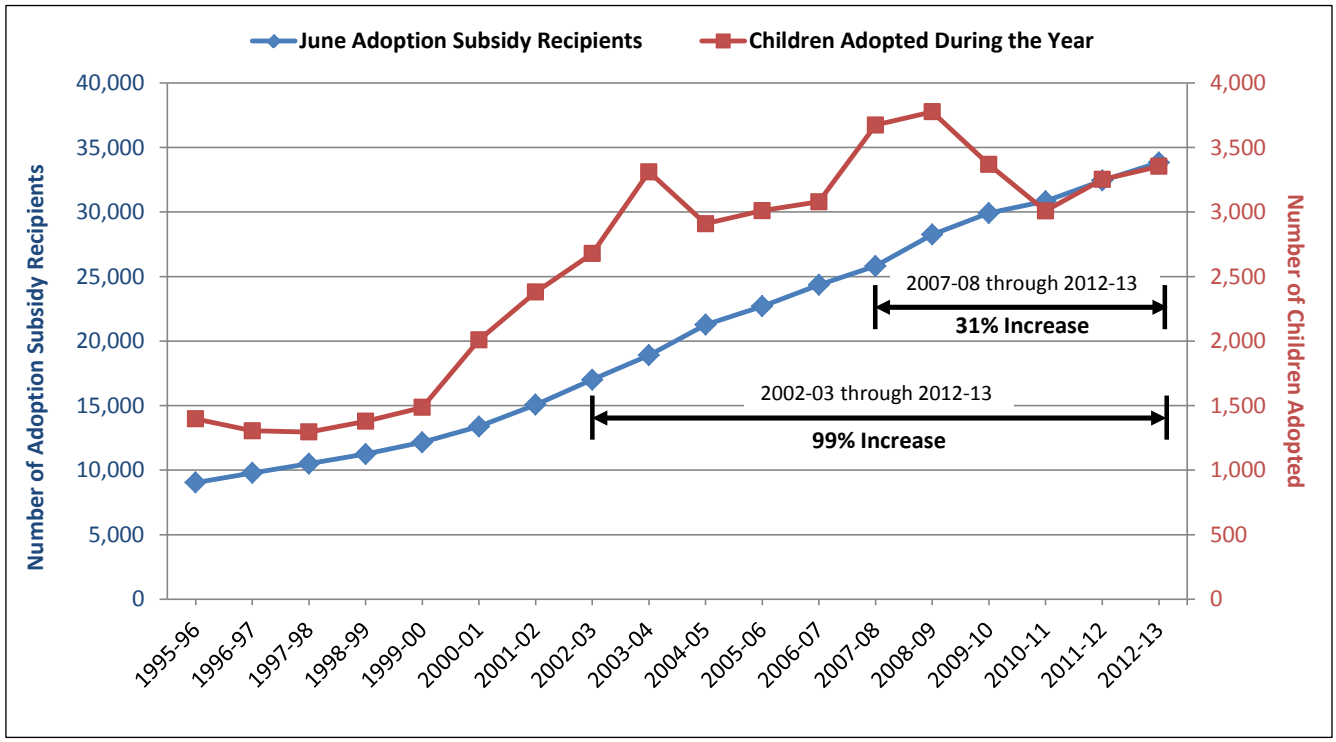
Source: Department of Children and Families.

An increase in adoptions is primarily responsible for the increase in Adoption Assistance Program expenditures. Adoptions have increased from approximately 1,500 in Fiscal Year 1999-00 to almost 3,400 in Fiscal Year 2012-13. As a result of these adoptions, the number of subsidy recipients has increased. Over the past 5 fiscal years (Fiscal Year 2007-08 through Fiscal Year 2012-13), the number of subsidy recipients increased 31%; over the past 10 fiscal years, the number of subsidy recipients increased 99%. (See Exhibit 2.) According to lead agency officials, adoption specialists are placing greater emphasis on adopting children once thought to be unadoptable, such as older children, children with mental and physical disabilities, and children with serious medical conditions.

[11] For a state to increase or reduce IV-E-funded subsidy payments, the foster care room and board rate would have to be increased or reduced statewide, thus raising or lowering the maximum subsidy amount. Adoption agreements terminate when the child dies, reaches 18 years of age, is emancipated, is no longer receiving support from the adoptive parents, or is no longer the legal responsibility of the adoptive parents.

[12] The Legislature appropriated $157 million for the Adoption Assistance Program for Fiscal Year 2013-14.

Exhibit 2
Increases in Adoptions Have Increased the Number of Adoption Subsidy Recipients



Source: OPPAGA analysis of Department of Children and Families data.

Increases in the standard subsidy amount have also contributed to growth in spending. The average subsidy payment increased from approximately $343 at the end of June 2008 to approximately $376 at the end of June 2013.[13] This increase is primarily due to changes in the standard subsidy amount for most families. (See Exhibit 3.)

Exhibit 3
The Standard Adoption Subsidy Amount Has Increased Over the Last 12 Fiscal Years

	Standard Subsidy Payments		
Child's Age at Adoption	FY 2000-01 through FY 2005-06[1]	FY 2006-07[1]	FY 2007-08 through FY 2013-14
Birth to 5 Years Old	$295	$343	$417
6 Years Old to 12 Years Old	304	352	417
13 Years and Older	364	412	417
Adopted from Medical Foster Care	444	504	504

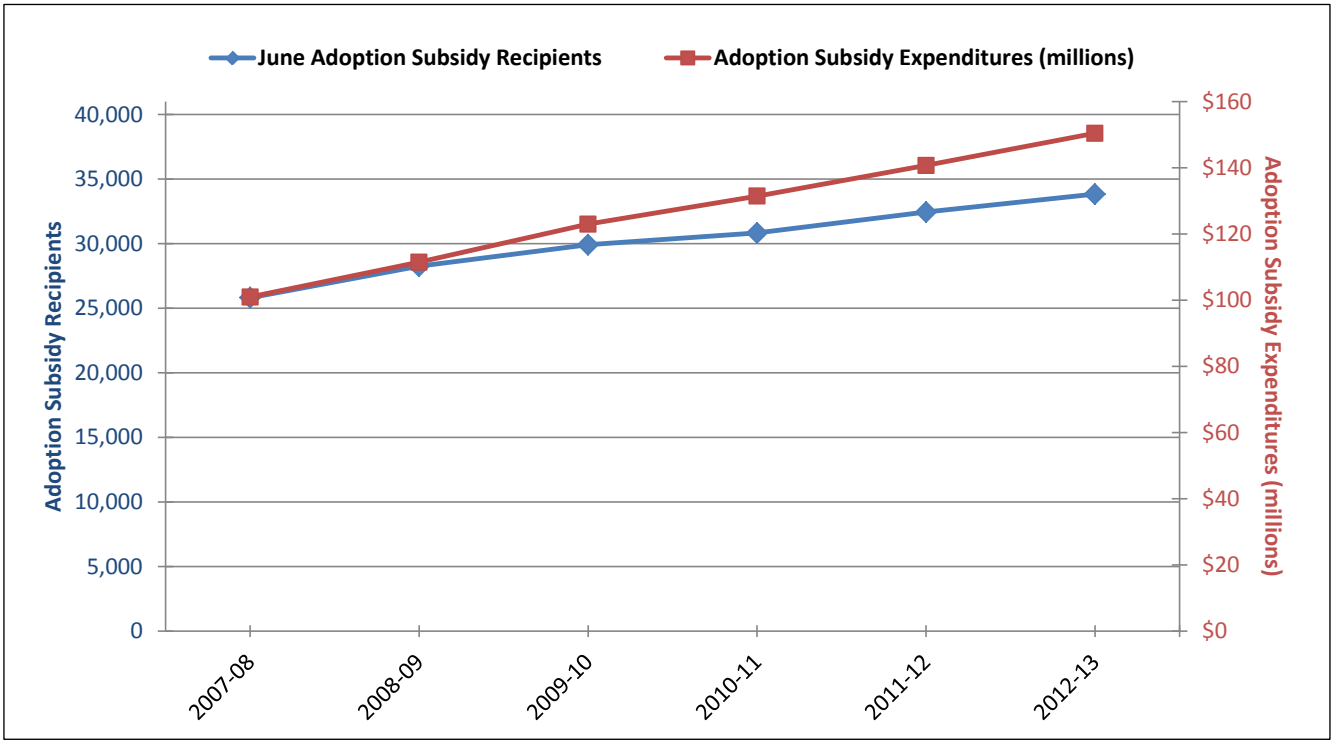
[1] These rates represent 80% of the maximum established foster care board rate during the specified years.

Source: Department of Children and Families.

[13] The average June subsidy payment amount includes some children who only received payment for part of the month and therefore may differ from the average monthly rate children receive for full-month subsidy payments.

Prior to July 2007, the standard subsidy amount was 80% of the maximum established foster care board rate. The Legislature increased the maximum foster care board rate in Fiscal Years 2000-01 and 2006-07.[14] In 2007, to increase the rate of adoptions, the Legislature established the subsidy amount at $5,000 annually, or $417 per month, which is higher than 80% of the foster care board rate for most children.[15] As shown in Exhibit 4, growth in adoption subsidy expenditures exceeded growth in the number of adoption subsidy recipients over the past five years. This indicates that part of the growth in adoption subsidy expenditures was due to increases in the expenditures per recipient.

Exhibit 4
Growth in Adoption Subsidy Expenditures Were Only Partly Due to Growth in the Number of Subsidy Recipients



Source: OPPAGA analysis of Department of Children and Families data.

Lead agency officials reported that most adoptive families do not renegotiate their subsidy rate after the child is adopted, even if the standard adoption subsidy amounts increase.[16] Therefore, as older children adopted under lower subsidy amounts turn 18 and stop receiving subsidies, children adopted under the new, higher subsidy rates will account for a greater percentage of subsidy recipients. (See Appendix B for details.)

[14] Prior to Fiscal Year 2000-01, the maximum foster care board rates were $350, $361, and $432 depending on the child's age. In Fiscal Year 2000-01, foster care board rates were raised 5% to $369, $380, and $455 depending on the child's age. In Fiscal Year 2006-07, board rates increased by $60 per month to the current rates of $429, $440, and $515.

[15] Three lead agency officials reported that it remains their agency's policy to give adopted children a subsidy amount that is 80% of the foster care board rate.

[16] For example, of children who were adopted in Fiscal Year 2004-05 and received a subsidy in June 2013, approximately 80% still receive the standard subsidy amount they would have received in 2004-05.

If the number of children adopted does not decline, adoption subsidy expenditures will continue to grow. If adoption trends continue, the number of subsidy recipients will continue to increase for several more years, because the number of children adopted will continue to exceed the number of children who turn age 18 and no longer receive a subsidy. For example, if the same number of adoptions occur in Fiscal Year 2013-14 as occurred in Fiscal Year 2012-13, approximately 3,354 children will start receiving a subsidy and approximately 2,090 children will stop receiving a subsidy, resulting in a net increase of 1,264 subsidy recipients. (See Appendix A, Exhibit A-2.) In addition, the average subsidy payment will continue to increase as children adopted under the standard amount of $417 become a larger share of subsidy recipients.[17] (See Appendix B, Exhibit B-3.)

However, for children eligible for Title IV-E adoption assistance payments, the state's share of subsidy expenditures should decrease. The 2008 federal Fostering Connections to Success and Increasing Adoptions Act revised Title IV-E adoption assistance eligibility criteria by gradually increasing the number of children eligible for Title IV-E adoption assistance payments. As a result, nearly all special needs children adopted after the start of federal Fiscal Year 2018 will be eligible for Title IV-E-funded adoption assistance.[18, 19]

How do other states determine maintenance adoption subsidy amounts?

Many states determine subsidy amounts in a manner similar to Florida. However, some states have taken other approaches, including means testing, reducing subsidy amounts, and capping specialized care subsidy amounts.

Two states consider the adoptive family's income when determining eligibility for state-only funded maintenance adoption subsidies. When determining the federal subsidy amount, federal guidelines prohibit states from considering income and other assets of the adoptive families, which is often referred to as means testing. Many states, including Florida, have chosen to operate their state-only funded subsidy program using the same guidelines. However, two states—Louisiana and Ohio—determine eligibility for the state-only funded maintenance adoption subsidy based on the adoptive family's income. In Louisiana, the payment amount may be appealed to the state office; in Ohio, there is no appeals process. In addition, Arkansas previously means tested its state-funded subsidy program but discontinued the practice in July of 2011.

Several states have made or attempted to make modifications to their adoption subsidy programs. In 2012, OPPAGA reported that four states (Indiana, Missouri, New Hampshire, and Oregon) had made or attempted to make modifications to their entire adoption subsidy program, not just the portion funded with state funds.[20] With the exception of implementing a waiting list for state-funded subsidies in Indiana, attempted modifications by Indiana, Missouri, and Oregon were legally challenged and found to be inconsistent with federal law and rule, and therefore, these changes were not implemented. In July 2011, New Hampshire repealed state rules related to adoption subsidies and made the state-funded program subject to appropriations; therefore, new adoptive families may or may not receive a subsidy. At the time of this review, this action has not been legally challenged. (See Exhibit 5.)

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[17] However, the number of children receiving subsidies should stop increasing approximately 17 years after the number of children adopted plateaus. The rapid growth in adoptions ended in Fiscal Year 2003-04. Therefore, if adoptions do not increase for another seven to eight years, growth in the number of children receiving subsidies should subside around Fiscal Year 2019-20.

[18] A small number of adoptive children may not be eligible because of federal eligibility criteria for Title IV-E that will remain in effect, such as citizenship and immigration status requirements.

[19] *Child Welfare: A Detailed Overview of Program Eligibility and Funding for Foster Care, Adoption Assistance and Kinship Guardianship Assistance Under Title IV-E of the Social Security Act*, Congressional Research Service, October 2012.

[20] *Maintenance Adoption Subsidy*, OPPAGA Memorandum, January 20, 2012.

Exhibit 5
Four States Have Attempted to Modify Their Adoption Assistance Program

State	Attempted Modification	Outcome
Indiana	▪ Place new adoptive families on waiting list for state-funded adoption subsidy payments	▪ Implemented – waiting list for state-funded subsidies in effect since 2009
	▪ Reduce per diem foster care rate and adoption subsidy amounts	▪ Not implemented – rate reductions legally challenged and a preliminary injunction was granted by the court
Missouri	▪ Require all adoption agreements to be renewed annually	▪ Not implemented – found to be in violation of federal law
	▪ Implement a means test for new and existing adoptive families	▪ Not implemented – found to violate the U.S. Constitution
New Hampshire	▪ Repealed statute and rule related to maintenance adoption subsidy	▪ Enacted July 1, 2011; no legal challenge to date
	▪ Effective July 1, 2011, the state-funded program is subject to appropriations; therefore, new adoptive families may not receive adoption subsidies under this funding source	
Oregon	▪ Implement a 7.5% reduction in adoption subsidy payments	▪ Not implemented – challenged in court and overturned

Source: OPPAGA analysis of information provided by state adoption officials and the North American Council on Adoptable Children.

In addition, two states (Maine and Washington) have modified their subsidy programs to reduce costs. During the 2013 legislative session, Maine enacted a one-time, three-month 25% reduction in the subsidy amount for state-funded subsides. Washington, effective July 1, 2013, changed the maximum subsidy amount to 80% of the foster care board rate for its entire adoption subsidy program.

States place limits on specialized or enhanced subsidy amounts. Foster care board rates are determined on a state-by-state basis; because the maximum subsidy amount is based on the foster care board rate the child would have received had the child remained in care, subsidy amounts vary by state. A state may have high foster care, medical foster care, and/or therapeutic foster care board rates, thus increasing the available maximum subsidy amount. We identified six states that cap specialized or enhanced rates for children who have been in medical or therapeutic foster care. (See Exhibit 6.)

Exhibit 6
Six States Cap Specialized or Enhanced Adoption Subsidy Rates

State	Cap of Specialized or Enhanced Adoption Subsidy Rate[1]
Alabama	Limits medically fragile adoption subsidy to $1,080 per month
Georgia	Limits adoption subsidies for children with mental health needs to the maximum family foster care rate (e.g., $487 for teenagers)
Louisiana[2]	Limits enhanced monthly adoption assistance payments to $258 per month in addition to the foster care board rate for children who have been in therapeutic or specialized foster care
Maryland	Limits medically fragile adoption subsidy to $2,000 per month
Mississippi	Limits medically fragile adoption subsidy to $900 per month and limits adoption subsidies for children with mental health needs to $700 per month
Tennessee	Limits extraordinary adoption assistance rates to $1,800 per month

[1] Florida's medically fragile rate can be $2,500 or more per month, and lead agencies often negotiate extraordinary adoption assistance rates at the special therapeutic foster care rate of up to $2,400 per month.

[2] For example, the rate for children in therapeutic or specialized foster care would be $659 per month ($401 adolescent foster care rate plus $258 in additional payments).

Source: OPPAGA analysis of other states' adoption subsidy program policies and procedures.

Can adoptive families recoup legal and other adoption-related expenses through federal tax credits?

The one-time federal adoption tax credit is available to families who adopt a special needs child. Since 2003, the federal adoption tax credit has been available to families who adopt a child with special needs from the foster care system, even if they have no adoption expenses.[21] Eligibility for the tax credit may depend on the family's income and other adoption benefits. As a tax credit, families do not receive a refund for adoption expenses; rather, the credit is subtracted from their tax liability. The adoption tax credit is available one time per child adopted.[22]

In addition to the federal adoption tax credit, because the Internal Revenue Service (IRS) has determined that adoption assistance payments are public welfare, adoptive parents are not typically required to include adoption assistance payments in their taxable incomes. Further, since the IRS recognizes that an adopted child is like any other child, adoptive parents may claim their child as a dependent and should be able to claim the child tax credit.

Adoptive families cannot claim expenses on federal tax returns if they have received Title IV-E adoption assistance funds for non-recurring expenses. The Title IV-E Adoption Assistance Program allows states to offer non-recurring adoption expenses to cover an adoptive family's adoption-related expenses. Adoption expenses may include home study fees, travel fees for the adoption, or legal fees. Federal guidelines set the maximum non-recurring adoption expense amount a state may provide an adoptive family at $2,000. In Florida, the maximum amount for non-recurring adoption expenses is $1,000.[23] According to lead agency officials, this amount covers legal fees and is paid directly to the attorney who handled the adoption. If families receive non-recurring payments, they cannot claim these payments for federal income tax purposes, because IRS regulations prohibit adoptive families from claiming adoption expenses for which they received funds under any local, state, or federal program.

[21] With the passage of the federal Fostering Connections to Success and Increasing Adoptions Act of 2008, states are required to inform adoptive families of the availability of the adoption tax credit.

[22] Congress made the federal adoption tax credit permanent in 2013.

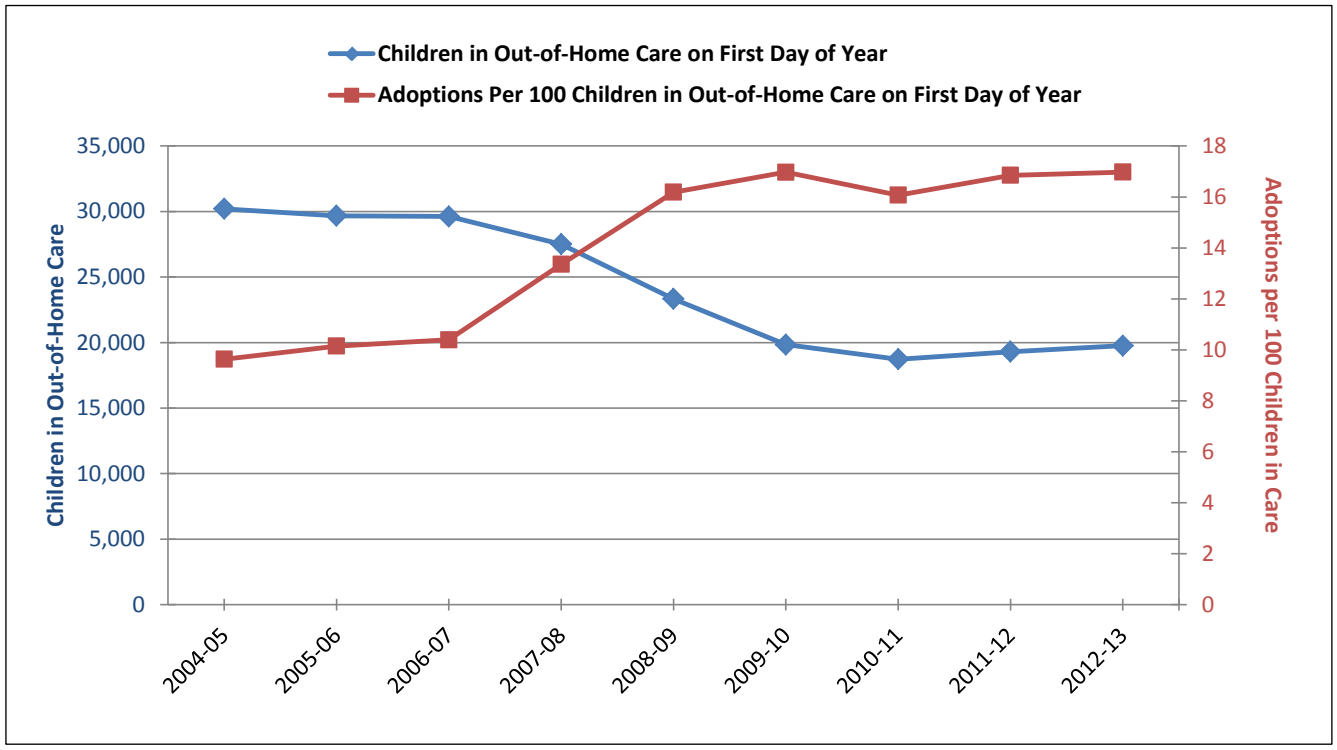
[23] The state waives the home study fees for adoptive families.

Appendix A

The Number of Children Adopted and the Number of Subsidy Recipients Has Increased as the Number of Children in Out-of-Home Care Has Decreased

As shown in Exhibit A-1, the child adoption rate has increased from Fiscal Year 2004-05 to Fiscal Year 2012-13, while the number of children in out-of-home care decreased 35% during this period.

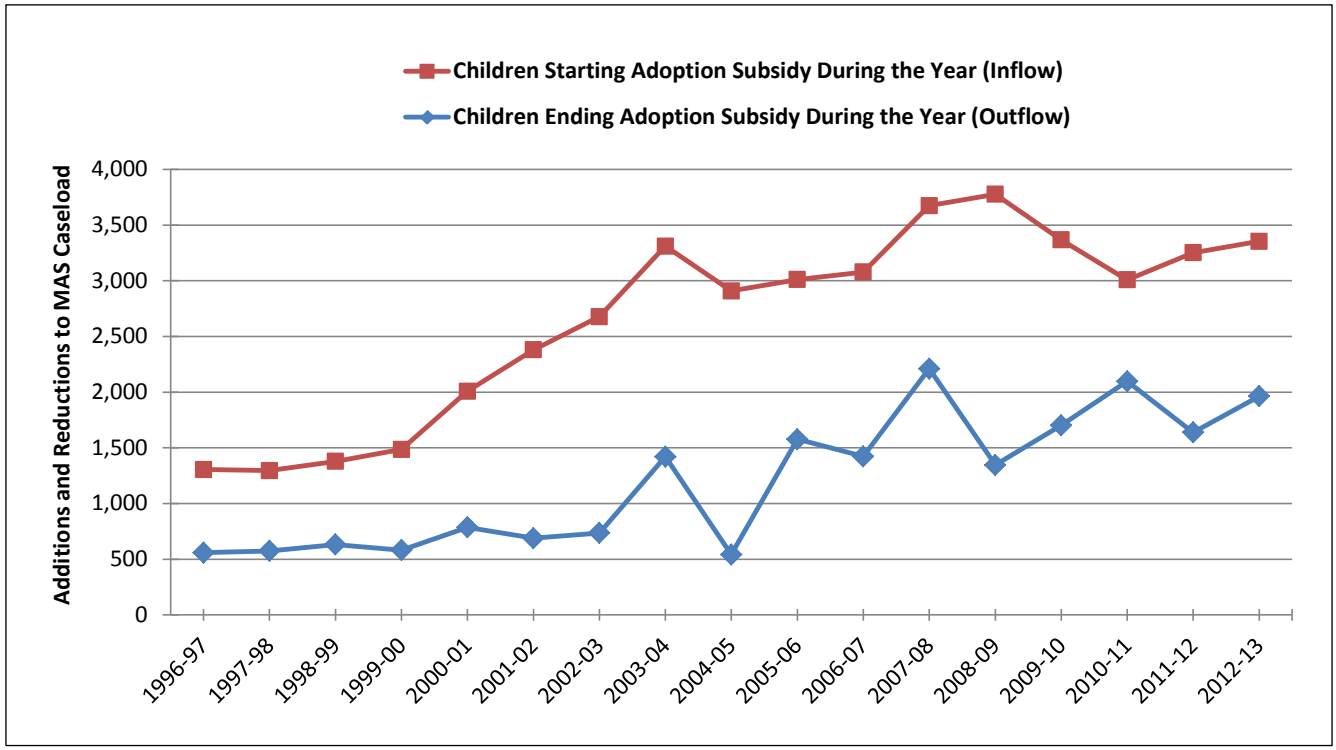
Exhibit A-1
Adoption Rates Have Risen as the Number of Children in Care Have Declined



Source: OPPAGA analysis of Department of Children and Families data.

As shown in Exhibit A-2, the number of children who began to receive a subsidy exceeded the number of children who stopped receiving a subsidy each year since Fiscal Year 1995-96 due to the high number of adoptions. If the number of children adopted each year remains at the current level, the outflow of children from the Adoption Assistance Program will eventually equal the inflow of children, thus halting the growth in the number of subsidy recipients.

Exhibit A-2
The Number of Adoption Subsidy Recipients Has Increased Due to Adoptions Exceeding Subsidy Terminations[1]



[1] According to department officials, nearly all children adopted during the year receive an adoption subsidy.

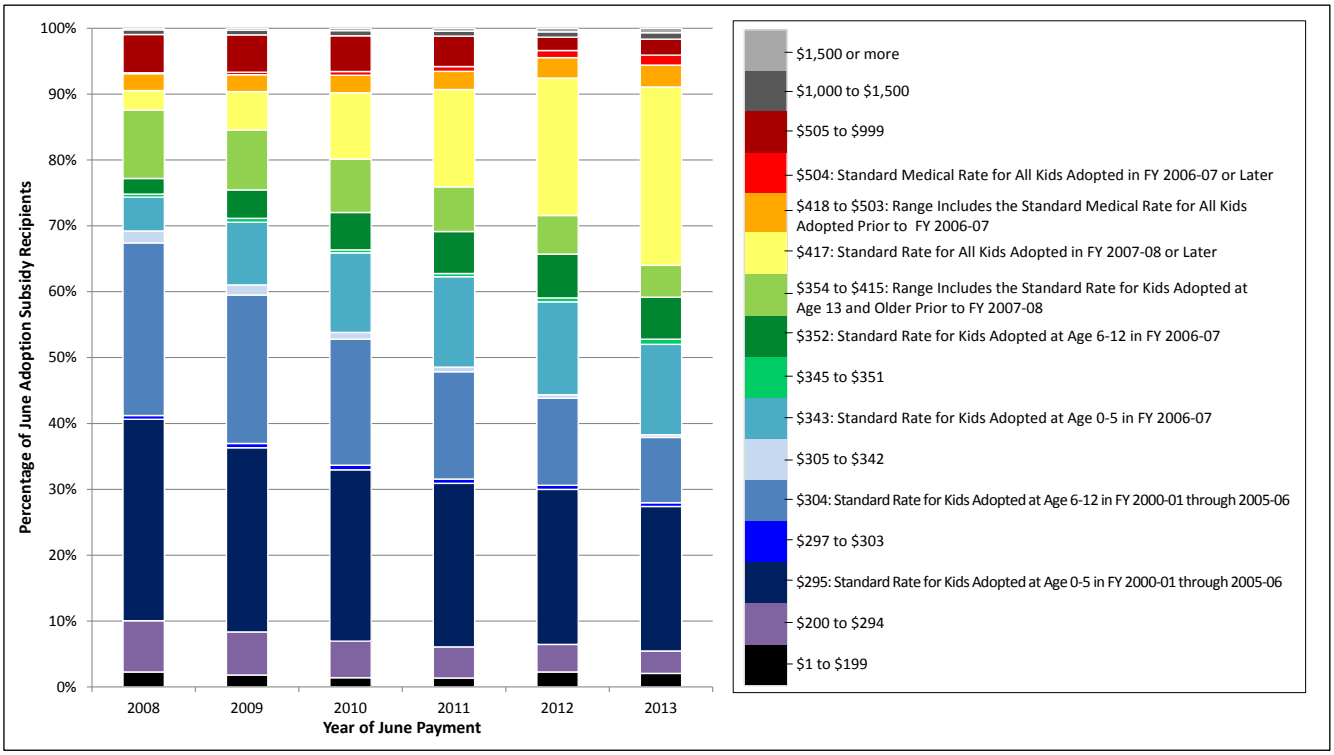
Source: OPPAGA analysis of Department of Children and Families data.

Appendix B

Increases in the Average Subsidy Payment Have Also Contributed to Growth in Adoption Subsidy Expenditures

As shown in Exhibit B-1, higher standard subsidies have contributed to the growth in adoption subsidy expenditures. Most of the growth is due to an increase in the share of children receiving $417 and a decrease in the share of children receiving the standard subsidy rate of 80% of the maximum established foster care board rate.

Exhibit B-1
Higher Standard Subsidies Have Become a Larger Share of all Subsidies Paid



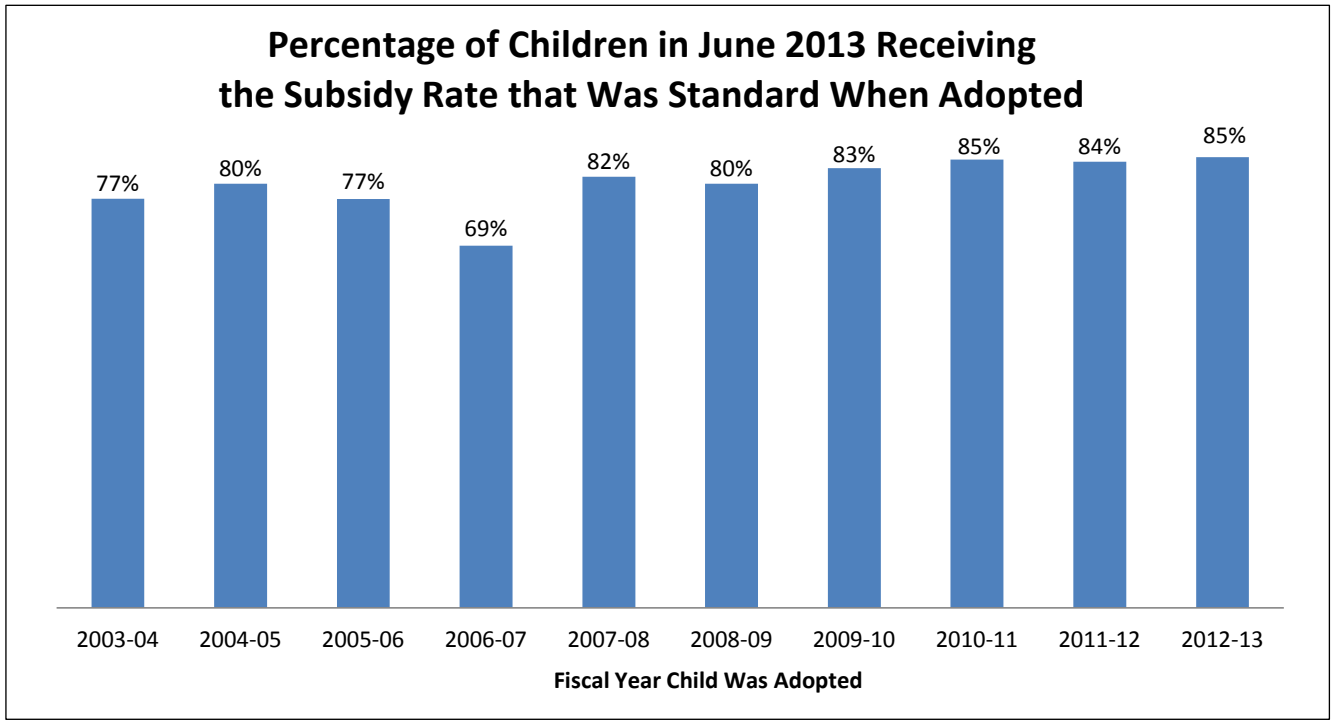
Source: OPPAGA analysis of Department of Children and Families' June adoption subsidy payment data.

In general, growth in the share of children receiving a subsidy of $417 is not due to renegotiation of existing subsidies when rates increased. Department officials reported that most adoptive families do not renegotiate their subsidy after the child is adopted, even if the rates increase; analysis of June 2013 subsidy payments supports this conclusion. Exhibit B-2 shows the percentage of children who received a June 2013 payment equal to the subsidy that was standard in the year in which the child was adopted.[24] Approximately 85% of children adopted in the last three years received a June 2013 payment equal to the subsidy at the time the child was adopted. Even though the rate has increased twice since Fiscal Year 2005-06, only a slightly lower percentage of children adopted during

[24] Due to delays in implementation of newly established rates, we determined that a child was receiving the rate that was standard at the time the child was adopted if the child received the rate for the year in which the child was adopted or the most recent prior rate.

Fiscal Years 2003-04 through 2005-06 continue to receive the rate that was standard at the time the child was adopted.[25] Implementation of the $417 rate took several years. For example, nearly half of the children adopted in Fiscal Year 2009-10 still receive the 80% of the foster care board rate that was in effect prior to Fiscal Year 2007-08, with only 37% receiving the rate established in Fiscal Year 2007-08 ($5,000 annually or $417 per month). In contrast, 73% of children adopted in Fiscal Year 2012-13 receive the Fiscal Year 2007-08 rate.

Exhibit B-2
Most Children Continue to Receive the Subsidy that Was Standard at the Time the Child Was Adopted

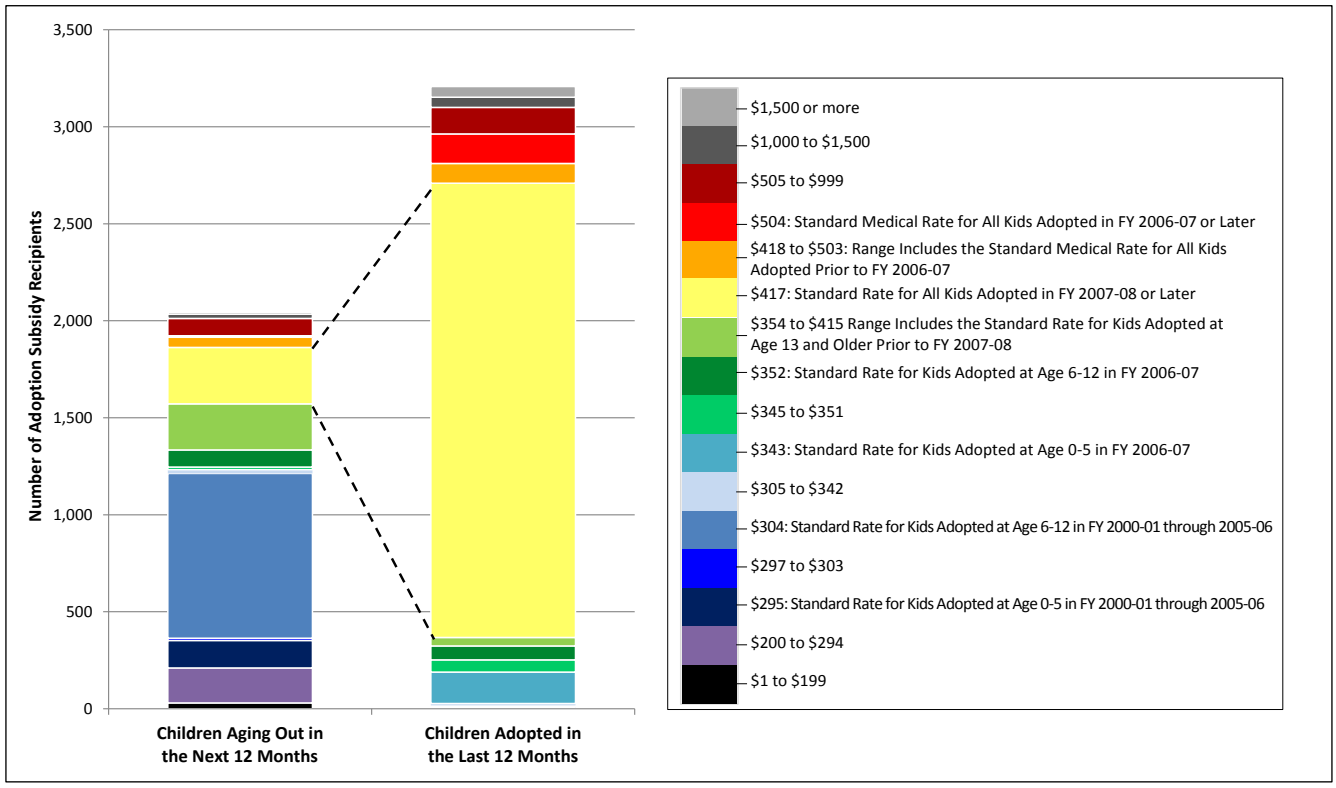


Source: OPPAGA analysis of Department of Children and Families' June 2013 adoption subsidy payment data.

[25] The established rate changed at the beginning and end of Fiscal Year 2006-07. The process of transitioning between three different sets of rates may explain why fewer children adopted in 2006-07 receive the rate that was technically in effect for that year.

As shown in Exhibit B-3, most of the growth in the average subsidy payments is due to children who received 80% of the board rate being replaced with children who are receiving the subsidy amount of $417. As children adopted under older, lower subsidy rates turn 18 and stop receiving a subsidy, children adopted under the new, higher subsidies account for a greater percentage of subsidy recipients.

Exhibit B-3
Children Who Have Received Lower Subsidies Are Being Replaced by Children Who Are Receiving Higher Subsidies



Source: OPPAGA analysis of Department of Children and Families' June 2013 adoption subsidy payment and adoptions data.

(1)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/15/14
Meeting Date

Topic Graduate Medical Education & Quality Assessments Bill Number _____ *(if applicable)*

Name Justin Senior Amendment Barcode _____ *(if applicable)*

Job Title Medicaid Director

Address 2727 Mahan Drive Phone 850-412-4007
Street

Tallahassee FL 32308 E-mail _____
City *State* *Zip*

Speaking: ☐ For ☐ Against ☒ Information

Representing Agency for Health Care Administration

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)

(2)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/15/14
Meeting Date

Topic Graduate Medical Education

Bill Number n/a *(if applicable)*

Name Lindy Kennedy

Amendment Barcode *(if applicable)*

Job Title Vice President

Address 101 N. Gadsden
Street
Tallahassee FL 32309
City *State* *Zip*

Phone 850 201-2096

E-mail lindy@snhafl.net

Speaking: ☑ For ☐ Against ☑ Information

Representing Safety Net Hospital Alliance of FL

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)

(3)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/15/14
Meeting Date

Topic DCF Maintenance Adoption Subsidy Program Bill Number _____ *(if applicable)*

Name Justin Graham Amendment Barcode _____ *(if applicable)*

Job Title Chief Legislative Analyst - OPPAGA

Address 111 W. Madison St, Suite 312 Phone 850-717-0508
Street

Tallahassee FL 32399 E-mail Justin.Graham@oppaga.fl.gov
City *State* *Zip*

Speaking: ☐ For ☐ Against ☑ Information

Representing OPPAGA

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

Tallahassee, Florida 32399-1100

COMMITTEES:
Communications, Energy, and Public Utilities, Vice Chair
Appropriations Subcommittee on Criminal and Civil Justice
Appropriations Subcommittee on Health and Human Services
Transportation
Health Policy
Agriculture
Transportation

JOINT COMMITTEE:
Joint Committee on Administrative Procedures

SENATOR RENE GARCIA
38th District

January 15, 2014

The Honorable Denise Grimsley
306 Senate Office Building
404 South Monroe Street
Tallahassee, FL 32399-1100

Dear Chairwoman Grimsley:

Due to a district concern I was resolving; I was not able to attend the Health and Human Services Appropriations Committee Meeting which was scheduled for Wednesday January 15, 2014. Please do not hesitate to contact my office if you have any questions. Thank you.

Sincerely,

State Senator René García
District 38
RG:dm

CC: Scarlet Pigott, Staff Director

REPLY TO:
❒ 2100 Coral Way, Suite 505, Miami, Florida 33145 (305) 643-7200
❒ 312 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5040

Senate's Website: *www.flsenate.gov*

DON GAETZ
President of the Senate

GARRETT RICHTER
President Pro Tempore

CourtSmart Tag Report

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

Started: 1/15/2014 2:03:15 PM
Ends: 1/15/2014 2:47:12 PM **Length: 00:43:58**

2:03:18 PM Call to Order
2:03:26 PM Roll Call
2:03:49 PM Chair Grimsley - Opening Remarks
2:04:12 PM Tab 1: Presentation on Graduate Medical Education Funding Methodology by the Agency for Health Care Administration (AHCA)
2:04:27 PM Justin Senior, Medicaid Director
2:10:35 PM Tab 2: Presentation on Quality Assessments by the Agency for Health Care Administration (AHCA)
2:10:51 PM Justin Senior, Medicaid Director
2:25:48 PM Tab 3: Maintenance Adoption Research by the Office of Program Policy Analysis & Government Accountability
2:26:22 PM Justin Graham, Chief Legislative Analyst
2:46:57 PM Meeting Adjourned